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Controversial aspects of the concept of health needs and their impact on the accessibility of medicine and health services

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Abstract *This article aimed to present the problems related to accessibility of health services by re-reading four case studies which illustrate the different dimensions of the definition of health needs and their impact on the accessibility of medicine and health services. The theoretical model of Vargas-Peláez et al.[1], which allows a better understanding of the complexity of the definition of health needs and its impact on the demand for medicines and services, was adopted to re-read the case studies on the prices of patented medicines, the models of public provision, hemodynamic services, and prescription of anxiolytics. The results may shed some light on the complexity of the challenges to achieve health rights in a peripheral capitalist society where the production and distribution of goods and services is organized from the perspective of the market, even though public policies seek to regulate them. In this sense, it seems essential that the State plays a major role in guaranteeing equality in the achievement of social rights, not only influencing the industrial sector in reducing the prices of medicines and improving their supply, but also guaranteeing access to medicine and health services.*

Key words *Health policy, Industrial policy, Pharmaceutical services, Health needs, Accessibility*

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Introduction

According to Soares[2] *accessibility is a characteristic of a health system, related to its ability to provide the necessary products and services, in a collective perspective, which includes the totality of the population.* In that sense, we may wonder if the economic-industrial health complex (CEIS, in Portuguese) is capable of offering the necessary goods and services and make them available to those who need them, guaranteeing the right to a universal health system, as defined in the 1988 Brazilian Constitution. The concept of CEIS is understood as the set of resources necessary to provide a health system, which depends on government and public elements as well, involved in the production and provision of services[3].

Since the writing of the Constitution, many endeavors have been taken to achieve this goal. Some examples of health policies are: the creation of the Unified Health System (SUS, in Portuguese) in 1990, responsible for the universal provision of health; the National Medicines Policy (PNM, in Portuguese) in 1998, a landmark for guaranteeing access to essential medicine; and the Policy for Pharmaceutical Care, in 2004, expanding the reach of the concept to full pharmaceutical care[4]. Some examples of innovations in industrial policies, related to CEIS, are the Industrial, Technological and Foreign trade Policy (PITCE, in Portuguese), aimed at promoting competitiveness and innovation in the Brazilian industry, the Productive Development Policy (PDP, in Portuguese), aimed at the expansion of innovation and competitiveness, and the Greater Brazil Policy (PMB, in Portuguese), aimed at encouraging inclusive, sustainable development by means of technological innovation[5]. However, three decades after the constitution was written, there has been little progress in terms of building a universal health system[4,6].

The health system's accessibility to all citizens in a universal perspective, is an extremely complex subject, since it involves private and public interests. The hypothesis of this study is that this complexity could, in part, be better understood with the analysis of the several elements that determine the concept of health needs and have an impact on the system's accessibility. In other words, the different views concerning health needs from each system – first from the perspective of health itself, second from the perspective of the market – partly explaining the problem of the difficulty in achieving accessibility.

All this happens because health systems are social constructs, which depend on specific trajectories, power structures, interests, and interdependence, and are influenced by the values and principles of the stakeholders (government, health professionals, the industrial-medical complex, service providers, among others). The particular interests of each stakeholder and the objective of the policies, with distinct perspectives in terms of the concept of health needs, have an impact on the health system.

According to Vargas-Peláez et al.[1], the medicine, from a health perspective, is deemed as a social good, or as defined in medical literature, a public good, which has the purpose of preventing and solving health problems, in a limitless fashion and with no cost. Still, according to the same authors, from a market perspective, a medicine is deemed as a commodity like any other. It is produced and sold by companies that seek constant innovation, and it is commercialized through marketing that specifically targets medical professionals.

The accessibility of the health system will depend, however, on a series of different dimensions of the concept of health needs, always influenced - in an unbalanced fashion – by the health perspective and by the market's perspective. It is influenced by normative issues, such as the definition by the World Health Organization of essential medicines and health rights, the guarantee of access to medicine, and policies and regulations, the matter of the patents, the production of generic medicine, public production, and judicialization. It is also related to the definition of Human Rights and relates to values such as social justice, equality, and efficiency. Finally, the demand for health, articulated with individual actions to obtain health products and services, and the organization of the production and consumption of goods will also have an impact on the accessibility of the health system[7].

Considering the different perspectives, guaranteeing a fair balance between the forces of health and the forces of market is the big challenge at hand. In Brazil, the production and the provision of health products and services is done, essentially, by the private sector[8], despite the existence of SUS and production by state-owned laboratories. Therefore, the difficulties in keeping the balance between the health perspective and the market perspective are even more present.

This article aims to show the contradictions that are evident in terms of access to health services, through the re-reading of four studies previously published by the authors, following the Vargas-Peláez et al. model. We hope to reveal the contradictions between the aforementioned

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distinctive dimensions of health and the disagreement between the distinctive stakeholders on health perspectives, as well as the difficulty in reaching a balanced and fair view of those perspectives on the provisions of medicine and health services. Besides revealing the contradictions between the different definitions of health needs, the re-examination of the cases studied herein also illustrates the difficulties to reach a universality of and full access to health services and medicines, which is established and covered by the Brazilian public health system.

This article is divided into three sections, in addition to this introduction. In the first section, we present the methodology used to re-examine the previous case studies that followed the perspective of different dimensions and definitions of health needs, and how they influence access to medicine and health services. In the second section, we develop the re-examination of the four case studies, in the perspective mentioned above. Finally, in the final considerations, we highlight the countless difficulties in reaching a better balance between the antagonist forces of health and the market, demonstrated in the cases.

Theoretical approach and methodology

The theoretical model built by Vargas-Peláez et al.[1] was chosen to base the re-examination of the studies developed by researchers from Universidade Federal do Rio de Janeiro (UFRJ), Universidade Cândido Mendes (UCAM), and Escola Nacional de Saúde Pública Sergio Arouca (ENSP). The main contribution of the chosen model is that it brings forth the complexity of the definition of health needs in the context of the demand for medicine and health services, and it also considers the antagonist interests of society - the market's point of view and the point of view of health - to understand the problems in reaching a universal public health system.

According to the authors of the model, there are several different approaches concerning health needs, mainly by the complexity and lack of uniformity of the concept. The authors chose three of the main studies that can be found in literature, concerning the problem of the definitions of necessities: Bradshaw[9], Willard[10], and Max-Neef et al.[11].

The studies by Max-Neef et al.[11] and Willard[10] emphasize the historical and social perspective of health needs, showing that this is an idea, a construct, which changes over time, and that there are a series of subjective and evolutionary values which relate to how a society structures itself. These values tend to interfere in the functions, expectations, and social demands, thus generating distinctive views regarding health needs.

The study by Bradshaw[9] agrees with the two first authors and defines that the concept of social need - including medical needs - is inherent to the idea of social service, and the history of social services is the history of the recognition of the needs and the structuring of society to meet those needs. From that assumption, the author pragmatically proposes four dimensions for the definition of health needs. The first is the normative dimension, that which the specialist or professional administrator or social scientist defines as "needs" in any situation. Therefore, the normative definition of needs, according to this author, may be different according to the value system of the specialist - in his or her judgement concerning the amount of resources which should be directed toward fulfilling the need or if the available abilities are able to resolve the problem or not. Normative standards change over time and change with the evolution of knowledge, as seen in the changes of societal values concerning the definition of the medicines that should be provided by the health system.

The second dimension of the definition of "needs" deals with *perceived need*, in which "need" corresponds to wish/want. When evaluating the need of a service, the population is questioned if that service is really necessary or just a false need induced by marketing and other social influences. Perceived need is, on its own, an inadequate measure of "real need", being limited by individual perceptions, to a medical prescription or to the effect of pharmaceutical marketing.

The third dimension of the definition is *expressed need* or demand, in other words, the perceived need transformed into action. Under this definition, "total need" is defined as the needs of the people who demand a service. A service will not be demanded, unless people feel a need. On the other hand, it is common that an expressed need is not fulfilled. Expressed need, unfulfilled, is often found in health services, in the form of waiting lists that represent the measure of an unfulfilled need.

Finally, the fourth dimension of the definition is *compared need*, which is a measure of need found by the study of the characteristics of a population in terms of receiving a service. If there are people with similar characteristics who do not receive a service, those people would be *in need*.

From this understanding of the concept of *health needs*, also followed in this article, and its many dimensions, Vargas-Peláez et al.[1] conclude that when the many dimensions of health needs are not reached, there is an access barrier in the health system. The model suggested by the authors highlights the fact that in a capitalist society, where production and services are organized by the market, and goods and services are products, it is necessary for the State to guarantee that individuals can exercise their citizenship, providing a health system that is efficient and egalitarian and that provides access to medicine according to the principles of human rights[12].

The State should also establish public policies to stimulate and regulate the market, such as policies of innovation and intellectual property, as well as price control and sanitary regulation. Such policies seek to promote the development of economic sectors, which are crucial for the increase in economic efficiency, to generate capital, and to expand employment and income[13].

These are the aspects taken into consideration in the theoretical model chosen for the re-examination of the case studies. The methodological procedure of this article is based on revisiting the results of four case studies already written and published, following the theoretical model of Vargas-Peláez et al.[1]. The case studies focus on different aspects of accessibility to medicine and health services through SUS. As a contribution, we hope to show the several dimensions of health needs and the different perspectives of the stakeholders, from the points of view of health and the market, made explicit in the model, and thus help to understand and interpret the difficulties in access to medicine and health services shown in the case studies. It is important to make it clear that this article does not propose to make a case study, but simply aims to re-read other case studies, using the theoretical model described above.

Results and discussion about the case studies

This section shows the real difficulties of access to medicine and health services in Brazil, investigated in four case studies developed at UFRJ, UCAM, and ENSP. The two first studies analyze the issue of accessibility from the standpoint of the offer, in two dimensions: availability of medicine at a fair price and models of provision of medicine to the health system. The two other case studies analyze the issue of accessibility from the standpoint of the demand for hemodynamic services, which are dependent on equipment, as well as the issue of prescription of anxiolytic medicine.

The first study[14] illustrates the normative necessities from the standpoint of the availability of medicine at fair prices. Among the factors that explain this definition of normative necessity are: to what extent the patent legislation and the local production (of generic, public medicine) are relevant normative elements to explain, at least in part, the issue of the accessibility of medicine. The patent legislation illustrates an international norm, which needs to be adjusted to each country, so that it does not constitute a barrier to achieving fair prices, meanwhile the local production shows the involvement of the State in encouraging the supply of products, looking to compensate for the prejudicial effects of patent barriers.

The second study[15] exemplifies *compared need* from the standpoint of the supply, that is, the ability of the health system to respond equitably to people's needs, thereby achieving access to medicine. That definition relates to human rights, as well as to values of social justice, equality, and efficiency. Each health system defines the population to be covered and the origin of the resources allocated to guarantee access to the health system. The study focused on the models of provision and financing of medicine available nowadays and on the contradictions in reaching a universality of and full access to medicine.

The third study[16] reveals the definition of *expressed needs* from the standpoint of the demand for health services. The elements of accessibility of health services (for instance, organization, geographic distribution, and financial issues) and the facilitating factors (for instance, socioeconomic status, perception of the system from the standpoint of the right to health) influence the possibility of access to this kind of service, which is dependent on equipment, and therefore requires substantial initial investments so that it can be offered. The focus of the study was to understand aspects of geographic distribution and financing of this kind of medical services, which compromise access to hemodynamic services.

Finally, the fourth study[17] clarifies the definition of *perceived needs* - perceived by the patients from the standpoint of demand. The factors that explain the category of perceived need have to do with the view of needs created by the market through pharmaceutical marketing (trademarks and diffusion among the prescribers), as well as

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the belief that scientific progress always brings an increased well-being and a new kind of treatment is always better than the old one, illustrating the idea known in literature as "medicalization of life", which brings the perception of medicines as a health necessity. The focus of this study was on the influence of these factors in the consumption of anxiolytic medicine in a rural community from Campos dos Goytacazes, a town located in the state of Rio de Janeiro. The following four sections summarize the re-examination of the objectives and the results of each one of those previous studies performed in the light of the definitions proposed by the model, aiming to highlight the real contradictions which stand in the way of achieving a health system that guarantees free and universal access. This re-examination will allow for an improved understanding of the challenges observed in each study and will contribute to finding solutions.

Availability of medicine at a fair price

The primary motivation of the first study[14] was to demonstrate that, without local production, it would not be possible to have a health policy capable of guaranteeing the offer of medicine at a fair price. The market of pharmaceuticals is very unequal and competition is entirely based on innovation[18]. Local production and innovation are important - even producing generic medicine or similar in order to face the monopoly power of established companies, which are usually multinational.

Since the second half of the 1990's, Brazil has switched from the monopoly of European and American pharmaceutical companies, to the Indian and Chinese monopoly. The initiatives of China and India in the 1990's brought down the prices of chemical inputs and medicine considerably, but in the beginning of the 2000s, the prices rose again[19]. Thus, with no local production, the availability of medicine was reduced, resulting in abusive prices that were not feasible for the public budget. One of the consequences is that the provision of products for the health system becomes dependent on the availability of strong currency for importation. When the Paris Convention for the Protection of Industrial Property was in effect, there was a possibility of not needing patents in some areas of technology for countries who were signatories but whose know-how in the area was considered insufficient to justify the maintenance of an intellectual property regimen. However, with the signing of the Trade-Related Aspects of the Intellectual Property Rights agreement (TRIPS) in 1994, that possibility ceased to exist and the strategy of copying medicine with valid patents for learning and for local production had to be abandoned, so new strategies had to be sought.

The study illustrates the definition of normative need, presented in the model, to the extent that it focuses on the importance of the regulation policies, including patent regulation, production of generic medicine and public production, making it possible to guarantee the offer of medicine at fair prices after the changes in international legislation that were introduced by the TRIPS agreement. The study emphasizes the importance of patent regulation and local production, by means of incentives to the production of generic medicine and by public production as well, two relevant strategies to guarantee accessibility of medicine.

Three cases of challenging monopoly by suspending patents, feasible according to the norms of TRIPS practiced in Brazil, were chosen: one case in which the patent had already been granted, and two cases of potential monopolies, in other words, cases in which the patents were merely filed. The result of the challenge of each case was distinct: in the Efavirenz case, the government decided for a compulsory license; in the Tenofovir case, a patent examination subsidy was decided; in the Atazanavir case, a voluntary license was given. These cases show different initiatives of local production in the context of price negotiation, followed by industrial development. However, we will see that the effects on price reduction were differentiated.

The main conclusion of the study[14] was that, as the outcomes changed from compulsory license, to examination subsidy, to voluntary license, the desired effect of price reduction decreased. The greater price reduction was achieved with the compulsory license. This way of challenging constituted the most serious threat for the competition because it uses the resource of the mandatory cession of patent rights, directly challenging the monopoly power of the company that owns the patent. In second place was the examination subsidy, which resulted in the patent not being granting, but allowed for a significant price reduction. Lastly, the voluntary license, a case in which the price reduction was insignificant.

The common finding in the three cases studied in the article[14] is that the path of encouraging competition is essential for the success in

price reduction, but it is not sufficient. The lesson learned is that when price regulation is not combined with local production and innovation, its effect is not as significant due to the intrinsic characteristics of the pharmaceuticals market. The aspects revealed by the Vargas-Peláez et al.[1] model made it possible to show that different factors - international norms and national policies - interfere in the availability of medicine at fair prices. Moreover, the health perspectives and the market perspective, as well as the interests of all stakeholders, do not necessarily merge into a position in which all interests are satisfied without conflict, which also affects accessibility to medicine for the health system.

There is no question that the Ministry of Health has sought to adjust its policies of incentive to domestic production and innovation since 2008 (when the Partnerships for Productive Development were published) and with the instrument of partnerships of productive development in 2009, looking for ways to conciliate the interests of the stakeholders who manufacture medicine, by guaranteeing a share of the public market for up to 10 years. The partnerships are established between the official pharmaceutical laboratories, which receive technology, and national or international companies, which transfer technology. The conclusion is that, even though the Brazilian strategy to overcome the patent barriers has evolved, it still presents serious weaknesses.

The main weakness is the lack of commitment on the part of the Brazilian government in terms of investing in research and development, which includes investment in training professionals from the public laboratories that receive new technology[20]. This problem is putting at risk the capacity of absorbing technology. That risk can be in the medium term or in the long term. In the medium term, there is a risk that the public laboratories will not be able to produce the medicine after the end of the partnership. In the long term, the national facilities might not be able to produce new medicine that is introduced into the market, and the country has to acquire foreign technology again, once it has not progressed in terms of technological capacity and its dependency continues.

The re-examination of the study therefore shows the importance of the partnerships for productive development, as an alternative to overcome the patent barriers; however, it also indicates that the government needs to reach a compromise with investments in public pharmaceuticals laboratories so that they can do their part in the partnerships.

System of the provision of medicines

The aim of the second re-examined study[15] was to analyze how the provision of medicine in the health system is financed and organized, with the objective of responding equally to people' needs, providing universal access to medicine. The study illustrates the definition of *compared need* - explained in the model - which is defined and described by studying the characteristics of the population, aiming to provide health services and guarantee access to medicine. Each health system defines its population coverage and the origin of the resources it needs to reach its objective. This definition of need relates to the principle of equality and social justice, making sure that universality is guaranteed even for those who do not have a health plan.

The study[15] claims that, historically, the main way to obtain medicine in Brazil was, initially, by out-of-pocket expenditures at private drugstores. That model inequality, since the access and consumptions patterns are conditioned by income, following a market perspective. However, with the creation of SUS, Brazil began to develop a universal and free of charge model of provision of medicines by public health clinics (PS, in Portuguese) and Basic Health Units (UBS, in Portuguese) with a public three-party financing system, executed and managed at the municipal level.

The Brazilian Popular Pharmacy program (PFPB, in Portuguese) was created in 2004, parallel to the distribution of medicine carried out by SUS. At the first moment, a public network of pharmacies was created, and after 2006, the program became wider, credentialing private pharmacies. Additionally, the program adopted the co-payment system, in which the user pays for part of the price of the medicine. Those changes in the system of provision of medicine reflect the influence of different political, economic, and ideological aspects present throughout the period.

In the period of establishment of SUS, the change was motivated by the Sanitary Reform and by demands for improvements in the health system. This motivation was not enough to avoid the situation of the underfinancing of SUS, and there was an attempt to resolve the problem through the creation of the Popular Pharmacy program, resulting in the partnership with pri-

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vate pharmacies as *modus operandi* and as the way to expand the PFPB. The partnership with the private sector, which at first was complementary to the network of public pharmacies, ended up becoming the current format of the Program, side by side with the provision of medicine by SUS.

We noticed that political aspects redefined the role of the Government in providing medicines: from a unified system of free charge distribution to a complementary system of public-private distribution with co-payment. The interests of the users of health plans, who have easier access to medical appointments, ended up becoming stronger than those of the rest of the people, resulting in a more unequal access. In fact, the provision of medicines by SUS is predominant, especially for chronic, prevalent diseases, but it is quite heterogeneous in access and faces many problems in terms of financing, management, infrastructure, and human resources, besides the fact that it does not have a unified information system, making it difficult to monitor its operation. However, the PFPB, functioning through the network of private pharmacies, has an adequate information system, but its geographic distribution is more limited, it offers less variety of medicines, and the population who resorts to it is much smaller than the one that relies on distribution by the public network[21].

It is important to highlight that public policies of pharmaceutical care have historically had social and political influences and have not been able to reverse the predominance of the model that requires payment from the consumer; that is a challenge to be overcome in terms of providing universality and correcting historical inequalities in access to medicine[22]. Another negative aspect of having two systems of provision is that it interferes in the planning process of local industry, since the information that it provides on demand for medicine is imprecise and underestimated. In fact, the absence of adequate information and the overlapping of the provision systems makes the health system incapable of reaching its universality objective and generates inequality, since the PFPB ends up covering more those who has health plans and lives in metropolitan areas[21].

The re-examination of the article through the Vargas-Peláez et al.[1] model enabled us to clarify the different ideological factors that influenced the recent changes in the Brazilian public policies of the provision of medicine, and the conflict between health needs and human rights. If the PFPB provision model becomes prevalent over the system of distribution by the PS and the UBS, as seems likely by the recent tendencies of financing, the market perspective will come into direct conflict with the health needs and human rights.

Demand for health services that require equipment

The third study to be re-examined[16] clarifies the definition of *expressed needs* in the case of health services that require equipment and its consequence for the access to those services. The Vargas-Peláez et al.[1] model reveals the importance of such factors as organization, geographic distribution, and financial matters, and factors that facilitate access for the users, for example, socioeconomic status, perception of the health system, and the right to health. According to the authors, all those factors influence the demand for health services and modulate the desire to have that kind of care.

The study[16] chose to look into aspects of geographic distribution and financing, checking how that interferes with accessibility to medical services of hemodynamics, which require equipment. Such high complexity services are directly related to issues of the infrastructure of medical and hospital equipment. The organization of high complexity services should be done by health regions, due to the high cost of its initial investment, and its distribution should be done through the networks of urgent and emergency care, given the need for fast medical response related to coronary diseases. However, this regionalization of health services did not occur equally throughout the country, resulting in some concerns regarding accessibility of the service, as in the case of the North and Northeast regions of the state of Rio de Janeiro. In this case, there is a flaw in the pact between the different parts responsible for the organization of high complexity services.

Among the main results of the study[16], there is clear evidence that there are not enough medical teams specialized in this kind of health care. Moreover, these specialists are also the owners of the equipment, which in most cases is located in philanthropic hospitals. It is not clear how many procedures are financed by SUS and how many by health plans in each facility, and what are the results of the care provided, in terms of waiting time and quality, which are very relevant aspects in this kind of service.

We also noticed that, in the region studied, one of the problems which compromises access,

despite decentralization and regionalization of services, is the lack of legal structure for a regional network which can offer services financed by SUS. Consequently, there was, to some extent, excessive supply in one of the towns and a lack of supply in others, requiring that patients travel from place to place to receive the necessary care. Another noticeable aspect is that patients with health plans ended up having priority in receiving care.

In the re-examination of the study, it became clear that the institutional arrangement, in other words, the incomplete federative pact of decentralization, pleases several constitutive interests of economic sectors which profit with high cost and complexity health care, and which may be hampering the access to quality, equitable services to all users. This case study once again shows the difficulties in implementing a universal and equal health system in a society with major problems of public health service infrastructure and income inequality. Moreover, the institutional arrangement responsible for the management of service distribution will depend on the ability of the government to reduce regional inequalities by means of a reorganization of interests, prioritizing universal access.

Demand for medicine and market influence

The aim of the last re-examined study[17] was to understand the influence of consumer factors related to anxiolytic medicine in a rural community in the Northern region of the state of Rio de Janeiro. In particular, the study focused on factors which led the rural population from the Marrecas district, near the town of Campos dos Goytacazes, to excessive and prolonged use of benzodiazepines (BDZs, in Portuguese). This study clarifies the definition of *perceived need*, defined by Vargas-Peláez et al.[1], and how it affects access to the health system. The authors call attention to the fact that the need for medicine is influenced by the market, through brands and diffusion among doctors and patients. The study[17] discusses the reasons that lead a rural community to excessive and prolonged use of anxiolytic medicine in a place where the stress of urban life is not present. Moreover, it seeks to understand why this situation persists even in face of public policies designed to inhibit the irrational use of medicine, and the regulations which restrain pharmaceutical marketing[23,24].

The first result obtained by the study[17] verified a deficit in health services offered to that population and a large number of exaggerated diagnoses which prioritize pharmacological therapy[25]. It also verified the lack of medical counseling in terms of prescription medicine and the practice of renewing prescriptions without medical appointments, which contributed to extending the use of BDZs among that population, going completely against the recommendations of the national medicine policy. The conclusion is that the simple existence of this policy, without psychological and social service and follow-up for the patients, makes the control policies unviable.

The second result has to do with cultural aspects of the population studied. There is an over emphasis on daily problems and search for tranquilizers as a way to instantly neutralize feelings and emotions that are deemed as negative and abnormal in a mediatic society. Moreover, one may find a distortion of the health concept, which is seen as something that can be purchased at a drugstore. A clear influence of the market perspective over the health perspective is evident in the idea of perceived need, a phenomenon which literature calls the "medicalization of life"[17]. According to Vargas-Peláez et al.[1], and made clear by the re-examination of the results of the research, the health needs are not facts, but rather values that emanate from doctors and patients, even if they do not realize it. The conclusion is that these understanding lead, first, to the difficulty in defining *health needs* when it is something that comes from the values of the doctors and patients influenced by pharmaceutical marketing. Secondly, the concept of health is difficult to specify, since it considers the values of a knowledge society, in which techniques and procedures are more valued than the health of the patient, by the diffusion of a positivist notion of science.

Final considerations

The re-examination of the studies, according to the perspective of the different dimensions of *health needs* and their influence on accessibility of the health system showed that there is often an overlap of the explaining factors of each definition of health needs. For instance, the concept of essentiality which influences the definition or *normative need* may be influenced by *perceived need*, with the inclusion of new medicine according to the notion that "whatever is new is better than what is old". The main contribution of the article was to illustrate an old, but at the same time current, theme in health economics, which is the problematic definition of health needs and

its influence on the accessibility of the health system. The main lesson to be learned is that balance between the market perspective and the health perspective - represented respectively by the CEIS and by SUS - in the different dimensions of *needs* is what contributes to reaching a public and universal health system. If on one hand health demands goods and high complexity services, high costs and frontline innovations, on the other hand the health sector contributes with roughly 9.2% of the gross national product[8], and it could become a sector which is capable of dynamizing the economy, helping local production to reach a higher level of productivity. Moreover, committing to the development of the CEIS would be an important measure in order to achieve health service provisions and products at fair prices, since it would challenge international competition by stimulating price reductions.

However, those endeavors of supply may not be enough. Since the organization of the production of goods and services is capitalist, the State, at the same time, must play a role in the coordination of production activities and in regulating them. The State must also guarantee opportunities and the distribution of wealth in the way of the access to medicine, which is essential to health care. The implementation of a health system which is universal and gratuitous seems to be a one-way street for a country like Brazil, which still struggles with the problems of regional inequalities and poor income distribution.

In conclusion, the re-examination of the articles provided an opportunity to make a reflection and to demonstrate that there are many challenges in the achievement of health rights in a capitalist society, where the production and distribution of goods and services are organized according to the market's perspective. Hence, it seems incontrovertible that the State does indeed play a predominant role in the search for equality in achieving social rights.

Collaborations

L Hasenclever worked in the conception, methodology, critical revision, and final writing. CMA Souza worked in the conception and revision. G Chaves, André Luís Almeida ALA Peixoto, Leonardo VidalLV Mattos, and JS Viana worked in the research case's studies.

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