

Basic health care as the backbone for SUS: when our consensuses are not enough!

Atenção básica como eixo estruturante do SUS:
quando nossos consensos já não bastam!

La atención básica como eje estructurador del
SUS: ¿cuando nuestros consensos ya no son
suficientes!

Luiz Carlos de Oliveira Cecilio ¹
Ademar Arthur Chioro dos Reis ¹

doi: 10.1590/0102-311X00136718

We wish to thank Ligia Giovanella and Maria Guadalupe Medina for their careful and consistent comments on our article. We see a strong convergence of ideas in the points raised, and if the three texts were “hybridized” they would result in a more powerful article than the original, providing a nearly consensual view of the dilemmas facing basic health care today. Perhaps our main challenge is to “dismantle our consensuses” and raise new problems for discussion.

Our research group at Federal University of São Paulo (Unifesp) has endeavored to understand the obstacles for basic health care to approach the ideal projected for it in recent decades. Our point of departure is a series of underlying questions: how does the health workforce translate or “trans-create” the basic health care policy expressed in official documents? ^{1,2} How do users re-signify basic health care and other services and make use of them? ^{3,4} Is it possible, considering the actual work conditions and the “real workers” that provide daily care while facing a growing demand, to operate a health care model that aspires to combine treating disease, conducting prevention and health education, “qualified listening”, and valorization of subjectivity, all mixed together?

The discussants appropriately emphasize the strides and impacts resulting from the expansion of basic health care. This is the starting point for our consensus. However, we reiterate the article’s basic question: beyond the shortage of physicians and chronic underfinancing, what other factors impede the consolidation of a powerful basic health care network with case-resolution capacity? Our working hypothesis is that without new subjects, and thus if new perspectives are not incorporated into this debate, we will make little progress. We insist on the need for “new political air”, exploring new angles, needs, and desires when reflecting on the necessary steps forward for basic health care. We may need to incorporate “users/utilizers” (an intentional pleonasm) and their potentialities in managing the life and work of health units and in the formal circuits in which they move. And we should keep in mind the transformative/creative (but also conservative) force of health professionals in their daily work. We will only be able to escape the circularity (and repetition) of discussions on basic health care with the real incorporation of new subjects. How can we do this?

We agree with Medina when she refers to: “*the degree to which the disconnect between formulation and implementation results from the national policy’s incapacity to grasp the actual limitations or ‘conditions of possibility’ of the real world (the municipalities in this case)*”.

For us, the “conditions of possibility of the real world” refer to both the restrictions and the potentialities, creativity, and permanent production of modes of care that result from the encounters

¹ Universidade Federal de São Paulo, São Paulo, Brasil.

Correspondence

L. C. O. Cecilio
Escola Paulista de Medicina,
Universidade Federal de São Paulo.
Rua Botucatu 740, São Paulo,
SP 04023-062, Brasil.
luizcecilio60@gmail.com



between health workers and users. This understanding can lead us to two types of strategies for the improvement of basic health care. The first is the need to develop studies whose epistemological basis is the inversion of the relationship between the researcher and the researched, where the ethical and methodological thrust is the incorporation of health workers and users in the studies as subjects, producers, and owners of the new knowledge. Our experience has already taught us that this incorporation does not depend only on our wish and invitation. The second is the adoption of training and work management technologies along the lines of permanent education, a complex policy, since it is performed even as it produces its subjects.

Another discussion, identified appropriately by the discussants, relates to the top-down induction policy featuring financial incentives from the Brazilian Ministry of Health. We agree with Giovanella when she contends that “*financial induction is a fundamental mechanism for reducing regional and social heterogeneities and inequalities, as well as for promoting equity*”. However, to solve the equation between financial induction and unique local projects with new subjects as protagonists is still an open question.

Meanwhile, even agreeing that there is a consensus on the ideals of basic health care as the backbone for a Brazilian Unified National Health System (SUS) with quality, Giovanella points to a discursive tension between the approaches in our basic health care/primary health care, drawing on the polarity between programmed actions and serving the spontaneous demand, among other examples. Do these notes by the author disallow us from speaking of a consensus or consensuses? Let us examine this question.

The Brazilian National Basic Health Care Policy (PNAB) was developed more emphatically and visibly in the first decade of the 21st century, with the intent of extensiveness, which intentionally or unintentionally took as its underlying principle the incorporation, in some “conciliating” way, of the “discursive tensions” on basic health care/primary health care identified by Giovanella. This explains the complexity that the PNAB acquired during its operationalization, resulting in a marked disconnect between the official policy and the services’ daily reality, as we stated in the article.

Could we also say that we produce a consensus about our disagreements when we intend to include various competing definitions under the same generous umbrella of the PNAB? Approaches such as “prevention/health promotion-based”, “expanded clinic-centered”, “programmatic”, “family medicine-centered”, “inter-sector”, etc. in some way see themselves under this “PNAB-marquee”, which appears to shelter so many definitions. “PNAB-marquee”: problem or solution? Such is a paradox if its operationalization is conceived in the diversity of existing basic health care “networks” in Brazil.

On this point, it might be worthwhile to acknowledge that the dispute between the terms “primary care” and “basic care” may not really be relevant. More important, as Medina states, is that the formulation of basic health care involves the movement of actors and disputes in the complex field where the struggles for the right to health and for organizational reforms take place. Giovanella notes that the study and formulation of the basic health care policy progresses to the detriment of “*certain topics that now appear as epistemological obstacles to knowledge of the country’s reality*”. An example is the atavistic resistance by Brazil’s Public Health field to conduct studies in hospitals.

We have coordinated and participated in studies on basic care (and other “points” in the health system), valuing micro-policy in daily relations and issues of a multiple order, as opposed to the standardization and homogeneity intended by the official policy. We seek to problematize the idea that it is possible to study, intervene in, and transform basic health care “per se”, to work with “a stagnant model of primary health care practices”, as stated by Giovanella. We see basic health care as the intersection of persons, desires, and meanings, a prime place for discovering new potentialities of life and to welcome the necessary disagreements that help us add new issues to the direction of basic health care.

The debate is challenging given Brazil’s current situation, so adverse for inclusive universal policies like the SUS, when an illegitimate government is imposing an unprecedented fiscal adjustment policy and working to destroy everything that was built so painstakingly over the course of three decades.

Contributors

L. C. O. Cecilio made significant contributions to the text's conception, design, and elaboration. A. A. C. Reis conducted a substantial critical revision of the content.

1. Melo SM, Cecilio LCO, Andreazza R. Nem sempre sim, nem sempre não: os encontros entre trabalhadores e usuários em uma unidade de saúde. *Saúde Debate* 2017; 41:195-207.
2. Oliveira LA, Cecilio LCO, Andreazza R, Araujo EC. Processos microrregulatórios em uma unidade básica de saúde e a produção do cuidado. *Saúde Debate* 2016; 408-21.
3. Meneses CS, Cecilio LCO, Andreazza R, Carapineiro G, Andrade MGG, Santiago SM, et al. O agir leigo e a produção de mapas de cuidado mistos público-privados. *Ciênc Saúde Coletiva* 2017; 22:2013-24.
4. Cecilio LCO, Carapineiro G, Andreazza R, Souza ALM, Andrade MGG, Santiago SM, et al. O agir leigo e o cuidado em saúde: a produção de mapas de cuidado. *Cad Saúde Pública* 2014; 30:1502-14.

Submitted on 10/Jul/2018
Approved on 13/Jul/2018