Basic Healthcare Network, field of forces and micropolitics: implications for health management and care

Rede Básica, campo de forças e micropolítica: implicações para a gestão e cuidado em saúde

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ABSTRACT The purpose of this paper is to discuss the micropolitics of health management and care in the Basic Healthcare Network (RB). It starts by what is understood by RB and then by micropolitics – of management and of care. We analyze the forces that are operating in the daily routine of the RB that are established in the relational acts, in the meetings, between managers and workers, among workers, among all these and the users, constituting fields of force, which shape ways of being in the meeting, managing processes of subjectivation. Five central value forces stand out so that the inside and the outside of everyday events of health care practices can be thought of: labor force-value, territory force-value, government of self and government of the other force-value, clinical-care force-value and teamwork force-value. The bet on a way of caring in RB, centered on the production of potencies to face the challenges of living with suffering, with illness and its unfoldings in diverse and adverse situations should contribute to the production of possible and favorable existences to the best ways of walking life with all its challenges.

KEYWORDS Comprehensive health care. Primary Health Care. Public Health Policy. Interpersonal Relations. Professional Practice.

RESUMO *A proposta deste ensaio é discutir a micropolítica da gestão e do cuidado em saúde na Rede Básica (RB). Inicia-se pelo que se entende por RB e depois por micropolítica – da gestão e do cuidado. Analisam-se as forças que estão operando no cotidiano da RB que se instauram nos atos relacionais, nos encontros, entre gestores e trabalhadores, entre trabalhadores, entre todos esses e os usuários, constituindo campos de força, que conformam modos de estar no encontro, agenciando processos de subjetivação. Destacam-se cinco forças-valores centrais para que sejam pensados o dentro e o fora do comum dos acontecimentos que ocorrem no dia a dia das práticas de cuidado em saúde: a força-valor trabalho, a força-valor território, a força-valor governo de si e do outro, força-valor clínica-cuidado e a força-valor trabalho em equipe. A aposta em um modo de cuidar na RB centrado na produção de potências para o enfrentamento dos desafios do viver com sofrimento, com o adoecimento e seus desdobramentos em situações diversas e adversas deve contribuir para produção de existências possíveis e favoráveis aos melhores modos de andar a vida, com todos os seus desafios.*

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Introduction

This essay discusses the micropolitics of health management and care in the Basic Network (RB). We begin by presenting what we mean by RB and then by micropolitics – of management and care – in health care.

RB is a bet to bring health care to the different territories where life is produced. Contextualized care, which recognizes the uniqueness of the production of each existence and also the specific circumstances of life in each territory, in function of relationships that amplify or constrain the power of lives. That is, the RB is a bet of organizing the singular care, articulating the individual and the collective, being health understood in an enlarged way, not only referred to the biological body and its sicknesses.

A bet that calls for the combination of multiple knowledge in health, both technical, from different professions, as those produced from the experimentation of life in different times and territories. This is a RB that asks interprofessionality and sharing with users, their knowledge and lives, to be able to produce care capable of expanding the life powers, favoring the production of better ways to live with problems that cannot be solved, to dialogue with the diversity of ways and senses that life has for the different people living at every moment.

This bet of organizing RB as a territorialized care, articulating individual attention and collective actions, began to be discussed in Brazil in the early 1960s[1], was expressed in the debates of the III National Health Conference and had the sanitarian Mário Magalhães da Silveira as its main formulator.

Movement interrupted by the military coup, the construction of the RB has been tried, with different arrangements, since the mid-1970s, in different places in Brazil, gaining capillarity from the construction of the Unified Health System (SUS).

This idea of RB, as well as that of collective health, is a formulation that expresses specificities of the Brazilian struggle for health as a right of all and a duty of the State. RB that is not limited to be the 'first level of care', as it brings as constitutive the guarantee of continuous care, produced in network by different types of services, health or not. RB which is not simply 'the entrance door' of the healthcare system, as there are several other entrances, depending on the problems that lead users to look for services.

RB that goes far beyond primary health care, which has been consolidated as a proposal to organize interconnected health care[2], produced by a generalist – and, therefore, always needs to be accompanied by the offer of so-called public health actions – vaccination, epidemiological surveillance, etc., offered by other teams or services[3]. In this RB, all this is articulated in the actions and care produced by health teams. It is the production of this RB that we are going to talk about.

A Basic Health Unit (BHU) is defined by health policies in a formal plan that establishes its purpose, its basic design, the roles of managers, workers and users. However, it is not only this formal policy plan that defines what goes on in a BHU, because in the process of policy production, at different times, confrontations between forces continue, marking more or less definitions and practices.

We emphasize that, defeated or victorious in the formulation of policy, these forces remain active in the concrete construction of practices, acting as molarities[4]. For example, the medical-hegemonic, biopolitical, market forces continue to operate and focus on the processes of subjectivation, even though health policies and their devices strain towards the broadening of the concept of health, the recognition of uniqueness in the production of health. existences, of the shared construction of therapeutic projects[4].

The forces that are operating in daily life constitute fields of dispute, which are established in the relational acts of the field of micropolitics, in power relations, in intersubjective relations. What does it mean? That is in the

encounters, between managers, workers and users, in the relationships that are established there, that the force fields are established, which form ways of being in the meeting, constituting processes of subjectivation.

Subjectivation processes are continuous processes of tensioning (produced by the forces in dispute) that conform the subjects in the daily life; here, in this debate, in the daily work and health care in RB. They are marked by the molarities, the life histories, the effects of the composition of the work teams or of the different collectives, the encounters with the population of a territory and its history, the political-religious convictions of each one and the encounter, every day, with users and their contexts, among others[4].

The processes of subjectivation are marked by the unpredictability of agency, that is, of the mutual effects that managers, workers and users produce on each other in their encounters. Therefore, we prefer to talk about the processes of subjectivation, not the subjects. The processes of subjectivation, as processes, are in continuous motion, are transient, subject to change. In contrast, the subject can give an idea of something given, fixed, established, structurally determined.

As we have said, these forces – structural or molar – are acting, composing the force field, always in dispute with other forces that tension the instituted in capitalist societies. That is, a force exists only because there is another force, intensively different, acting in the same field. Where there is one force acting in one direction, there is always another operating resistance; and generally in the force fields there are various forces in tension, not just contradictory pairs.

Thus, the resultant ones at each moment are the analysis of the agencying power of the different forces, because the subjectivation processes, despite the molarities, are provisional, in permanent movement and expressed through values, mobilized by the forces in tension.

Thus, a micropolitical analysis proposes to think about the various events in the daily world of care. Due to this changing dynamics of constant dispute and production, it would not be possible to map and point out all intensities operating in a given situation. This is because the event is not a given, but a happening, unique to each encounter and situation.

However, this does not prevent us from pointing to some emblematic intensities that have gained visibility in our experiences in the world of RB – through studies, research and our experiments in the field of work, management and permanent health education in several Brazilian municipalities[5-8].

In this micropolitical context, the aim of this essay is to highlight five core values-forces to think about the common and unusual events of everyday health care practices in RB: the values-forces work, territory, self-government and the other, clinical care and teamwork.

Work force-value

The forces-values that interfere in the configuration of health work are decisive in the design and betting of management (formal and informal) and the proposed arrangements for health care. Without pretending to exhaust the possibilities, we will highlight here some elements of this force field.

Health practices configure productive acts, seek to modify something and produce something new. They are work because they seek to change a state of affairs identified as a problem or as a potential health problem[9]. Of course, the definition of what is a problem is, per se, a product of disputes in a field of forces consisting of science, the modes of economic production and the production of life, the senses of life, which vary historically.

Therefore, health work is tensioned by 'social needs', interfered by the productive structure of society and the wishes and demands of its direct users. Moreover, in health services, acts of health production and consumption occur at the same time, with the

uniqueness that the product offered varies with the worker-user relationship, as the two parts affect and change each other, forming a relationship of intersection.

This intersection, this mutual affectation, happens in act, in encounters; therefore, health work takes place on the spot. The more health acts are affected by the uniqueness of the meeting, the greater the possibility of producing answers that make sense for both parties, the more alive the work. The less affected by uniqueness, the more oriented by *a priori* definitions (about what knowledge is valid, who is the user, what are their problems, and how should they be understood and faced), the greater is the prevalence of dead work.

Health work is technological – built using material and immaterial technologies[10]. Material technologies include all the tools and instruments produced to be used in a given way in given situations (equipment, instruments). These, according to Merhy[11], are the hard technologies. There are two types of immaterial technologies involved in health work[11]: light-hard technologies, which correspond to the structured knowledge of the health professions – which are partly hard because they are produced and made available *a priori*, but partly they are light because they can be used uniquely depending on the situation and the encounter; and there are light technologies that correspond to everything that is used to favor the encounter – listening, empathy, recognition, porosity, knowledge produced from the experience and brokered by the encounter, among others.

Such technologies are indispensable to health work, but depending on the type of technology that presides over the meeting, the potential caregiver will be greater or lesser, the porosity for the meeting greater or less, the exchange and construction of common meanings. Moreover, labor arrangements favor the presidency of one or another type of technology, as we will see later in the discussion of other value forces.

Another fundamental element to be considered in relation to the work force-value: in admitting that health work takes place in a type of meeting in which the parties influence each other, it is fundamental to recognize the legitimacy of knowledge, values, desires that drive the different types of health workers and users. Otherwise, some will have a voice and some will not. Therefore, it is fundamental to understand the work itself as a micropolitics, as a relational field.

All parties arrive informed and have an idea as to what should happen at that meeting – producing a diagnosis, listening to an affliction, an intervention that solves the problem or reduces suffering, the dismissal of the user, and others – about how production should take place and what is the role of each one. The meeting is fraught with, *a priori*, expectations and mutual interferences that give the product of health work an unpredictability; and since the encounter happens in action, it is partially unmanageable.

There is a work force-value that bets on the control of living work, which develops devices to control and standardize work according to *a priori* criteria, which values certain knowledge, not others, that defines and fixes places and roles, which considers norms and sufficient prescriptions for the production of responses and conduct. Managerialism, which has prevailed in health management stakes, is a tributary of this work force-value, producing strained and dissatisfied workers, users crushed and disobedient, imprisoned and threatened.

There is another work force-value that recognizes that, despite power relations, everyone governs health work to some extent, as everyone interferes, everyone enters into their bets, creating and disputing certain values and productions.

According to this force, to govern health work, recognizing that everyone governs and everyone disputes the project, it is necessary to create spaces for conversation and listening, placing the work in analysis to collect

the effects produced on those involved; it is necessary to tense the *a priori* and create situations that favor openness to the challenges that singularities impose on us. According to this force, health work, in order to favor the production of care, needs to be built collectively and shared, and always in question. The micropolitical management of work and health care is constitutive of this second work force-value.

Territory force-value

The concept of territory has been used and developed in various fields of knowledge and practices, including Brazilian collective health, with multiple dimensions and meanings. This polysemy can be observed in different experiments in the field of RB. This gets a lot of visibility in the dispute between trying to impose an idea of territory as site maps – which define how distinct collectives should be treated – and the way users and movements position themselves – considering which territory corresponds to their unique processes of building and living their lives as Existential Living Networks[12].

The territory is not reduced to its material dimension; it is a force field, a web or network of relationships. It is historically constructed, referring to different contexts, intensities and scales: the self – as self-production (existential territories)[7] and the places of life production (the house, the street, the work, the neighborhood, the city, the region, the nation, the planet).

Territory is a polysemic concept because different forces, at different times, within certain discursive fields, appropriate the issue and produce different values. Not only fields of knowledge and disciplinary practices, therefore, for native peoples, for example, territory is defined by the inseparability of the constitutiveness of the living and the Mother Earth.

We are interested here to explore the territory force-value as a field of tensions that crosses the health practices in RB – fundamental, because RB was thought as a possibility of territorialized care.

Collective health and primary care policies evoke the formulation of Milton Santos[13], which indicates geographical space as a mediation between the world and society, an indispensable concept for understanding the functioning of the world. However, there is a territory force-value operating in the RB that has led to the concept of territory in everyday life being reduced to assigned territory, since the first municipal experiences. Territory understood as spatial delimitation, known from demographic, geographic, economic, social, cultural and epidemiological data.

There is a territory value-force that mobilizes teams to map the geographic and social territory of the groups that will be cared for as if they were 'physical' places. These places can be fully known *a priori*, without the effective participation of the other, through the use of certain tools that supposedly allow knowing about where and how they live. This unilateral knowledge often used as the basis for programmatic health action planning is limited to the production of health care.

Such force negotiates subjectivations that authorize the programmatic action on the assigned population, since the territories covered by the RB, especially in the Family Health Strategy (FHS), are marked by social vulnerability, such as poverty, poor infrastructure, very limited access to goods and services services of all orders. Vulnerability that manufactures those who live there as 'needy', 'people with special needs', powerless. Still, this value force harbors fear and prejudice, because the city, including health workers, closes car windows, bars streets, militarizes itself, while newspapers talk of war on the hills, in the outskirts, in the slums. Little know them, but fear their residents and blame them for urban violence.

There is another territory force-value that acts in the same sense, which mobilizes the 'know about' to discipline and control behaviors, ways of living[14]. This direction is present when, for example, misuse of environmental risk maps, such as landfill, garbage dump, areas subject to landslides, burial or flood, source of pollutants, geographical barriers, among others. This value force, even without wishing, ends up embarrassing, blaming and producing prejudices towards the population living in these areas, who often live in these spaces because they have no other options.

This is a mark of the FHS, built primarily from the field of health surveillance, according to which, in addition to direct surveillance over homes, action in the territory was very focused on the environment[15], without recognizing that, yes, the ways of living in these territories they are producers of suffering, but also of their own powers and modes of relations that need to be recognized and worked upon in their uniqueness. Singularity that 'collective actions', mostly of education and orientation, cannot contemplate. This agency, later, was further aggravated from the managerial goals of intervention on the assigned population.

These territory force-values have been largely successful in tensioning with another territory value force that recognizes the ways of living of the multiplicity of collectives that inhabit these spaces. Collectives that are singularly constituted in existential territories, bearers of knowledge, desires and strategies to live (not only survive), despite the difficulties and restrictions to which they are subjected.

Thinkers such as Milton Santos[13], Suely Rolnik and Felix Guattari[16] discuss the processes of territorialization and deterritorialization that are inscribed in the production of living territories. Foucault[14] marks this field as politics of existences. Field in which living is disputed as a work of art, as a creation and invention of oneself and others for oneself, always in the field of micropolitical relations. Places of confrontation of a multiplicity of forces of knowledge-powers-becomings. Places of invention of ways of life that potentialize more lives. Places of a war for territories while becomings-life.

Self-government and of the other force-value

Health is a field of practices and knowledge constituted in each country in different ways and at different times, as part of the disciplining devices of bodies and after life regulation[14]. Health becomes a policy issue because of the need to discipline bodies and the occupation of cities, as well as producing new values such as hygiene, work, family. In this perspective, the State 'takes care' of health according to certain interests, and the population and workers begin to tense the limits and meanings of this care. Whenever we are talking about health we are in the force field governing the lives of others – self-government[17] in a constitutive tension that goes beyond the formal field of government and management.

In RB – territorialized care, the closest to where life is produced (not just in homes) – this issue is vehemently posed. Being close, knowing life, understanding relationships and movements can serve at the same time to take better care and better control. The tension is on all the time.

On the other hand, as work produced in the micropolitics of the encounter, there is a tangle of relationships in which all those involved in the production of care exercise, to some extent, self-government and the government of the other. In the complex and multifaceted world of care, "everyone rules: managers, workers and users"[9(68)].

Managers, through institutional policies, aim at governing services, workers and the population. Workers, however, have their bodies marked by concepts, conceptions, interests and ways of being in the world, which interfere with the conduct of their practices,

besides being affected, in the most diverse ways, by meeting with users. Thus, in live work in action, they exercise self-government, with a high degree of autonomy, despite the management designs and the wishes and demands of users. The users, however, exercise their self-government incorporating or not the established therapeutic prescriptions, or seek to govern the services and workers disputing, based on their desires and conceptions of care, the ways of operating the services and meetings.

In this context in which everyone governs, there are forces and tensions permanently in dispute, seeking the hegemony of their projects, autonomy, control. The forces operate by capturing or managing care, with everyone disputing how health practices should be operated in different circumstances.

In research, management, and care experiences in RB, we saw the self-government and government of the other force-value as agency managers, services and workers towards health actions as "disciplinary or control practices"[18(300)], from prescriptive acts and protocols defined, *a priori*, by clinical and epidemiological markers. These practices, by producing therapeutic projects that medicalize and normalize lives (individually and collectively), curtail the caring actions that take place in the meeting, in the field of light technologies, mutual affections, live work in action, which can place at the center of care the singularities and multiplicities pulsating in the existential and geographical lives and territories.

In many situations, therefore, RB can operate more as a disciplining device of bodies than as a device that provides elements for users to live their lives, with increased power facing their health problems.

The biopolitical and biopower forces permanently go through the arrangements and ways of producing care in health services. In the field of biopolitics, the biological body is a powerful point of government for others through the regulation of life[19]. In the field

of biopower, a certain know-how of health workers agency ways of doing domination over the other's life, prescribing ways of living and producing values to reorient habits and behaviors.

In this process of governing and disciplining the user, it is worth bringing to the scene elements that intensify the value-power 'government of the other' in the double government of life. Workers orient their practices with strong regard to the biological body, and its 'abnormalities'. What are essentially valued for the definition of health practices and therapeutic projects are the clinical diagnosis and the search for the 'normal' recommended for the different population groups[20] either through healing mechanisms for the diseased body or through treatments for the healthy body not getting sick[18].

One of the forces in this field seeks to assist managers, health workers and users based on protocols, procedures and prescriptions conceived from the latest scientific and technological advances, with medicines, equipment and behaviors that promise to cure or prevent the disease affects the biological bodies of individuals and collectivities[18]. It is an active force in health services and society, empowered by public health, as a way to categorize crowds, intensely seeking to manage the lives of others, act on their bodies and their ways of living[20].

In RB, this disciplining component is enhanced by the predominance of socially vulnerable users. They are usually taken as individuals or collectives with little or no calling and claiming power over their wishes and care projects; or as mistaken desiring machines, often not even recognized as desiring. In this context, with little listening and sensitivity to the demands of the lives that seek care in the teams, the forces operated to control the ways of walking the users' lives, and the choices of care projects, which negotiate the capture of the living work and the reduction of porosity for the meeting.

The little porosity happens when teams, swallowed by offers of 'care' established *a priori*, with programmed agendas triggered by policy, managers or the team itself, protocols and goals to be met, find no room for the wishes and issues brought by users who are not considered 'priorities' for the service. Even powerful meeting spaces, such as home visits, can be captured and transformed into mechanical procedures or times of intensive discipline.

In this context, the user has two options: 'fits' into the 'menu' of actions offered or otherwise exerts the self-government and of the other force-value and, from his/her agencying processes, assumes his/her care and adopts his/her own strategies to answer their questions and to make use of the system offerings. Users adapt prescriptions, disregarding what does not make sense to them, incorporating caring actions that have some connection with their existences, which can be operated on in their lives. They create/activate Existential Living Networks[12] to help them in this process of taking care of themselves and their own, competing for therapeutic projects.

It is important to highlight that, even though 'clinical diagnosis' is the same, living the illness is unique to each living person; the brands, stories and contexts that each one experiences interfere in the ways of conducting their existence. The same health condition is incapable of producing "subjectivizing serialization in the way of desiring and producing life"[18(295)]. However, many teams operate an authoritarian model of care, fundamentally prescriptive, predictable and normative[19], without admitting other possibilities of care, whose senses would be constructed in the meeting.

In the micropolitics of meetings between workers and users, there is nothing decided beforehand, there is always a dispute between who cares and who is cared for. The self-government and of the other force-value is an event, permanently crossed by other forces in tension in the world of life and care.

Clinical-care force-value

There is a field of clinical-care forces, very important in the encounter between workers and users in RB, which has to do with knowledge recognized as legitimate or not and with the possibility or not of shared construction of a therapeutic project, so that it make sense for the user and serve to enrich their lives, despite the problems and sufferings that eventually need to live or face.

As already mentioned, the basis of the clinic of the various health professions is hegemonic technical knowledge, with the pretense of truth produced from science, which takes the body as a given, definite, fixed biological machine, displaced from the intensities of living. Technical knowledge produced in a fragmented way, due to specializations. This clinical-care force-value is fueled by a number of other forces that contribute to its legitimation as truth – a field of market forces, the equipment, medicine, technological devices, which socially help to build certain truths about health, disease and ways to protect one and get rid of the other.

There is another type of knowledge about health in the care force-value that is knowledge produced from life, from living. This is a knowledge of the body. It has to do with feeling good and bad, with and without strength, with and without will, with recognizing something as suffering, pain, pleasure, as recognizing what is good and bad for you, which has to do with life experiences in their multiplicity in different situations. This knowledge from the experiments of the body is subjective and singular.

The care force-value, being constituted from the experience of life, crosses everyone, because at any moment a manager or worker can become a user. Therefore, this force brings implication with the other, solidarity with

human suffering, understanding with weaknesses, greater sensitivity to the singularities and existential multiplicities of each user.

While the clinical force-value mobilizes the user as the object of the workers' action, the care force-value involves the user as a protagonist in the production of his/her existence and as a legitimate way of feeling and facing suffering, problems and difficulties. It provides for the recognition of the intensities of living that, at that moment, are traversed by the possibility of getting sick, due to illness or a suffering without name defined by science.

Thus, in the meetings between health workers and users, moved by these two forces, there are various possibilities of disputes, conflicts and confrontations. To begin with, in defining/recognizing the legitimacy of what is presented as a health problem, of what is recognized as suffering.

The scientifically framed look aims to define technically what are legitimate health problems and ways to address them. Problems referred to by users are, then, judged and cataloged as 'true' or not, appropriate or not to the type of service offered in primary care, for example.

Within the teams themselves, this clash of forces very commonly delegitimizes the knowledge of community agents regarding what should be considered a problem and the ways of coping with situations. Moreover, it crosses the disputes for hegemony between the different health professions, as well as fostering the lack of responsibility of each other in relation to problems not considered 'own' in their field or pertinent to the scope of primary care.

The clinical force-value operates in the sense of tensing the relationships in the team and in the encounter with the users, because the clinic belongs to some, and not to others; The clinic of some is more valued than that of others. In a dialogue produced on the basis of the clinic, even if it is 'expanded', some are inside, others are outside.

The expectations of each one in this meeting are also different and increase the tension. Some, brokered by the clinical force-value, want the disease to occupy a central place in the organization of life, and technical knowledge determines what should be accomplished. Others, brokered by the care force-value, want help to continue to live in the most potent and pleasurable way possible, despite the problem/illness/suffering[21].

Because it belongs to everyone's world of experience, care force-value may favor negotiation. Care belongs to everyone, is not even exclusive to health, because family, friends, teachers take care. Therefore, the care force-value manages the conversation and the meetings from the live work in action, favoring the articulation of knowledge that belongs to the molecularity of the world of life and is not imprisoned by the instrumental reason of the clinic.

Tensioned by their own experiments, intensified by the meetings, the workers, with the users, can interrogate the clinic of the professions from the problems that do not fit. Rather than being rejected 'because they are not part of the scope of action of the professions or RB', these problems favor the invention of new strategies and management from the composition of all knowledge – from staff and users. They favor that the clinic's own knowledge be operated lightly and may be useful in the management of problems. Interrogated and modified by singularities, adding possibilities, they produce interferences that can be decisive for well-being.

The clinic, subsumed by the care, becomes an important element in the shared construction – among all – of therapeutic projects that expand the power of life, really at the service of better coping with situations. The tension produced between clinical and care value forces produces completely different effects depending on the predominance of one over the other. The

issue is not resolved by abandoning one or the other. With the effects of the encounter and light technologies in the centrality of care, based on the uniqueness of the users, structured knowledge about the body can be presented as an offer, not as an imposition and only reference.

In the micropolitical management of health work, it is necessary to stress the instituted – the clinical value-strength and the centrality of hard and light-hard technologies in conducting meetings with users. It is necessary to interrogate the instituted from the own life experiences of managers and workers, from the widening of listening and the encounter with the uniqueness of users' experience.

Thus, intensive meetings between professionals and users can become relationships between living creatures, with different stories and life experiences. They favor the construction of spaces for listening and recognizing the other, and the production of unique arrangements and managements that, even if they do not 'solve' the problem, allow it to be experienced by users in the best possible way.

Teamwork force-value

RB stands out as the place of care populated by a diversity of health professionals. In the beginning, its experimentation was with large multidisciplinary teams (with up to ten different professions), and others not so large, counting on three medical specialties, nursing, psychology, social work.

With the expansion of the FHS, even with the minimum staff (doctor, nurse, nursing technicians, community health workers, initially; then dentist and oral health technician, as well as administrative, cleaning and safety workers), a broader team than PHC offers in most countries was already involved in RB.

With the incorporation, as of 2008, of the Family Health Support Centers, even if in the matrix support mode, an even greater diversity of workers is involved. Not to mention other networked matrixial practices, such as mental health and other specialists, which also multiply throughout the Country. This reflects a bet, from the Brazilian Health Reform and SUS movement, that to operate health in a broader way and in the territory, as opposed to the hegemonic model, it would be important to have multiprofessional teams.

However, in order to work in teams, it is not enough to bring together a diversity of workers, nor to assign them tasks that intersect, nor to establish normatively that one must work in teams and even allow time for them to come together. Team, just like a network, is an active construction, which implies facing differences, power relations and the construction of a common one[21].

There is a teamwork force-value that mobilizes meetings only at the formal and hierarchical levels, with low power to overcome tensions and differences, leading to the production of conflict and bureaucratization.

There is another teamwork force-value that drives the dialogue between the nuclei of knowledge, in a certain matrix logic. However, as already discussed in the work force-value and the clinical-care force-value, each health professional when acting acts mobilizes knowledge of the professional core and knowledge of experience. In general, despite disputes between professions, in almost all technical knowledge is strongly based on knowledge centered on the biological body, with the potential caregiver of all impoverished.

The dialogue triggered from the professional nuclei excludes users, tends to take them as objects, because the clinical force-value predominates. Moreover, this teamwork force-value tends to produce relationships that are not cooperative but imparting technical knowledge, in which some

know and others learn. Professional centers are established as "islands of competence that continually operate their machine through ever-increasing specialties and specialties, manufacturing and extending new incompetence and disallowances to produce care"[22(93)], establishing a field in which force from a movement to care is often obstructed by the strength of the professional nucleus.

There is, however, at least, a third teamwork force-value, dependent on care force-value and work force-value, which recognizes that everyone rules. This force tensions the knowledge cores of each profession, placing the uniqueness of the situations experienced by users at the center of interaction to form a common. Thus, starting from the encounter with the user and their questions, one can arrive at problems that are new to the professional nuclei, that is, that will require the production of new answers, will impose challenges to the construction/composition of the technological action of the professionals. There is no magic, it is necessary to open extended listening space to users and their questions.

This common, produced from the complexity and uniqueness of situations, gives visibility to poverty and the limit of the isolated responses of each core of technical knowledge. This common calls for composition, not only among workers, but with users. Thus, an inversion in this professional core tension is negotiated – care, favoring that workers

> position their truths as secondary to another more important one: the defense of life in its various plans of production, in the bets that the other makes to produce[23(3)].

Another plan of tension produced by this third teamwork force-value has to do with recognizing that everyone rules and, therefore, the whole construction of health work dynamics needs to be shared. However, this does not happen spontaneously. In contrast, power relations and design disputes tend to produce fragmentation and unaccountability.

Final considerations

RB can be a privileged space for approaching the different territories in which lives are produced in multiplicity, in which health care can gain meaning, being produced in a shared way and capable of expanding the powers of living. However, it may also be the site of the cruelest capture of stocks, producing sad lives and medicalized serializations. It all depends on how we work the meeting, organize the government, whether or not we favor invention and the production of shared meanings.

Permanent health education, making room for reflection and exchange, is fundamental to support another dynamic. Everyone learns from experience, so they have to do it collectively, which greatly enriches the possibility of questioning, of putting the work produced and its effects into analysis[24]. How does my work affect each other? How does what I desire interfere with each other's ways of working or living? How can we take care of user X, not user Y? Many questions and provocations, singularly produced from the lived situations, make it possible to open other visibilities for the work and bring the complexity of lives to the scene.

National policies of primary care and health education do not favor this living work of questioning and reflection. With rare exceptions, they are focused on updating technical knowledge[25]. Therefore, it is up to managers, workers and users of local/municipal spaces to produce such movements.

The micropolitical management of care opens spaces for power, but it takes work, challenges us and puts us in the face of uncertainty. It is up to all of us to position ourselves in the face of these important challenges.

Finally, we do not intend to close this debate, but to bring to the analysis important and common aspects of the daily work in RB and, thus, to provoke reflections and questions about how we produce health care, enhanced by the micropolitics of the meetings. In this sense, it will be necessary to carry out research with this objective.

Collaborators

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