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Family Health: expansion, consolidation and challenges

In 1988 the universal, comprehensive, hierarchical, decentralized and state guidelines for the Unified Health System (SUS) were established. Since then, clinical and health public action should have as its core unit a network of municipal services for primary healthcare (PHC), or basic, accessible and personalized care, that is technologically secure and effective, culturally appropriate and economically viable, as has been recommended since the Alma-Ata Declaration.

As regards illness, clinical care (biomedically referenced) should be a civic right, funded by general accessible and effective medical services. The service should have access to specialized medical care and other professions (secondary care) for those who need it, as well as tertiary/hospital care. Since its creation 23 years ago, SUS has grown and become a complex reality and made great steps forward, though its basic features have not been effectively and satisfactorily implemented in the country. About 50% of the population is 'covered' by the Family Health Strategy (FHS) and, according to the Ministry of Health, nearly 30% of PHC services are without this strategy and it is unclear what they 'cover'. Despite growth in the last decade, PHC/FHS has not gained broad social legitimacy; it is not lauded by the media; the middle class hardly use it; is not strongly promoted by social movements for clinical care; it is still perceived in practice rather than in discourse as a service for the poor. Secondary care lacks an induced "model," with the exception of the Support Nuclei for Family Health, which is a promising format, though it does not yet incorporate the bulk of specialized medicine.

Regarding the functions of public health, disease prevention and health promotion, although they depend heavily on other institutional spheres, political arenas and social actors (decentralization of income, worker and urban health, quality education, drinking water and waste treatment, food security, specific regulation aspects and sanitary inspection, etc.), part of which should be performed by PHC professionals through individual and collective actions, in partnership with other sectors, including social empowerment actions. Given the technological consumerism and medicalization of life and the risks, both increasing, the PHC must also equip itself to act in the symbolic and cultural reconstruction of health, care, prevention and promotion.

Hence the importance, relevance and timeliness of the discussion of FHS, possibly the sole federal policy (until now: July 23, 2011) that strongly backs the expansion of PHC in Brazil in a consistent manner with attributes such as longitudinality (clinical-health ties and accountability). It also calls for integrality, a filter function, easy access, focus on family and community, cultural adaptation and effectiveness. This would enable and induce the integration of clinical care, disease prevention and health promotion in the direction of a technical and political quality that transcends the control and social discipline function of the population through these services.

This discussion, for which this special issue contributes with various articles on PHC/FHS, is even more important considering the recent statements of the Ministry of Health in increasing federal financial funding for PHC/FHS linked to assessments of access, quality and performance.

This special issue features articles on PHC/FHS assessment addressing access and quality of service and characterization of its use; professional qualification; cultural and gender issues and therapeutic itineraries; the relationship between academic and popular wisdom; work processes involving subjective and clinical care, home visits and specific preventive and educational practices for professionals and users. It also addresses nutrition and eating habits, physical activity, oral health, mental health and the National Policy of Humanization.

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