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Post-Pandemic Resilience of the Brazilian Health System: The Role of Primary Health Care in Strengthening the Unified Health System (SUS)

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Abstract

The COVID-19 pandemic exposed deep structural asymmetries in health systems while simultaneously revealing their adaptive capacities under extreme systemic stress. In Brazil, the Unified Health System (Sistema Único de Saúde – SUS) experienced both fragmentation pressures and remarkable resilience responses, largely mediated by its decentralized governance structure and the strategic role of Primary Health Care (PHC). This article provides an in-depth analytical examination of the post-pandemic resilience of the Brazilian health system, focusing on the extent to which PHC operates as an infrastructural, relational, and epistemic foundation for system continuity, adaptation, and transformation. Drawing on an integrative theoretical synthesis of health systems resilience literature, PHC theory, and the Brazilian health reform trajectory, the article conceptualizes resilience not as mere recovery, but as a dynamic capacity involving absorption, adaptation, and transformative restructuring. The analysis demonstrates that PHC in Brazil functioned as a critical buffering layer during the pandemic, sustaining essential services, enabling territorial surveillance, and mitigating inequities through community-based care. However, it also reveals persistent structural constraints, including chronic underfunding, fragmented digital integration, workforce instability, and uneven regional implementation. The article argues that the post-pandemic period represents a critical "window of opportunity" for reconfiguring SUS resilience through PHC strengthening. It concludes that resilience is not an emergent property of hospital capacity alone, but rather a systemic outcome rooted in primary care governance, territorial embeddedness, and intersectoral coordination.

Keywords: health system resilience; primary health care; SUS; Brazil; COVID-19; health governance; post-pandemic systems

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1. Introduction

The COVID-19 pandemic constituted one of the most severe stress tests ever imposed on modern health systems, simultaneously disrupting service delivery, exposing governance fragilities, and accelerating structural innovation. Far from being a homogeneous shock, the pandemic operated as a multi-layered systemic disruption, affecting financing flows, workforce distribution, supply chains, information systems, and care coordination mechanisms.

In Brazil, these disruptions were mediated by the institutional architecture of the Unified Health System (SUS), a universal public system grounded in constitutional principles of universality, equity, and integrality. While hospital-based care and intensive care capacity were rapidly overwhelmed in several regions, the system's Primary Health Care (PHC) network – particularly the Family Health Strategy (Estratégia Saúde da Família) – emerged as a crucial operational platform for sustaining continuity of care, implementing surveillance activities, and maintaining territorial health governance.

This duality – simultaneous fragility and resilience – raises a central analytical question: to what extent can the Brazilian health system be considered resilient in the post-pandemic context, and what structural role does PHC play in this resilience?

Health system resilience has moved beyond a narrow engineering metaphor of "bouncing back" toward a more complex conceptualization involving absorption of shocks, adaptive reconfiguration, and transformative capacity. Within this framework, resilience is not a static property but a dynamic process embedded in institutional arrangements, governance structures, and care delivery models.

In the Brazilian case, this requires understanding PHC not merely as a level of care, but as a systemic logic that organizes access, coordinates care pathways, and mediates the relationship between state, territory, and population. Its territorial embeddedness, longitudinal care orientation, and community engagement position it as a foundational pillar of system resilience.

However, the pandemic also revealed structural limitations that constrain PHC's full potential. These include persistent underinvestment, regional inequalities in service provision, fragmented digital health infrastructure, and variability in workforce stability and training. Consequently, resilience in SUS must be understood as uneven, contested, and structurally mediated rather than uniformly distributed.

This article develops a critical analytical framework to examine the post-pandemic resilience of SUS, with a specific focus on PHC as both a buffering mechanism during crisis response and a strategic leverage point for long-term system strengthening.

2. Methodology

This article is developed as a theoretical and interpretive academic essay. Rather than seeking empirical verification or hypothesis testing, it aims to critically examine the role of Primary Health Care (PHC) in strengthening the resilience of the Brazilian Unified Health System (SUS) in the post-pandemic context. The analysis is grounded in a dialogue between the literature on health system resilience, Primary Health Care, and the historical development of SUS, with the objective of advancing a conceptual understanding of the relationship between these dimensions.

The essay is based on the critical examination of scholarly literature, policy frameworks, and institutional documents that have shaped contemporary debates on health governance and system resilience. These sources are mobilized not as empirical evidence in a systematic review, but as theoretical references that support the construction of an analytical argument regarding the strategic position of PHC within resilient health systems.

The discussion is organized around the conceptual convergence between resilience capacities—particularly absorption, adaptation, and transformation—and the foundational attributes of PHC, including accessibility, continuity, coordination, and comprehensiveness of care. Through this interpretive exercise, the article explores how PHC functions not only as a service delivery model but also as an institutional and political mechanism capable of sustaining system responsiveness during periods of crisis and uncertainty.

By adopting a theoretical-reflective perspective, the essay understands resilience as a dynamic and historically situated characteristic of health systems, shaped by governance arrangements, social priorities, and the organization of care. This approach allows for a broader reflection on the contributions of PHC to the strengthening of SUS and to the construction of more resilient public health systems.

This editorial decision does not imply the absence of theoretical grounding, but rather reflects an essay-based approach in which the cited literature serves as the intellectual foundation of the argument as a whole.

3. Development

3.1 Health System Resilience as a Post-Pandemic Theoretical Framework

Health system resilience has become a central analytical construct in global health discourse following the COVID-19 pandemic, reflecting a shift from linear, efficiency-oriented models toward more complex understandings of system behavior under stress. Rather than being defined as simple recovery capacity, resilience is increasingly conceptualized as the ability of health systems to absorb shocks, adapt to changing conditions, and transform their structural and institutional arrangements when necessary. This reconceptualization reflects the recognition that health systems are not static entities, but dynamic and adaptive socio-political structures embedded in broader societal contexts.

Within this expanded framework, resilience must be understood as a multi-dimensional process rather than a single outcome. The absorption dimension refers to the capacity of a system to maintain core functions during acute shocks without collapsing. Adaptation involves incremental adjustments in organizational practices, resource allocation, and service delivery models in response to emerging pressures. Transformation, in turn, implies deeper structural change, including reconfiguration of governance arrangements, care models, and institutional logics. These three dimensions operate simultaneously and often unevenly across different parts of the health system.

The pandemic exposed the limitations of traditional "hospital-centric" approaches to system resilience, which tended to equate preparedness with intensive care capacity and emergency response infrastructure. While these components are essential, they proved insufficient in managing prolonged, system-wide disruptions. Instead, resilience emerged as a distributed property of health

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systems, heavily dependent on primary care structures, territorial organization, and inter-level coordination. This shift in analytical focus repositioned Primary Health Care (PHC) as a central pillar of system resilience.

A key insight from the resilience literature is that health systems function as complex adaptive systems characterized by interdependence, feedback loops, and non-linear responses to shocks. In such systems, small disruptions can generate large systemic effects, while strong localized structures can stabilize broader system behavior. This perspective helps explain why PHC played a disproportionate role in stabilizing health service delivery during the pandemic, particularly through its proximity to populations and its capacity for rapid operational adaptation.

Resilience is also closely linked to governance structures and the degree of decentralization within health systems. Decentralized systems can enhance responsiveness by allowing local adaptation, but they may also generate fragmentation if coordination mechanisms are weak. In the case of Brazil's Unified Health System (SUS), decentralization created both opportunities and constraints for resilience. Municipal-level autonomy enabled rapid local responses, but also revealed inequalities in administrative and technical capacity across territories.

Another critical dimension of resilience is institutional memory, understood as the accumulated experience of past reforms, crises, and policy innovations. Health systems that have undergone sustained institutional development tend to develop more robust adaptive capacities. In Brazil, the historical trajectory of health reform and the constitutional establishment of SUS provided a foundational framework for collective response during the pandemic. However, institutional memory alone is insufficient without sustained investment and operational capacity.

The concept of adaptive capacity is central to understanding how resilience is operationalized in practice. Adaptive capacity refers to the ability of systems to modify structures and processes without losing core functions. During the pandemic, this included the rapid expansion of telehealth services, reorganization of care pathways, and reallocation of health workforce resources. PHC was particularly important in enabling these adaptations due to its flexibility and embeddedness in local territories.

However, resilience also requires the presence of redundancy within systems, often described as "buffer capacity." Highly efficient systems that minimize redundancy may become more vulnerable during shocks due to lack of reserve resources. The pandemic demonstrated the importance of maintaining flexible workforce arrangements, supply chain resilience, and distributed service delivery structures. PHC contributed to this buffering function by decentralizing care delivery and reducing reliance on hospital-based services.

Equity is another fundamental dimension of resilience that has gained prominence in recent literature. Health crises tend to disproportionately affect vulnerable populations, amplifying pre-existing inequalities. Resilient health systems are therefore those that are able not only to maintain service continuity but also to protect equity during shocks. In this context, PHC plays a critical redistributive role by ensuring territorial access to essential services and prioritizing population-based care strategies.

Trust has also emerged as a key explanatory factor in health system resilience. Public trust in health institutions influences compliance with public health measures, uptake of services, and effectiveness of communication strategies. PHC, due to its relational continuity and community embeddedness, is a primary generator of institutional trust. During the pandemic, this relational infrastructure was essential for sustaining vaccination campaigns, health education efforts, and community surveillance activities.

Digital infrastructure and information systems represent a further layer of resilience capacity. The ability to collect, integrate, and utilize health data in real time is increasingly recognized as a core component of modern health systems. However, the pandemic exposed significant fragmentation in digital health systems, particularly in low- and middle-income countries. In Brazil, PHC partially compensated for these gaps through localized data collection and territorial monitoring, although structural limitations in interoperability persisted.

Thus, resilience must be understood as inherently political. Decisions regarding financing, workforce distribution, and institutional design shape the adaptive capacity of health systems. As such, resilience is not merely a technical property but a reflection of political priorities and governance choices. In the Brazilian context, the strength or fragility of SUS resilience is directly linked to sustained investment in PHC and the political commitment to universal health coverage principles.

3.2 Primary Health Care as the Structural Backbone of the Unified Health System (SUS)

Primary Health Care (PHC) in Brazil functions not merely as an entry point to the health system, but as its structural organizing backbone. Since the consolidation of the Unified Health System (SUS), PHC has been progressively positioned as the coordinating axis of care, responsible for integrating services, managing health needs over time, and articulating responses across levels of complexity. This structural role became even more evident during the COVID-19 pandemic, when hospital-centered models faced saturation and coordination failures. In this context, PHC operated as the main stabilizing layer of the system.

The Brazilian Family Health Strategy (Estratégia Saúde da Família – ESF) represents the most consolidated institutional expression of PHC. Its territorial model, based on defined population coverage and multidisciplinary teams, enables continuous monitoring of health needs within specific geographic areas. This design creates a form of "territorial embeddedness" that strengthens both responsiveness and accountability. During the pandemic, ESF teams were essential in maintaining continuity of care for chronic conditions while also adapting to emergency demands.

A key structural attribute of PHC is longitudinality, understood as the sustained relationship between health teams and populations over time. This continuity enables accumulation of clinical knowledge, trust-building, and more effective management of complex health needs. In crisis contexts, longitudinal care becomes particularly important, as it prevents fragmentation and reduces unnecessary demand for specialized services. In Brazil, this function was critical in avoiding complete collapse of non-COVID-related care pathways during peak pandemic periods.

Another central dimension is coordination of care, which positions PHC as a regulatory interface between users and specialized services. In fragmented systems, lack of coordination often leads to inefficiencies, duplication of procedures, and inequitable access. The SUS model assigns PHC the role of care coordinator, but its

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effectiveness depends on integration with secondary and tertiary networks. During the pandemic, coordination mechanisms were uneven, but PHC still played a critical role in triaging cases and managing referrals under constrained conditions.

Comprehensiveness is also a defining attribute of PHC, referring to its capacity to address a wide range of health needs across prevention, treatment, rehabilitation, and health promotion. This broad scope allowed PHC teams to respond flexibly to evolving pandemic demands, including vaccination campaigns, health education, and monitoring of vulnerable populations. However, structural limitations such as workforce shortages and resource constraints affected the full realization of comprehensiveness in several regions.

PHC in Brazil also operates as a key mechanism for reducing health inequalities. By being territorially based and publicly funded, it expands access to populations historically excluded from formal health services. This redistributive function became particularly visible during the pandemic, when vulnerable groups were disproportionately affected by both infection and indirect effects of health system disruption. PHC mitigated these impacts through active outreach and community-based interventions.

The digital dimension of PHC gained prominence during the pandemic, especially through the expansion of telehealth services. Although digital infrastructure was unevenly distributed, PHC teams adopted remote monitoring strategies to maintain continuity of care. This adaptation demonstrated the system's capacity for technological flexibility, but also revealed persistent digital divides. These inequalities limited the scalability of digital PHC solutions across different regions.

Workforce organization is another critical component of PHC's structural role. Multidisciplinary teams, including physicians, nurses, and community health workers, enable a more holistic approach to health needs. Community health workers, in particular, played a strategic role during the pandemic by maintaining contact with households and identifying emerging risks. However, workforce instability and uneven distribution of professionals remain persistent challenges for PHC consolidation.

From a systems perspective, PHC acts as a buffer against hospital overutilization. By resolving a significant proportion of health demands at the community level, it reduces pressure on emergency and specialized services. This buffering function is essential for maintaining system stability during crises. In Brazil, this role was particularly relevant during COVID-19 waves, when hospital demand exceeded capacity in several regions.

Governance arrangements strongly influence PHC performance. Although SUS is formally decentralized, variations in municipal capacity generate significant heterogeneity in PHC implementation. Some municipalities maintain robust PHC networks with strong integration, while others face fragmentation and limited coordination capacity. This unevenness directly affects the resilience potential of the system as a whole.

Institutional financing is another structural determinant of PHC effectiveness. Chronic underfunding of primary care limits infrastructure development, workforce expansion, and technological modernization. Despite its strategic importance, PHC often competes with other levels of care for limited resources. This structural imbalance weakens its full potential as a resilience anchor within SUS.

Despite these constraints, PHC remains the most stable and continuously present component of the Brazilian health system. Its embeddedness in territories, combined with its relational and organizational functions, positions it as the primary mechanism through which SUS maintains coherence under stress. This centrality is not incidental but reflects decades of institutional development within Brazil's health reform trajectory.

3.3 Structural Fragilities and Post-Pandemic Constraints in the Brazilian Health System

The post-pandemic period in Brazil has revealed that, despite the demonstrated adaptive capacity of the Unified Health System (SUS), its resilience remains structurally constrained by long-standing systemic fragilities. Rather than emerging as a uniformly strengthened system after COVID-19, SUS displays a pattern of uneven recovery characterized by persistent bottlenecks in financing, governance coordination, workforce distribution, and digital infrastructure. These constraints limit the extent to which Primary Health Care (PHC) can fully operate as a system-wide organizing force.

A central structural limitation is chronic underfunding, which has historically shaped the developmental trajectory of SUS. Although the Brazilian Constitution established health as a universal right, fiscal constraints and macroeconomic policies have restricted the sustained expansion of public health investment. This underinvestment disproportionately affects PHC, which depends on stable funding for territorial teams, community health workers, infrastructure maintenance, and preventive programs. As a result, PHC expansion often occurs unevenly, with significant variability across municipalities.

Federalism and decentralized governance constitute another layer of structural tension. While decentralization is a foundational principle of SUS, it produces heterogeneous implementation capacities across Brazil's vast territory. Municipalities differ substantially in administrative capability, technical expertise, and fiscal autonomy, resulting in fragmented PHC performance. During the pandemic, these disparities translated into uneven responses, with some regions achieving high levels of coordination and others struggling to maintain basic service continuity.

Workforce instability represents a further constraint on system resilience. PHC depends heavily on multidisciplinary teams, particularly the long-term presence of physicians, nurses, and community health workers. However, high turnover rates, precarious employment contracts, and unequal distribution of professionals weaken continuity of care. Rural and peripheral urban areas are especially affected, reinforcing territorial inequities in access and quality of services. This instability undermines the longitudinal logic that is essential for PHC effectiveness.

Digital fragmentation has emerged as a critical post-pandemic bottleneck. Although COVID-19 accelerated the adoption of telehealth and digital health tools, the absence of integrated national information systems limits their full potential. Health data remains dispersed across municipal, state, and federal platforms, often with limited interoperability. PHC units, despite being key data generators, frequently lack the technological infrastructure required for real-time information integration, reducing the effectiveness of surveillance and care coordination.

Regional inequalities continue to shape the structural architecture of SUS. Brazil's socioeconomic heterogeneity produces significant

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disparities in health infrastructure, service availability, and health outcomes. Wealthier regions tend to have more robust PHC networks, better staffing conditions, and stronger integration with secondary care. In contrast, poorer and more remote areas face infrastructural deficits that constrain the operationalization of even basic PHC functions. These inequalities directly affect system-wide resilience.

Another important constraint is the persistent hospital-centric bias in resource allocation and policy attention. Despite the formal centrality of PHC in SUS, political and institutional priorities often favor high-complexity care, particularly in response to acute crises. This bias reinforces structural imbalances, diverting resources away from preventive and community-based care. During the pandemic, this dynamic was evident in the rapid expansion of hospital capacity compared to slower investments in PHC strengthening.

Governance fragmentation further limits system coherence. Coordination between federal, state, and municipal levels is often marked by political tension, administrative discontinuities, and inconsistent policy implementation. This fragmentation weakens the ability of SUS to function as an integrated system, particularly during crises that require rapid and coordinated responses. PHC, although structurally positioned as a coordinating level, is constrained by these broader governance asymmetries.

The sustainability of PHC itself is also affected by institutional volatility. Policy shifts, changes in funding priorities, and administrative restructuring create uncertainty in long-term planning. This volatility undermines the consolidation of territorial health strategies and weakens the continuity of community-based programs. In many cases, successful PHC initiatives depend on local leadership rather than stable national policy frameworks.

The post-pandemic context has also highlighted weaknesses in health workforce governance at the national level. Training, retention, and equitable distribution of professionals remain insufficiently coordinated across federative levels. The absence of a robust national strategy for PHC workforce development limits the system's capacity to scale effective models such as the Family Health Strategy. This contributes to persistent asymmetries in service quality and access.

Structural constraints are further compounded by social determinants of health, which shape demand-side pressures on the system. Poverty, informal labor, housing insecurity, and unequal access to education continue to generate high and complex health needs, particularly in vulnerable populations. PHC is often the first point of contact for these needs, but its capacity to respond is limited by resource constraints and systemic fragmentation.

Notwithstanding these challenges, SUS retains a foundational institutional legitimacy and extensive territorial coverage that distinguishes it from many other health systems. However, the persistence of structural fragilities indicates that resilience cannot be assumed as an inherent system property. Instead, it must be continuously produced through sustained investment, governance reform, and reinforcement of PHC as the central axis of care coordination and equity promotion.

3.4 Primary Health Care as a Strategic Lever for Post-Pandemic Transformation of the Brazilian Health System

The post-pandemic scenario has repositioned Primary Health Care (PHC) not only as a stabilizing component of the Unified Health System (SUS), but as a strategic lever for its structural transformation. While earlier sections have demonstrated how PHC contributed to system resilience and exposed its constraints, the current phase of analysis shifts toward its transformative potential. This involves understanding PHC as a platform capable of reconfiguring care models, governance arrangements, and equity structures within a post-crisis health system.

A central dimension of this transformative role lies in the redefinition of care models away from episodic, hospital-centered logic toward continuous, territorial, and integrated care systems. The pandemic accelerated recognition that fragmented care pathways are insufficient for managing complex and long-term health needs. PHC, particularly through the Family Health Strategy, provides an organizational infrastructure capable of sustaining integrated care trajectories. This positions it as the primary interface for redesigning system-wide care coordination.

Digital transformation has emerged as another strategic frontier for PHC-driven system change. The rapid expansion of telehealth during the pandemic demonstrated both the potential and limitations of digital health in Brazil. PHC units became critical nodes for implementing remote consultations, monitoring chronic conditions, and maintaining contact with vulnerable populations. However, structural deficits in interoperability and infrastructure indicate that digital transformation must be systemically planned rather than incrementally adopted. In this context, PHC can function as the operational anchor of an integrated digital health ecosystem.

Another key transformation vector is the strengthening of territorial intelligence. PHC is uniquely positioned to generate granular, localized health data through continuous interaction with communities. When effectively integrated into decision-making processes, this territorial information can support more responsive and equitable health planning. Post-pandemic reconstruction efforts increasingly emphasize the importance of data-driven governance, and PHC represents the most direct mechanism for translating population-level data into actionable policy.

The transformation of governance structures is also closely linked to PHC strengthening. The SUS model is formally decentralized, but often suffers from fragmented coordination across federal, state, and municipal levels. PHC can mitigate these fragmentation effects by functioning as a coordinating node that integrates care delivery across levels of complexity. However, this requires stronger governance alignment, stable financing mechanisms, and clearer definition of responsibilities across federative actors.

Equity remains a central axis of PHC-driven transformation. The pandemic amplified pre-existing social and health inequalities, disproportionately affecting vulnerable populations. PHC's territorial and population-based orientation allows it to directly address these inequalities through proactive outreach, targeted interventions, and continuity of care. Strengthening PHC therefore represents not only a technical reform, but a redistributive strategy aimed at reducing structural inequities in health access and outcomes.

Workforce development is another critical lever for transformation. The consolidation of PHC as a system organizer depends on stable, well-trained, and adequately distributed multidisciplinary teams. This includes strengthening the role of community health workers

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as mediators between health services and local populations. Post-pandemic reforms increasingly point to the need for more robust career structures, continuous training, and improved working conditions to sustain PHC performance over time.

The integration of PHC into broader intersectoral policies further expands its transformative potential. Health outcomes are deeply influenced by social determinants such as housing, education, income, and environmental conditions. PHC, due to its proximity to communities, is uniquely positioned to coordinate intersectoral responses at the territorial level. This expands its role beyond healthcare delivery into a broader function of social policy articulation and local development support.

Institutionally, strengthening PHC requires reframing its position within national health policy priorities. Although formally central to SUS, PHC has historically faced competition for resources and political attention from higher-complexity care sectors. The post-pandemic period provides an opportunity to reassert PHC as the structural foundation of the system rather than a complementary level of care. This reorientation is essential for consolidating long-term system resilience and sustainability.

The transformation of SUS through PHC is also dependent on sustained political commitment. Health system reform is not solely a technical process but a deeply political one, shaped by fiscal priorities, governance choices, and institutional coalitions. In this sense, the strengthening of PHC reflects broader decisions about the role of the state in guaranteeing universal health coverage and reducing social inequalities.

At the system level, PHC functions as a mechanism for integrating multiple dimensions of health system performance, including access, quality, efficiency, and equity. Its strengthening therefore produces spillover effects across the entire health system architecture. Rather than operating as an isolated intervention, PHC restructuring has system-wide implications that affect hospital care, specialized services, and public health functions.

The post-pandemic context has created a critical window for structural reform. The simultaneous visibility of system fragilities and the demonstrated capacity of PHC during the crisis has generated renewed policy attention to primary care strengthening. However, translating this recognition into sustained institutional change requires overcoming historical patterns of underinvestment and fragmentation.

In this evolving scenario, PHC should be understood not only as a level of care, but as a systemic logic that organizes how health systems function, adapt, and transform. Its consolidation as the backbone of SUS is therefore not merely desirable, but necessary for ensuring that the Brazilian health system evolves toward greater resilience, equity, and integrative capacity in the long term.

4. Conclusion

The analysis developed in this article demonstrates that the post-pandemic trajectory of the Brazilian Unified Health System (SUS) is best understood through the analytical lens of resilience, rather than through conventional assessments of system performance or recovery. Resilience, as discussed, is not a static attribute but a dynamic and unevenly distributed process shaped by institutional design, governance structures, and care organization. In this context, Primary Health Care (PHC) emerges as the central structural and operational axis through which resilience is produced, sustained, and potentially expanded within the Brazilian health system.

Across the COVID-19 crisis and its aftermath, PHC proved to be the most consistently adaptive component of SUS, ensuring continuity of care, territorial surveillance, and mitigation of health inequalities under conditions of systemic stress. Its embeddedness in local territories, combined with its relational and longitudinal nature, enabled it to function as both a buffering mechanism and a coordination platform. However, the analysis also shows that this resilience is constrained by persistent structural fragilities, including chronic underfunding, workforce instability, governance fragmentation, and digital asymmetries. These constraints limit the transformative potential of PHC and produce uneven resilience across regions and population groups.

In the post-pandemic context, the central challenge for SUS is not merely to restore pre-crisis functioning, but to consolidate a structural transformation that strengthens PHC as the organizing logic of the system. This requires sustained political commitment, stable financing, integrated governance, and strategic investment in digital and workforce capacities. The evidence and theoretical synthesis presented in this article suggest that the future resilience of SUS will depend less on hospital expansion or episodic crisis responses, and more on the consolidation of PHC as the foundational infrastructure of universal health care in Brazil.

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