Modes of care production and universal access – an analysis of federal guidance on the work of Primary Healthcare teams in Brazil

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Abstract *This article analyzes federal guidance on the organization of primary healthcare work processes and the modes of production of care aimed at promoting universal access to services. A qualitative document analysis was undertaken of documents related to the National Health Policy, National Program for Improving Primary Care Access and Quality, More Doctors Program, and National Tele health Networks Brazil Program. Five thematic categories were defined for content analysis: staff training, valuing staff and work, organization of health actions for/with people and communities, complexity of healthcare and multiprofessional work, and collective construction of health as a right. The results show that advances were made in promoting universal access, particularly in the documents issued before 2015, with actions related to staff training, welcoming, the establishment of evaluation processes, and expansion of the scope of actions. However, there has been a shift towards the universal coverage model, as shown by measures encouraging reductions in the functional diversity of health teams and the flexibilization of working hours, hindering the implementation of the SUS as an inclusive social policy.*

Key words *Primary Healthcare, Access to health services, Healthcare, Universal coverage, Unified Health System*

Introduction

Public policy expresses not only government priorities, but also society's choices about the kind of nation it wants to build. It reflects state guidance, translated into rules, laws, guidelines, procedures, and strategies, as well as values considered to be priorities for living collectively. A society constitutes, and is constituted by, the way it creates the conceptual and legal bases of public policy[1].Instituted by the 1988 Federal Constitution as a social policy to guarantee universal and equal access to healthcare for all, Brazil's primary public health policy, *o Sistema Único de Saúde* (SUS) or Unified Health System, is underpinned by the values of social justice and solidarity and considers Brazilian citizens to be subjects of rights[2].

Policy conception, formulation, and implementation involves political, social, economic, institutional, ideological, technical, and cultural aspects[1]. A range of actors participate in this process, giving rise to political disputes over distinct conceptions of the right to health, thereby resulting in different forms of access to and use of services. Depending on the outcome of these disputes, access to health may be provided as a "charitable measure, benefit acquired through pre-payment, enjoyment of citizens' rights"[1], or a right inherent to the human condition[3]. These distinct conceptions guide the formulation of government strategies and may contradict the Constitution and other legal bases underpinning the SUS.

We are witnessing a period in which a range of austerity measures are being adopted globally, resulting in retrograde steps and seriously threatening important social policy advances. In Brazil, the ceiling placed on primary expenditure, cuts in minimum spending on health and education, and structural reforms[4] are guided and supported by the argument that universal public service systems are economically infeasible and based on restricted equality of opportunity, meritocracy, and market agency[5].

Anchored in a neoliberal framework, these options risk jeopardizing the operationalization of the principles of universal access – which presupposes equal rights between people, regardless of social class, gender, color/ethnic group, and religion – and equity as a path to social equality. Against this backdrop, it is vital to distinguish between universal access and universal coverage, which, despite important differences between the concepts, are often used as synonyms. The aim of universal coverage is that everyone can afford health insurance. The function of the state is limited to regulating the system and guaranteeing a minimum level of care for those who cannot afford health insurance, prioritizing market value and individualism. This model gained force in the recently published Declaration of Astana endorsed at the Global Conference on Primary Health Care in 2018[6].

As the structure of the SUS took shape, access to health services improved significantly, with positive impacts on the epidemiological profile. There was a reduction in the number of temporary employment contracts, investment in staffing and staff training, the promotion and formalization of public participation, and increased public awareness of the right to health bound to citizenship[7]. However, the SUS envisioned by the 1988 Constitution has not has not been allowed to realize its full potential, suffering from underfunding and facing countless ongoing threats ever since its creation[2].

The organization of the SUS around primary healthcare (PHC), including the adoption and expansion of the Family Health Strategy (FHS), aims, among other things, to guarantee universal access to healthcare, understood as the multidimensional capacity of health services and systems to effectively respond to people's health needs. Universal access is one of the essential prerequisites and a constituent part of/for the provision of quality care[8]. However, beyond the expansion of coverage of actions and services, the SUS must address the challenges related to the ways in which teams produce health actions and work management[2]. These challenges demand –from those who defend the SUS– constant effort and ongoing evaluation of the policies and programs implemented to correct its trajectory, improve quality, and secure the system's financial sustainability:

By presenting how health policy [...] *takes shape on a day-to-day basis, it is possible to understand how, amid technical actions, political and organizational strategies, and wrangling over resources and ideas, social policy fulfills its wider function of protecting communities*[1].

Considering the key role the federal government plays in formulating and guiding public policy and in the allocation and administration of financial resources, this article analyses Ministry of Health guidance on the organization of PHC team work processes and the modes of production of healthcare towards achieving universal access to health services.

Method

A qualitative document analysis was undertaken[9] on primary sources that set out and regulate current health policy in Brazil. The corpus of documents consisted of 29 official documents related to the National Primary Care Policy (NPCP, acronym in Portuguese), National Program for Improving Primary Care Access and Quality (NPIPCAC), More Doctors Program (MDP), and National Telehealth Networks Brazil Program published between January 2011 and December 2017. The documents included laws, ministerial orders, reports, manuals, and technical publications issued by the Department of Primary Care and Secretariat for Work Management and Health Education of the Ministry of Health related to federally funded programs and policies and whose content included guidance on healthcare practices adopted by PHC teams (Chart 1).

The document selection criteria included federally funded policies and programs because federal funding is key to ensuring their implementation by local governments. Policies and programs related to specific health problems and life cycles and specific programs were excluded. For similar documents published in different years, the latest year was considered.

The documents were taken from the Ministry of Health's website[10] and organized and systematized into a spreadsheet. For the purposes of data collection and analysis, we adopted pre-analytical categories based on the elements of work and values that influence the capacity of services to ensure access adapted from Menezes et al.[11,12] (Chart 2).

Five thematic categories were defined for content analysis: (1) staff training in and for PHC; (2) valuing staff and work; (3) organization of health actions for/with people and communities; (4) complexity of health care and multiprofessional work; and (5) collective construction of health as a right. The results for each category were analyzed drawing upon on the theoretical frames of references everyday bioethics and work[13] and ergology[14]. These perspectives contribute to the understanding of health policy directed at PHC as components of a set of antecedent norms activated and renormalized by workers in face of the unpredictability of work activities, and also help reflect upon the values associated with the modes of production of healthcare, which influence the operationalization of the principle of universal access.

Results

Staff training in and for PHC – the responsibility for encouraging and providing health work training is shared across all spheres of government[P1,P3], which is why the policies analyzed recommend the following actions: permanent health education (PHE)[P1,P3,P8,P13], institutional support (IS)[P1,P3,P6,P8,P10,P11], matrix support (MS)[P1,P3,P6,P11,P12], horizontal cooperation[P1,P3,P6,P8,P10,P11], andin-service academic supervision[P16,P17,P20-P23]. In this regard, an important change was made to the NPCP: the removal of the provision that allows FHS workers to dedicate eight hours of their working week to specialist training courses in family health, multiprofessional and/or family and community medicine residencies, and PHE and MS activities[P1,P3].

Different modes of promoting PHE outlined by the policies include: telehealth educational strategies[P6,P7,P11,P12,P17,P23-P25,P27-P29];the Ministry of Health community of practice; spaces for exchanging experiences[P23,P25,P27,P29]; participation in refresher courses, training courses, and post-graduate training; discussion groups; interactive websites or collaborative social media; time set aside in periodic team meetings[P6,P7,P11,P12].

The documents also present proposals for expanding university places and increasing opportunities to access higher education smaller towns and rural areas and changes to undergraduate and postgraduate curriculums to adequately prepare professionals with the appropriate knowledge and skills for primary care[P1,P3,P15,P,16,P23]. The documents also envision there distribution of medical school places, clearly prioritizing health regions with lower numbers of university places and doctors per capita, and the establishment of new parameters for medical training, setting aside 30% of the work load of the internship for PHC and SUS urgent and emergency care services[P15,P,16,P23]. Other points include introducing student work experience in health services from the beginning of undergraduate courses, evaluation of student progress in the second, fourth, and sixth years, changes to course evaluation instruments, and the creation of the Organizational Contract for Public Education-Health Actions between SUS loco-regional administrators and educational institutions[P23]. It is also worth mentioning the expansion of the number of medical and multiprofessional residency positions, reformulation of curriculums, and changes to the rules for enrollment in medical residency

Chart 1. Documents included in the document analysis by policy and program.

Policy and Program		Document	
National Primary Care Policy	Ministerial Order 2.488, 21 October, 2011	Approves the National Primary Care Policy, revising the norms and guidelines for the organization of primary care, the Family Health Strategy and Community Health Agent Program.	P1
	Ministerial Order 2.355, 10 October 2013	Alters the formula used to calculate the ceiling for family health teams.	P2
	Ministerial Order 2.436, 21 September, 2017	Approves the National Primary Care Policy, revising the guidelines for the organization of primary care in the Unified Health System.	P3
National Program for Improving Primary Care Access and Quality (NPIPCAQ)	Ministerial Order 576, 19 September, 2011	Establishes new rules for weekly working hours for doctors, nurses, and dentists, as described in Appendix I. Establishes norms for registering primary care teams that are part of NPIPCAQ on the National Health Facility Registry and for including the type of team in the Type of Team Table of the Registry.	P4
	Ministerial Order 703, 21 October, 2011	Establishes norms for registering new teams that will be part of the Family Health Strategy in the National Health Facility Registry.	P5
	Self-evaluation for improving primary care access and quality 2nd Cycle - 2013	Self-evaluation support material for primary care teams (Family Health , Parameterized Primary Care, and Oral Health)	P6
	External evaluation instrument Health Closer to You – access and quality 2nd cycle (Family Health and parameterized primary care) 2013	External Evaluation Instrument Health Closer to You- access and quality 2nd cycle (Family Health and Parameterized Primary Care)	P7
	Health Closer to You Instruction manual – access and quality 2nd cycle – 2013	Health instruction manual for primary care teams (Family Health, Oral Health, and Parameterized Teams) and EFHTs 2nd cycle	P8
	Instruction manual – Appendix: Indicators sheet – 2013	Instruction manual – Appendix: indicators sheet	P9
	Ministerial Order 1.645, 2 October, 2015	Deals with the National Program for Improving Primary Care Access and Quality (NPIPCAQ)	P10
	Self-evaluation for improving primary care access and quality 3rd Cycle -2017	Self-evaluation support material for primary care teams (Family Health, Parameterized primary care, and Oral Health)	P11
	Health Closer to You External Evaluation Instrument – access and quality 3rd cycle (family health and parameterized primary care) – 2017	Health Closer to You External Evaluation Instrument- access and quality 3rd cycle (Family Health and parameterized primary care) – 2017	P12
	Health Closer to You Instruction Manual – access and quality 3rd cycle – 2017	Instruction manual for primary care teams and EFHTs	P13

Chart 1. Documents included in the document analysis by policy and program.

Policy and Program	Document		
More Doctors Program	Ministerial Order 1.834, 27 August, 2013	Institutes and redefines differentiated costing values for family health teams with doctors belonging to national procurement programs.	P14
	Law 12.871, 22 October, 2013	Institutes the More Doctors Program, amends Law 8.745 of 9 December, 1993 and Law 6.932 of 7 July, 1981.	P15
	Interministerial order 1.369, 8 July, 2013	Deals with the implementation of the More Doctors Program	P16
	More Doctors Program: Guidance on the organization of primary care in Brazil – 2013	More Doctors Program: Guidance on the organization of primary care in Brazil	P17
	Joint Ministerial Order 1, 21 January, 2014	Deals with the Module Welcoming and Evaluation of Exchange Doctors in training and professional development actions developed under the More Doctors Program.	P18
	Joint Ministerial Order 31, 5 June, 2015	Deals with the Module Welcoming and Evaluation of the More Doctors Program	P19
	Ministerial Order 585, 15 June, 2015	Deals with the regulation of academic supervision under the More Doctors Program	P20
	Resolution 2, 26 October, 2015	Deals with the educational nature of the Ministry of Health's Doctor Staffing Programs	P21
	Resolution 3, 6 November, 2015	Deals with Core Theme Professional Development and Extension of the 2nd Training Cycle of the More Doctors Program	P22
	More Doctors Program – two years on: More Health for Brazilians – 2015	Book – More Doctors Program – two years on: More Health for Brazilians	P23
National Telehealth Networks Brazil Program	Ministerial Order 2.554, 28 October, 2011	Institutes the component Computerization and Telehealth Networks Brazil in Primary care, integrated into the National Telehealth Networks Brazil Program within the Primary Care Center Upgrade Program	P24
	Ministerial Order 2.546, 27 October, 2011	Redefines and broadens the Telehealth Brazil Program, hereafter called the National Telehealth Networks Brazil Program (Telehealth Networks Brazil).	P25
	Ministerial Order 3.127, 28 December, 2012	Amends provisions of Ministerial Order 2.554 of 28 October, 2011, institutes the component Computerization and Telehealth Networks Brazil in Primary care, integrated into the National Telehealth Networks Brazil Program, within the Primary Care Center Upgrade Program	P26
	Telehealth Manual for Basic Care/Primary Healthcare – 2012	Telehealth Manual for Basic Care/Primary Healthcare	P27
	Telehealth Manual for Primary care/Primary Healthcare - 2013 - Teleconsulting response protocol	Telehealth Manual for Basic Care/Primary Healthcare – 2013 – 'Teleconsulting response protocol	P28
	Telehealth Manual for Basic Care/Primary Healthcare – 2013 – Teleconsultation request protocol	Telehealth Manual for Basic Care/Primary Healthcare – 2013 – 'Teleconsultation request protocol	P29

Chart 2. Elements that influence the capacity of services to ensure access grouped into pre-analytical categories based on values.

Pre-analytical categories	Elements that influence the capacity of services to ensure access	Values
Training, experience, and grasp of norms	Provision of permanent education	Solidarity, Justice, Health, Dignity, Care, Respect, and Responsibility
	Graduate training	
	Training and norms related to work in primary healthcare and the Family Health Strategy	
	Provision of support for everyday practices	
Satisfaction	Work overload: daily workload; service demand; productivity demands	
	Valuing staff: salaries; employment relationships; mechanisms for valuing staff and employee rewards; responsibility for caring for people; current image of public services and the importance of the work they do	
Management and organization of work processes	Territorialization: coverage of/responsibility to people and families; registration of families; linkage with place of residence/work	
	Team schedules: organization of service provision; Welcoming and risk screening x other modes of appointment making	
	Provision of actions: home visits, groups activities; collective activities; matrix support	
	PCC opening hours	
	Ambience	
Team working	Team work	
	Provision of team working tools	
	Team compositions: multiprofessionality, turnover, number of professionals	
Integration/ interaction with the community	Respect for knowledge, inclusion of singularities; cultural and moral questions; health needs and knowledge of local reality	
	Listening, bond, confidence, dialogue, and communication	
	Collective construction of opportunities and health planning	
	Public participation	

Adapted from Menezes et al.[11,12].

programs[P15,P23]. The minimum duration of the family and community medicine residency program was increased to two years, with the first year being compulsory for enrollment in some medical residency programs, while the MDP introduced training cycles for participating doctors with modules in the following areas: Welcoming and Evaluation, Professional Development, Extension, and Academic Supervision[P19-P22].

Valuing staff and work – federal, state and local governments also have the following roles and responsibilities: to guarantee workers' rights and the right to social security; to improve employment relationships; to implement career progression plans that associate staff development with service quality; and to select, hire, and pay professionals in accordance with the legislation[P1,P3]. Also in relation to this these elements– which influence the work processes of

PHC teams and therefore the operationalization of universal access –it is also important to highlight the change in the coverage ceiling for family health teams made in 2013[P2] (and reaffirmed by the 2017 NPCP[P3]). The ceiling sets the number of service users covered at 2,000 people, although this number may be lower in the most vulnerable areas.

The Ministry of Health's pay-for-performance strategy was established to broaden access to quality services by setting and implementing minimum standards of best practice and organization of primary care centers (PCCs)[P6,P7,P11-13]. For evaluation purposes, these standards are classified as mandatory, essential, strategic, and general[P6,P7,P11-P13] and, in the organizational guidelines of the 2017 NPCP, as essential and extended[P3]. The evaluation instruments list a set of actions that should be developed by health teams to

meet national quality standards[P6,P7,P11-13]. Performance-related pay and bonuses are instruments that measure performance against agreed targets and results, also considering career progression for length of service, academic qualifications and professional training, and the variation of working hours[P6,P7,P11,P12].

Organization of health actions for/with people and communities – the policies analyzed refer to territorialization both as an organizational guideline and priority action planning instrument aimed at ensuring the development of actions in accordance with the principle of equity[P6,P11]. Measures include: territory definition; risk and vulnerability assessment for the creation of PCCs; the reduction of distances between PCCs and the population; the dynamic monitoring of health status, considering geographical, environmental, social, economic, cultural, religious, demographic, and epidemiological aspects[P3,P6,P11].

It is recommended that health facility work schedules should be formulated and shared based on the health needs of the population, encompassing actions directed specific groups and spontaneous demand. Focused on spontaneous demand, *acolhimento*, literally "welcoming" in English, a concept with strong emphasis on promoting active listening and patient empowerment to ensure that healthcare is tailored as closely as possible to patients' needs, should be humanized and incorporated into everyday practice and involve risk and vulnerability screening, using relevant protocols and defining appointment scheduling criteria[P1,P3,P6,P11]. It is based on "a logic of health service organization and functioning shaped around the principle that PCCs should receive and listen to all those who seek their services, universally and without exclusion"[P1,P3,P6,P7,P11,P12], in response to low capacity to deal with acute health problems and with the aim of broadening access to quality healthcare[P13].

Some of the activities and responsibilities of PHC workers that appear recurrently in the documents are: individual clinical care, minor procedures and sample collection, therapeutic groups, community activities, complementary and integrative practices, educational activities, health promotion, health surveillance activities, collective actions in the territory, and planning and evaluation meetings[P1,P3,P6,P7,P11,P12]. The following activities were included in the 2017 NPCP for community health agents (CHAs): blood pressure and blood glucose measurement, clean wound dressing, providing in-home advice on and support for the administration of medi-

cation to patients in situations of vulnerability, provided they have adequate training and legal authorization[P3].

With regard to opening hours, PCCs should open for a minimum of 40 hours a week[P6,P11], five days a week, and 12 months a year. Alternative opening hours are permitted to meet the needs of the local population, which may be agreed in formal spaces for public participation[P3].

It is also important to mention actions related to ambience associated with the commitment of administrators to furnish PCCs with quality equipment, facilities, and information technology with the support of the federal government– such as those proposed by the PCC Upgrade Program[P1,P3,P23,P24] – and the understanding that PCCsare spaces for promoting teaching and learning and coordination and cooperation between educational institutions and services[P23].

Complexity of health care and multiprofessional work – the policies determine that PHC services should be delivered through multiprofessional and interdisciplinary working, understanding that family health teams should be made up of doctors, nurses, dentists, dental assistants/technicians, nursing assistants/technicians, and CHAs, in addition to other professions that work in extended family health teams (EFHTs)[P1,P3]. Formerly known as family health support teams[P1] before the name was changed by the latest NPCP[P3], like oral health teams, the decision on whether or not to implement EFHTs is that of the local government[P1,P3].

The latest revision of the NPCP also allows for the creation of transitory teams in the FHS with flexible working hours[P1,P4,P5], family health teams with only one CHA, and basic care teams composed of only doctors and nursing staff[P3]. Another example of flexibilization is that the requirement for 100%CHA coverage of the registered population[P1] only applies in areas with territorially dispersed, at risk, and vulnerable communities[P3].

Staffing increases to respond to shortages of professionals in health teams, investment in multiprofessional team training, the recognition of residents as member of teams working in theFHS[P23], and the appointment of PCC managers[P3] are some of the strategies present in the policies analyzed that are capable of contributing to strengthen team working. In this sense, some tools and spaces are recommended to aid the development of work, such as shared appointments, case discussion, treatment plans, definition of flows and staff roles and responsibilities,

and monitoring and evaluation of the results of shared care[P6,P11].

Collective construction of health as a right – encouraging public participation appears as a common role and responsibility across the different spheres of government and health teams, involving the promotion of training and participation in local and municipal health councils and boosting autonomy and capacity to build effective health services[P1,P3].

The documents highlight the need to understand the health needs of the population, bring health professionals closer to the community, promote critical and reflexive dialogue, integrate the work of health teams with that of traditional carers, and to respect people's moral conceptions and cultural habits[P6,P11]. It is also suggested that health teams provide ways and opportunities for evaluating user satisfaction[P3,P6,P11].

Finally, the policies suggest the following spaces for strengthening the collective construction of health as a right: specific action discussion groups, meetings of the local and municipal health councils, local and municipal health conferences, periodic health action planning and monitoring and evaluation meetings, and service user participation[P1,P3,P6,P7].

Discussion

The results of the content analysis showed a number of actions related to the five components of work that influence the capacity of services to ensure access (training, experience, and grasp of norms; satisfaction; management and organization of work processes; team working; and integration/interaction with the community)[11,12]. This demonstrates that sector policies recognize the challenges in operationalizing universal access. Chart 3 presents a synthesis of results, highlighting the elements that facilitate universal access and those that hinder it.

The results show that promoting PHE, IS, MS, horizontal cooperation, and academic supervision are concept-strategies for staff development and improving the quality of healthcare. Training developed at/forwork can help workers reflect upon their experiences in everyday practice, enabling the development of problem-solving skills, discussion of difficulties and alternatives, and knowledgeproduction[15]. In addition to practical knowledge, the policies present actions aimed at ensuring that health professionals have the relevant knowledge, skills and competencies

to deliver effective healthcare services, as well as changes to undergraduate curriculums with greater focus on medical training.

It is necessary to develop a training pathway built around the inseparability of the actions of health professionals from collective interests, changing health training, both in terms of scientific knowledge and in terms of the ethical and political aspects of training[16]. In this regard, "the historical transformations of health practices and medical training provide the opportunity to discuss the function of educational institutions in relation to the social reality and the reality of health and the health system inBrazil"[17] and in relation to the training of socially responsible and competent professionals in the construction of health as a right. To this end, it is necessary to expand the number of professionals from different social classes, because, "while doctors come from only one part of the population – the richest part – it will be difficult, though possible, to cut the umbilical cord with the class of origin and transform the traditional way of understanding medicine"[16]. Increasing opportunities to access higher education smaller towns and rural areas and affirmative policies, such as racial quotas in higher education, have possibly contributed to the necessary changes in the social background of health professionals.

These professionals and the health system they work in must be capable of tackling the everyday issues that affect the majority of the population, notwithstanding the advances in biomedicine that frequently point health actions and services in different directions[5].

In addition to training, worker satisfaction is an important element for broadening access to quality healthcare. Strategies for improving and regulating employment relationships were found in the results, but are still incipient. There was a reduction in employment of health workers under insecure and unprotected employment conditions in the FHS between 2001 and 2009 and an increase in protected employment contracts in local services (25% among doctors, 40.8% among dentists, and 67.8% among CHAs)[18]. However, precarious work remains a major problem in the majority of municipalities. Outsourcing of the work force and the flexibilisation of employment relationships in PHC services is more pronounced in larger municipalities[19]. The ministerial orders related to the NPCP issued between 2011 and 2017do not go very far towards tackling these problems, which compounded by the flexibilization of working hours and the composition of health teams[20].

Chart 3. Grouping of elements found in the documents related to universal access by thematic category.

Thematic category	Elements that go towards universal access	Elements that deviate from universal access
Staff training in and for PHC	Encouraging training developed in/for work Activities developed by health professionals that consider the interests of the community Changes in medical training Expansion of the number of professionals from different social classes	Time for permanent education in the health center not guaranteed
Valuing staff and work	Determination of the number of people covered Reduction in the number of people for the calculation of the ceiling for health teams	Flexibilization of the number of people covered (above 3,500) Lack of actions to improve employment relationships.
Organization of health actions for/ with people and communities	Expansion of scope of actions Categorization of actions into standards as evaluative criteria and setting milestones to be achieved on an ascending service quality scale Schedule organization considering individual and collective singularities Welcoming with emphasis on spontaneous demand	Expansion of scope of actions Large number of actions Excessive norms Productivity demands Standards as organizational guidelines, reducing PHC to a selective and fragmented model providing minimal services Welcoming restricted to spontaneous demand
Complexity of healthcare and multiprofessional work	Formation and expansion of multiprofessional teams Appointment of primary care center managers Flexibilization of primary care center opening hours and working hours.	Only one CHA per team required for funding "Integration" of the work of CHAs and EDCAs, generating work overload Funding of basic care teams with only doctors and nursing staff Change in the name of EFHTs Inclusion of extra roles and responsibilities for CHAs Flexibilization associated with cost reductions and restricted to basic care teams.
Collective construction of health as a right	Promotion of public participation Service user satisfaction evaluation Co-production of healthcare	Emphasis on satisfaction evaluation strategies using surveys and consultations Little guidance on how to work towards public participation

Attempts to broaden the scope of actions and organize schedules should take into account individual and collective singularities. Categorizing this scope into standards that serve as evaluative criteria can help set milestones to be achieved on an ascending service quality scale. However, the introduction of these standards as organizational guidelines can reduce PHC to a selective and fragmented model providing minimal services[21].

The name change proposed to family health support teams and the inclusion of new activities for CHAs should be treated with caution. This is because a discourse focused on resolvability that entails the prioritization of curative care and low-cost actions with reduced staffing is only likely lead to overburdening and worker dissatisfaction, thereby jeopardizing healthcare. The presence of adequately trained PCC mana-

gers supported by municipal management may potentiate democratic processes of healthcare production.

The diversity and quantity of actions, excessive norms, productivity demands, and excessive standardization lead to work overload[22]. We work for not only for individual fulfillment across various dimensions, but also to satisfy the needs of social groups[23] in an ongoing dialectic between that which is required of us by a particular setting and that which we consider to be the best[24]. Thus, attention should be paid to excessive standardization, because of the risk of standardizing beings rather than technology[25].

With emphasis on spontaneous demand, welcoming promotes patient-centered care, counterposing the idea that PHC focuses solely on health promotion and prevention, which results in a reduction in access and resolvability[26]. However, it is necessary to expand opportunities for improving patient experience, welcoming not only those who seek health facilities, but the whole community[27].

The creation of multiprofessional teams recognizes the complexity of PHC. Given the tendency to focus on the medical and biological dimensions of disease, reductions in the functional diversity, size, and number of health teams goes against broader concepts of health based on theories of the social production of health and disease[5]. Three other points related to this observation are worth noting: the possibility of forming PHC teams with only one CHA for federal funding; the "integration" of the work of CHAs with that of endemic disease control agents (EDCAs), which may overload and/or discharacterize their functions; and the funding of basic care teams composed only of doctors and nursing staff.

Teams with CHAs bring the team and service users closer together and facilitate access to health services[28-30]. In times of austerity, the possibility of having PHC teams with only one CHA, the flexibilization of CHA coverage, the revocation of flexible working arrangements for professionals working in FHS (maintained only for members of basic care teams),and the reduction in the size and composition of these teams could make basic care teams the first option for health managers over family health teams[21].

The flexibilization of PCC opening hours is a need felt in the territories, particularly to meet the needs of people who work standard office hours. However, associated with the flexibilization of working hours and cost reductions, this measure is likely to reduce both access and servi-

ce quality, considering the complexity of healthcare. This set of flexibilization measures designed to give municipalities more autonomy in creating health teams in accordance with specific local needs may conflict with the aim of providing comprehensive quality care.

The findings also show the importance of encouraging public participation, monitoring patient satisfaction, and the co-production of healthcare. However, little mention is made as to how this will be done in practice. The construction of the SUS as a universal public system presupposes that health is a fundamental value for life and requires the mutual recognition that we belong to the same humanity, rather than the conviction that it is possible to enjoy full health isolated from the suffering of others[5]. Thus, it is important that health workers effectively contribute to building opportunities for public participation, helping to resignify public space as a common good.

Equity, a constant presence in the documents, is associated with universal accessas a strategy for reducing health inequities in pursuit of equality. However, attention should be paid to the "importance of measures devoted to removing obstacles to well-being"[3], because providing equal opportunity means neither providing the same conditions, nor the extremeness of equality of outcomes.

Finally, it is worth briefly comparing the policies and programs of the different governments. The documents show that investment in PHC increased more than 100% between 2011 and 2015, with the declared objectives of promoting universal access to quality healthcare services[31]. The acting government that took power after the presidential impeachment in 2016 adopted a markedly different political and social stance, imposing reductionist measures, while at the same time showing itself favorable to a supplementary health system by encouraging the creation of so-called "popular" health insurance plans together with the private sector[4].

By associating the right to health to the ability-to-pay, this political U-turn against the SUS proposes a shift from a universal access model to a universal coverage model "where the only thing that matters is that the entire population is covered by a health service, regardless of whether it is paid or not and its capacity to solve the person's health problem"[4].

Against this backdrop and the new fiscal rules established by Constitutional Amendment 95/2016, guaranteeing the right to health in Brazil will face even greater challenges ahead due to

cuts in federal spending – even if the country witnesses a resumption of economic growth – resulting in declining state participation in social policy[32].

Final considerations

Universal access to health presupposes actions designed to broaden coverage, such as the structuring of PCCs, the supply of materials and supplies, the provision of adequate staff training and formation of multiprofessional teams, everyday support to overcome difficulties, and the identification of alternatives. Another important element is improving access to quality care for specific groups and spontaneous demand, strengthening the capacity of services to tailor healthcare to the specific needs of people and communities in a cooperative, participatory, and inclusive manner, thereby ensuring access to healthcare as a human right.

The analysis showed various proposals aimed at tackling obstacles to achieving universal access. However, at the same time, the findings also show that some measures deviate from this aim by reorienting the work of health teams towards the universal coverage model – particularly those issued after 2015. In this regard, it is important to highlight the limited emphasis placed on career plans in the SUS, the creation of basic care teams, the definition of essential extended standards as organizational work guidelines within PHC services, and the flexibilization of PCC opening hours and the maximum number of people covered by health teams.

The results also show that there was a tendency towards universal access in the documents published before 2015 and a tendency towards the universal coverage model after 2015, thus threatening the social gains made during the first three decades of the SUS. The government that took power in 2016 implemented a set of measures that go against those developed by the democratically elected government, taking major strides towards a minimal state by reducing investment in health and other social policies and increasing the role of the private sector and its own interests, which tend not to include solidarity and social justice.

In a truly democratic society, the right to health should be universal and constantly defended and prioritized. The formulation of policy recommendations and guidelines aimed at promoting universal access is fundamental, yet insufficient to tackle the challenges facing the SUS, which have persisted since its creation and significantly worsened in recent years.

Collaborations

ELC Menezes, MIM Verdi, and MDA Scherer participated in all stages of the preparation of this article; M Finkler participated in the critical revision of the article and approval of the final version to be published.

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