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THE DISMANTLING OF PRIMARY HEALTH CARE AND ITS REPERCUSSIONS ON THE WORK OF NURSES

O DESMONTE DA ATENÇÃO BÁSICA E AS REPERCUSSÕES NA PRÁTICA DA ENFERMEIRA

EL DESMONTE DE LA ATENCIÓN PRIMARIA Y LAS REPERCUSIONES EN LA PRÁCTICA DE LA ENFERMERA

Maria Auxiliadora Córdova Christófaro[1]

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The experience of articulating multiple and distinct organizations, institutions and social movements to align their principles and agreements for the creation of a unified health system in Brazil was a bold move, and the initiative continues to be a significant change of paradigms in relation to the prevalent *mode and model* of health care provision in Brazil.

In the last 30 years and within the context of struggles in favor of the democratic rule of law in Brazil, the health care reform movement (MRS) has brought to the legislators' agenda the implications of health care in the political, legal, economic and social spheres, considering the flagrant shortcomings of the fragmented and excluding model of health care that was prevalent in the past. The consistency and relevance of the proposal led by MRS made the legislators state in the Brazilian Constitution that "health is the right of all and duty of the State"[1]. This was an invaluable social achievement that required many definitions and operations. It also revealed requirements of different types and magnitudes for the State, for the so-called *health market*, for professional categories and health care providers and also for the society as a whole.

In view of what is established by Article 200 of the Federal Constitution of 1988[1], the Brazilian Unified Health System (SUS) is regulated throughout the national territory, including the actions and services performed separately or jointly, on a permanent or occasional manner, by natural or legal persons governed by public or private law[2].

The elements established in the health care model were restructured and reorganized in the wake of the movements that followed the collapse of the state of exception. However, they imposed a slow and regionally uneven pace to the implementation of the SUS. The resources and conditions to establish new forms of organization and operation of a health system in the country fell short of expectations in that political and economic context.

Determining and triggering processes and strategies that can make the SUS *effective* was and still is a constant challenge at all levels: public policies, articulation between federative entities (Union,

[1] Associate Professor (Retired), School of Nursing, Universidade Federal de Minas Gerais. Belo Horizonte, Minas Gerais, Brazil.

State, Municipality), decentralization, networked organization. In this context, factors related to funding, municipalization, and human resources for health and social participation create problems that are unique and pervasive to the entire process. If on the one hand strategies and operational feasibility exist, on the other hand, providing integral, equitable and universal health care requires each sphere of macropolitical management, each department, each team, each professional to make an effort to sign pacts and agreements to *enforce* strategies, resources, processes and *modus* of making health care in Brazil truly a right of all and the duty of the State.

Undeniably, full and universal access, integrality based on equity, organization in networks of care, management and funding shared by the three spheres of government have expanded the results and the positive impacts of SUS. Nevertheless, there are still some substantial weaknesses.

In this context, primary health care services have exponential and unique challenges to the full enforcement of the SUS. Historically *forsaken* when it comes to investments of all kinds (physical area, resources, appropriate equipment and technologies, composition of the teams and, consequently, the capacity and conditions of care and provision of health care to the population), primary health care units and services work as beacons for the progress and effectiveness of the SUS Health Care Network (RAS-SUS).

The exercise of responding, in fact and in law, for the attributions of the SUS in a context permeated by political, social, economic, cultural, technical and scientific diversity and adversities, imposes on the primary health care the responsibility of meeting health needs and demands of the population in the actual territory, in order to articulate the RAS-SUS. Consequently, this paradigm has repercussions on the organization of the work process and on the performance of the different professionals that compose the health care workforce.

Thus, in addition to being paradigmatic as the organizational foundation of the RAS-SUS, primary health care services and units are the places where different types of knowledge and expertise are articulated through dialogic combinations. In this way, it is possible to ensure the pertinence and technical specificity and actions that complement each other, establishing the quality of health care work and its organization as a networked system. It is in this perspective that the effectiveness of health care as an articulated set of actions and services is linked and depends on definitions of public policies and not on specific, individualized and selective actions.

Therefore, with the approval of PEC-95 (Constitutional Amendment n. 95, of 2016)[3] which freezes the resources for social policies in Brazil for 20 years, the *reformulation* of the national policy of primary care (PNAB) became the starting point towards freeing the State from directly fulfilling its constitutional duty in relation to health care: the SUS will face lack of investment and smaller state funding.

Ordinance n. 2.436, of September 21, 2017, which "Approves the National Policy of Primary Health Care, establishing the revision of guidelines for the organization of Primary Health Care, within the scope of the Unified Health System (SUS)"[4], defines the guidelines that will lead to a backlash in what has turned primary health care into the reference point of RAS-SUS. This backlash – or rather, this dismantling flow – is made explicit in the simplification of the primary health care. In practice, this is translated into the creation of a hierarchy and individuation of exclusive acts and occasional procedures geared toward selected demands.

These guidelines, summarized in priorities and protocols, dismantle structures and processes that have been built over time. Once these structures and processes are disarranged, there will be a significant impact on daily health care activities, both for those who provide care and manage services (the workers) and for the population that needs health care and assistance.

Once managed with restrictions of various types and forced to comply with limited and limiting prescriptions, primary health care services will be in disadvantage and may even be used as an argument in favor of *private health insurances*.

If, on the one hand, the directives emanating from this rationale about primary health care favor impasses and misconceptions as to the purposes of achieving health as a universal right and as the duty of State, on the other hand, it is forceful to recognize that the HCPs' definition of their own *professional activity* corroborates this dismantling, since they always divide health care into *exclusive acts*, in disregard of the objectives, purposes and principles of the SUS and also against the nature and characteristics of the work process in health: eminently collective and with multidisciplinary, interprofessional and multiprofessional interfaces.

These broad and general considerations so far are only intended to reaffirm that when we intend to identify, analyze, size or assess the repercussions of any standards, programs, guidelines and policies in the work process in health and, consequently, in the work of various professionals, some context is essential.

In today's complex and intricate landscape, there is an array of *essential questions* to be considered in the configuration and sizing of possible repercussions on the work and for the workers of Primary Health Care (ABS). For example:

- Which guidelines will guide the distribution of current primary health care workers (professionals with upper and middle education) among Family Health Teams (ESF) or Primary Health Care Teams (EAB), considering the differences in relation to the workload, composition and distribution of the work area, as defined in the current PNAB?
- The other different teams and their attributions are inseparable from the feasibility and effectiveness of primary care: Oral Health Team (eSB): modality I and II; Expanded Nucleus of Family Health and Primary Care (NASF-AB); Community Health Agents Strategy (EACS); Primary Care Teams for Specific Populations (Riparian Family Health Team/eSFR, Fluvial Family Health Teams/eSFF and Street/eCR Consulting Team). How can we ensure that planning, development, monitoring, and work program development strategies and activities are shared based on population/territory/area of coverage?

In addition to the issues inherent in a certain sphere of management – either a municipality or a state – it should be emphasized that the different compositions and attributions of these types of teams, as defined by the PNAB in force, keep in mind, as a common denominator, the need for critical and proactive analysis of the work dynamics and the movement/performance of the teams and the different professionals with a view to enhancing and enabling the *principles and guidelines of SUS and RAS to be operationalized in Primary health Care*.

The repercussions on the work and on the workers will be stronger at the level of each Unit and each team. Each one of the elements – workload, composition, work area distribution and common and specific assignments – is key to the identification and evaluation of repercussions on the dynamics and development of work in primary care and, of course, in the performance of each professional in each Unit and type of team.

In this scope, surely the nursing area – and each of its professional segments – can be taken as a mirror reflecting the movement and the trends of changes and the impacts of policies on primary health care.

In this brief summary of considerations and observations, there are no records in the country of any period when health services were performed without the presence of nursing professionals. This premise remains, in particular, in the different types of PNAB teams. Strongly inserted in care services (to promote conditions and healthy living conditions, risk and harm prevention and treatment of diseases), nursing workers are unique professionals and stand out for having a pervasive presence in the series of events that characterize health care work. This singularity is an unequivocal consequence of one of the aspects that categorize the work of the different nursing professionals (auxiliary nurse, nursing technician and nurse): they perform actions, acts and attributions that are common and specific to each

of the professions and also in actions and procedures that complement the performance of the other professionals.

Considering, therefore, that the actions of nursing professionals in primary health services is an undeniable fact in Brazilian history (vaccination campaigns, health clinics, primary care units, among others); that among nursing professionals, it is the nurse who coordinates the actions of nursing; that, in addition to nursing actions, the nurse often does the management of Basic Health Units (UBS), any measures that jeopardize the implementation of RAS-SUS, limiting or reducing the capillarity of the actions of nursing professionals, will have repercussions on the nurses' work.

Here there is no place for the nuanced and imprecise synonymy between the terms nursing-nurse. The imprecision and naturalization of this false synonymy facilitates and legitimizes opportunism and speculation (political, technical, labor and institutional) in the formulation and indication of theoretical and practical frameworks that transpose the relations and the value of work in and for the nursing area.

Certainly, in some types of work whose regulation imposes that one of the professionals, always and at any context, acts as the boss of others (the nursing area is one of these cases) the most common consequence is the weakening of the structure and the organization of that work. This mode of regulation – authoritarian beforehand and always out of context – combines with the historical circumstantiality that creates and sustains, at each time and place, the distinct concentration-dispersion-recognition movements of the work of each nursing professional. This situation gives rise to different forms of disruption of the dialogical relationship of the nursing work and, consequently, of the collective, multiprofessional and interprofessional nature of health care work. Surely, the nursing professional who stands the most and is most integrated to the transit of this activity is the nurse.

As Nurse Shirley Díaz Morales (National Health Adviser and President of the Union of Nurses of Sergipe) says:

> "There is no super professional" [...] it is only possible to guarantee integral care [...] based on "multiprofessional views" [...] the health care model that came to life with the Family Health Strategy (ESF) is at risk with the reform of the National Policy of Primary Care (Pnab) [...] "If this mindset prevails, the SUS will fail to be universal. It will be a selective SUS"[5].

Thus put, in conclusion, the dismantling of primary health care will affect the SUS in all its health *practices*. The repercussions on nurses' practice will be even stronger because nurses are the reference professionals (not the bosses) of the nursing team and, due to the vertical and horizontal dialogical relationship of this work, are also the articulators because of the internal and external complementarity of the actions they perform. The dismantling of the organization of primary health care will affect the work of all the teams, jeopardizing the role of primary health care as the network that manages the RAS-SUS demand. The nurse will eventually become a jack of all trades who transits indistinctly about the various landscapes imposed by the funding limits established in Constitutional Amendment n. 95/2016[3].

Without autonomy or participation in the definition of criteria and indicators that subsidize the definition of the *type* of team, population, area of coverage and work program, *the ethos* of the nurse's practice will be subsumed to the logic of selective primary health care, the starting point to incorporate the market strategy of *purportedly* affordable private health insurances and clinics.

So what is the outlook? The choice, in this case, is not an exit.

In fact, we have to look for different opportunities to intervene and to act in processes that enable the fulfillment of what is established in the current Constitution:

> Art. 196. Health is the right of all and the duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other conditions and universal and equal access to actions and services for their promotion, protection and recovery(2).

There is no denying the historical presence of nursing professionals in primary health care (even before this term and concept existed). This is a situation that remains in the composition of the different

types of teams defined by the PNAB. Nurses are therefore faced with a political, social, technical and ethical challenge: to accept being a "jack of all trades" professional or to play a leading role in the processes of recomposing and resetting resources, relationships and work in primary care so as to *effectively enforce the SUS*.

This challenge will have repercussions that will eventually link nursing professionals' thinking-doing to one of these extremes, establishing the identity of this primary health care nurse as a social player or as a professional-individual being.

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