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Challenges and potentials of the production of comprehensive care in Primary Health Care in Brazil

Desafios e potencialidades para produção do cuidado integral na Atenção Primária à Saúde brasileira

Desafíos y potencialidades para producción del cuidado integrado en la Atención Primaria de Salud brasileña

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ABSTRACT

Objective: To identify relational and organizational barriers related to the production of care and to map strategies and tools that favor comprehensive care. **Methods:** Scoping review of Brazilian publications from 2008 to 2018, related to the production of care in Primary Health Care. From the 348 studies found in the Virtual Health Library, 30 made up the final sample. Three book chapters were added, totaling 33 documents. **Results:** Three thematic categories were organized: Relational dimension between health professionals and users; Interactive dimension of the teamwork process; Organizational dimension and articulation in networks. Challenges of health practices out of context of the users' needs; inflexible and bureaucratic work processes; and organizational barriers to the access are highlighted. The potentials of mapped tools involved embracement, interprofessional actions and instituting care networks. **Final considerations:** The overview of challenges and processes that induce good practices facilitate a decision-making that is committed with comprehensive care.
Descriptors: Primary Health Care; Comprehensive Health Care; Patient Care Team; Public Health Practice; Public Health Policy.

RESUMO

Objetivo: Identificar entraves relacionais e organizacionais relativos à produção do cuidado e mapear estratégias e dispositivos favoráveis ao cuidado integral. **Métodos:** *Scoping review* de publicações brasileiras de 2008 a 2018, relacionadas à produção do cuidado na Atenção Primária à Saúde. Dos 348 estudos encontrados na Biblioteca Virtual da Saúde, 30 compuseram a amostra final, sendo acrescidos três capítulos de livro, totalizando 33 documentos. **Resultados:** Organizaram-se três eixos temáticos: Dimensão relacional entre profissionais de saúde e usuários; Dimensão interativa do processo de trabalho em equipe; e Dimensão organizacional e articulação em redes. Destacam-se desafios de práticas de saúde descontextualizadas das necessidades dos usuários; processos de trabalho cristalizados e burocratizados; e entraves organizacionais de barreiras de acesso. Potencialidades de dispositivos mapeados envolveram acolhimento, ferramentas de interprofissionalidade e redes instituintes de cuidado. **Considerações finais:** A panorâmica de desafios e processos indutores de boas práticas facilitam tomada de decisões comprometidas com um cuidado integral.
Descritores: Atenção Primária à Saúde; Assistência Integral à Saúde; Equipe de Assistência ao Paciente; Prática de Saúde Pública; Políticas Públicas de Saúde.

RESUMEN

Objetivo: Identificar bloqueos relacionales y organizacionales relativos a producción del cuidado y mapear estrategias y dispositivos favorables al cuidado integral. **Métodos:** *Scoping Review* de publicaciones brasileñas de 2008 a 2018, relacionadas a producción del cuidado en Atención Primaria de Salud. De 348 estudios encontrados en la Biblioteca Virtual de Salud, 30 comprendieron la muestra final, siendo acrecidos tres capítulos de libro, totalizando 33 documentos. **Resultados:** Organizaron tres ejes temáticos: Dimensión relacional entre profesionales de salud y usuarios; Dimensión interactiva del proceso laboral en equipo; y Dimensión organizacional y articulación en redes. Destacan desafíos de prácticas de salud descontextualizadas de las necesidades de los usuarios; procesos de trabajo cristalizados y burocratizados; y bloqueos organizacionales de barreras de acceso. Potencialidades de dispositivos mapeados envolvieron recepción, herramientas interprofesionales y redes instituyentes de cuidado. **Consideraciones finales:** Panorámica de desafíos y procesos inductores de buenas prácticas facilitan toma de decisiones comprometidas con un cuidado integral.
Descriptores: Atención Primaria de Salud; Atención Integral de Salud; Grupo de Atención al Paciente; Práctica de Salud Pública; Políticas Públicas de Salud.

INTRODUCTION

The production of care presupposes dialogical meetings, and the establishment of subjective relationships between users and health professionals that start from the mutual recognition of knowledge, expectations, and desires. These are influenced by the setting and by the degree of suffering and clinical instability involved, since there are very different types of care in health. While some produce tutoring and subjection, others strengthen the subjects' powers to face life, promoting autonomy[1]. The search for integrality values the needs of the subjects, making the production of care more complex, since it requires a work process that integrates the knowledge and actions of different professions and actions in care of the users themselves[2].

From the perspective of producing subjectivities, the production of care is guided by ethical precepts that reorganize the decision-making processes of practices in the daily life of services, considering the needs of users in a negotiated and inclusive way, as well as the articulation of knowledge for the active learning of relational and interactional dynamics[3].

The health worker, when producing care, turns himself into a subject of the action and recognizes the user as a subject too, both increasing knowledge through their encounter[4]. Certainly, when health professionals commit to the production of other existential territories, allowing themselves to be affected and perceiving the multiplicity of recognizing potential life in the other, the bonds and co-responsibility can be strengthened, to the detriment of "iatrogenesis, interdictions, atrocities and everyday microviolences"[5](p.404).

Understanding the interdependence of the other in exchange relations implies recognizing users as autonomous subjects, producers of care and not merely consumers of services. Consequently, this system of interpersonal exchanges involves the reciprocity of the movements of giving, receiving, and giving back. They interact in multiple perspectives, from sensitive approaches to necessary distances, constituting a setting for the production of spaces for protagonism and care[6].

Thus, the discussion on health care involves multiple references from different currents of thought, such as Merhy[7] and his studies on the micropolitics of alive work in action and health technologies; Campos[8], with *Saúde Paideia*, and the expanded and shared clinic; Ayres[9], with the processes of subjectification in health practices that imply quality and respect for the other; and Pinheiro and Mattos[10], with the multiple meanings of integrality that comprise the acts of care in health care.

Considering these assumptions, the desired change in the model of care, committed to the production of comprehensive care, requires an inversion of technological rationality that guides the knowledge and practices in health production to a work process centered on soft and soft-hard technologies[7]. These are materialized in relational practices, in dialogue, in respect for others, in qualified listening, in the sharing and co-responsibility of care. The result of this change consists of the so-called expanded clinic[8], centered around the user, their needs, subjectivation processes and projects to generate satisfaction[9].

Therefore, among the various settings that make up the care networks of the Unified Health System (SUS), Primary Health Care (PHC) is a privileged and well-connected locus that affects the process of reorienting the assistance in health, where the valorization of relational technologies and the investment in expanded and shared clinics can add quality to the work process, mobilizing the conditions for the realization of comprehensive care. It is worth mentioning that, in the Brazilian context, the Family Health Strategy (FHS) started to be adopted as a structuring model of PHC for the reorientation of knowledge and practices that guide health care[11].

However, even recognizing the PHC context as a fertile territory for a construction shared between users and health professionals, a powerful place for the recognition of life-producing relationships in the territory, and a place of strengthening bonds and relationships of trust, it has been admitted, in recent years, that there has been a tendency for these "meetings" to become less relevant. This is due to factors such as the overload of the teams, the rise of a managerialist perspective that invests in the control of the time and movements of the team instead of favoring an open and productive encounter, and the instrumental perspective about the territory and users, with the intention of governing their lives[1].

To make matters more complex, the approval of Constitutional Amendment 95/2016[12] came into play. This piece of legislation restricts the budget and freezes public spending on health, social assistance, and education for 20 years. This is a recognizable and clear threat to SUS and its entire network of actions and services made into an integrated public policy[13], capable of involving subjects who are ethically and politically committed to the production of comprehensive quality care.

Furthermore, the changes in the financial organization of SUS and the changes made to the National Primary Care Policy - PNAB[14] opened spaces for the logic of a selective and fragmented PHC, with repercussions on the model of care and management of health work. Some of its criticized aspects referred to the flexibility of the composition of the team and the workload, the changes in the attributions of the community health agents and the return of funding of traditional medical-centered primary care teams[15], in addition to the end of the stimulus to the formation of multidisciplinary teams.

These austerity measures and normative changes occurred even in the face of scientific evidence that indicates the importance of social protection policies to face the crises of capitalism[16], and despite the fact that the health situation and the access of the population to health services have improved in the these more than 30 years of SUS. Also, there are countless challenges for the achievement of the right to public, universal, and integral health in a continental and populous country[17].

The synthesis of some of this evidence can be seen in reviews by Arantes, Shimizu and Merchán-Hamann[18] on the contributions and challenges of the FHS as a model of care; and in the analyses by de Menezes et al.[19] on how Brazilian PHC professionals contribute to universal access to health services. It also can be seen in the study of Santos, Mishima and Merhy[20] on the potential of the work process in the FHS for the reconfiguration of the care model, by highlighting that the production of care based on the concept of integrality would be committed to health practices directed to the objective needs and subjective situations of people in their social context, apprehended and transformed into actions by a multidisciplinary team.

Given the above, the question is: What is the scientific evidence regarding the challenges and potential of the process of producing comprehensive care in the context of Primary Health Care in Brazil?

At first, the relational and organizational barriers that were highlighted in the studies which made up the corpus of this scope review were synthesized and expressed as disagreements between the subjects, resistances to collaborative work and access barriers. Then, an attempt was made to integrate the mapping of strategies and tools that favor a comprehensive care, providing concrete and successful responses and promoting meaningful intersubjective encounters, openness to change, and effective network flows.

OBJECTIVE

To identify scientific evidence on relational and organizational barriers related to the production of care and to map strategies and tools that favor comprehensive care.

MATERIALS AND METHOD

This is a scoping review[21], in which the instrument Preferred Reporting Items for Systematic reviews and Meta-Analyzes extension for Scoping Reviews (PRISMA-ScR)[22] was used to facilitate the organization and development. According to Munn et al.[23], the reasons for developing a scope review are, among others, to identify the types of evidence available and the knowledge gaps in a given theme; to clarify key concepts and definitions in literature; and to identify main characteristics or factors related to a concept.

To elaborate the research question, the strategy described by the mnemonic PCC - Population, Concept and Context - was adopted. This strategy was adapted to contemplate the objective of the review, where P was empirical research and theoretical essays published in Brazilian journals; C was challenges and potential of the comprehensive care production process; and C was Primary Health Care that constitutes the Primary Care of SUS.

The eligibility criteria consisted of scientific productions published in Brazilian journals that presented: challenging situations and obstacles in the relational or organizational context that interfered in the way in which the meeting between health professionals and users occurs; strategies or tools that enhance the care production process in the PHC services of the SUS care network in alignment with the premise of comprehensiveness.

A survey of scientific productions made available at the Virtual Health Library (BVS) was carried out between February and April 2020, using the key expression "care production" as a search strategy. Then, the following filters available in the database were used: full text, available in Brazilian Portuguese, published between 2008 and 2018. The choice of the Brazilian Portuguese language was justified by the authors' interest in publications of Brazilian journals. The ten-year interval considered the stage of expansion and consolidation of the FHS in the national territory, and the period in which it was sought to expand PHC's problem-solving capabilities with the creation of the Family Health Support Team (NASF).

For the eligibility process, the authors decided to include scientific articles from empirical research, theoretical essays, experience reports and reviews that contained as main subject the themes: "Primary Health Care", "Family health", "Family Health Strategy" or "comprehensive health care". Publications in the form of theses and dissertations, normative documents, repeated articles, or articles that did not contemplate the context of PHC were excluded.

In the initial study selection process, a total of 348 productions was found. Then, by reading the titles, 93 studies were considered eligible for reading the abstracts. At the end of this stage, 38 articles were selected to be read in full. Among these, 30 articles covered the guiding question and were selected to compose the process of analysis and synthesis of the results. In addition, three chapters of the collection entitled "Shared evaluation of health care: surprising what was instituted in the networks" were added, as they included important theoretical and practical reflections on tools linked to the production of comprehensive care in their discussions.

As a result, the final sample included a total of 33 documents that made up the corpus of the review, with 30 scientific articles and three book chapters available on a digital platform. The search and selection process of the studies is systematized in the flowchart of Figure 1, according to the recommendations of the Joanna Briggs Institute[22], following the instructions of PRISMA-ScR.

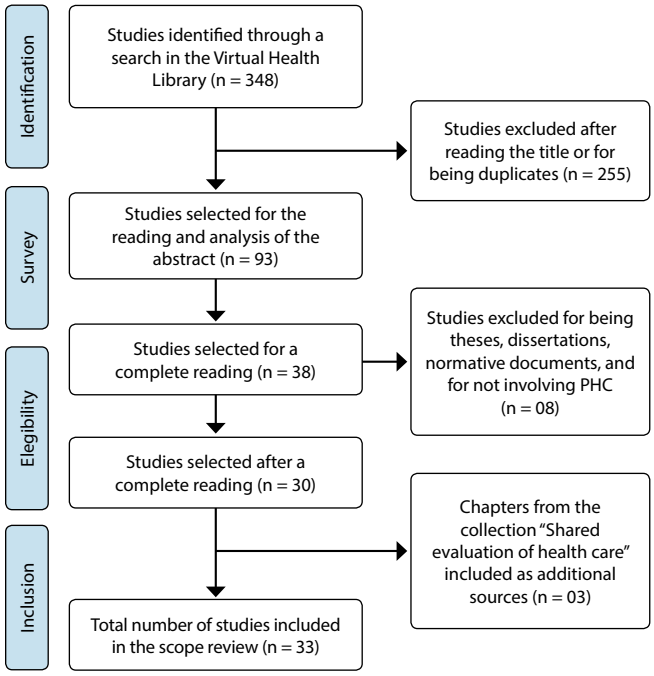

Figure 1 - Flowchart of the study selection process adapted from PRISMA[22]

The extraction of data from the articles was organized based on the elaboration of an instrument that contained the following items: title, authors, year of publication, journal or collection and type of study; and also challenges and obstacles, strategies and tools. The studies included in the scope review were listed in Table 1, with their respective codifications, titles, authorship, year of publication, sources, and types of study. Each study received a codification (E1, E2 ... E33), organized in chronological order of publication.

The data related directly to the guiding question were organized and summarized in three thematic axes, namely: I) Relational dimension between health professionals and users: meetings and mismatches; II) Interactive dimension of the teamwork process: openings and resistances; and III) Organizational dimension and articulation in networks: flow and barriers to access. In the analysis

process, the theoretical contributions of light technologies[7], expanded and shared clinic[8] and intersubjective meetings related to health practices[9] contributed to the conceptual mapping and the combination of the results obtained.

RESULTS

The 33 selected studies were published from 2008 to 2018. Among them, 24 were original articles of empirical research (E1, E3, E5, E6, E7, E9, E11, E12, E13, E14, E16, E18, E19, E21, E22, E23, E24, E25, E26, E27, E28, E30, E31, E32), 4 were theoretical essays (E2, E10, E29, E33), 3 were experience reports (E4, E15, E17), and 2 were reviews (E8, E20).

Of the 30 selected articles, 23 were published in public health journals (E1, E2, E3, E4, E5, E6, E8, E9, E10, E11, E12, E15, E16, E17, E18, E19, E20, E23, E26, E28, E31, E32, E33), 5 in nursing journals (E7, E14, E25, E27, E30), 1 in an odontology journal (E29), and 1 in the multidisciplinary health journal (E13).

Chart 1 - Studies related to the production of care, distributed by title, authors, year of publication, Journal/collection and type of study

TITLE	AUTHORS	YEAR	SOURCES	TYPES OF STUDY
E1. Social representation related to care in the family health program in Natal-Brazil[24]	Rodrigues; Lima; Roncalli	2008	Ciência e Saúde Coletiva	Empirical research
E2. Collectives arranged to produce integral care: a challenge to professional regulation[2]	Cavalcante-Filho	2009	Revista de APS	Theoretical essay
E3. The work process in health and the production of care in a Family Health Unit: limits to the reception and reflections on the emergency service[25]	Barros; Sá	2010	Ciência e Saúde Coletiva	Empirical research
E4. Care production and pedagogical production in participatory planning[26]	Franco; Koifman	2010	Interface (Botucatu)	Experience report
E5. Production of comprehensive prenatal care: a pregnant woman's route at a primary family healthcare unit[27]	Albuquerque et al.	2011	Interface (Botucatu)	Empirical research
E6. Healthcare regulation and healthcare management as tools to assure comprehensiveness and equity in health[28]	Baduy et al.	2011	Cadernos de Saúde Pública	Empirical research
E7. Saúde da família: visão dos usuários[29]	Nery et al.	2011	Revista de Enfermagem da UERJ	Empirical research
E8. The relationship between healthcare personnel and patients (user acceptance) regarding the family healthcare program: a review of approaches in Brazilian journals[30]	Vieira-dos-Santos; Santos	2011	Revista de Salud Pública	Systematic review
E9. The Interlocution of Mental Health with Primary Care in the City of Vitoria - ES[31]	Rodrigues; Moreira	2012	Saúde e Sociedade	Empirical research
E10. Cooperação interprofissional e a Reforma Sanitária no Brasil: implicações para o modelo de atenção à saúde[3]	Matuda; Aguiar; Frazão	2013	Saúde e Sociedade	Theoretical essay
E11. Link and responsibility as ways to provide care in family's health strategy[32]	Amorim; Assis; Santos	2014	Revista Baiana de Saúde Pública	Empirical research
E12. Lay agency and healthcare: producing healthcare maps[33]	Cecílio et al.	2014	Cadernos de Saúde Pública	Empirical research
E13. Health needs and production of care in a health unit in a city of the northeast part of Brazil[34]	Souza et al.	2014	O mundo da saúde	Empirical research
E14. Matrix support, individual therapeutic project and production in mental health care[35]	Jorge et al.	2015	Texto & Contexto Enfermagem	Empirical research
E15. Institutional support in primary health care: the experience in Salvador - BA[36]	Machado; Mattos	2015	Revista Baiana de Saúde Pública	Experience report
E16. Interprofessional collaboration in the Family Health Strategy: implications for the provision of care and work management[37]	Matuda et al.	2015	Ciência e Saúde Coletiva	Empirical research
E17. No beginning and no end ... with body practices and Expanded Clinics[38]	Mendes; Carvalho	2015	Interface (Botucatu)	Experience report
E18. Production of care in Brazil's Family Health Strategy: the challenges of work management and continuing health education[4]	Santos et al.	2015	Revista de APS	Empirical research
E19. About the reception: discourse and practice in the Basic Health Units in the city of Rio de Janeiro[39]	Silva; Romano	2015	Saúde em Debate	Empirical research
E20. The benefits and challenges of the Family Health Strategy in Brazilian Primary Health care: a literature review[18]	Arantes; Shimizu; Merchán-Hamann	2016	Ciência e Saúde Coletiva	Literature review
E21. Mas ele não adere! – o desafio de acolher o outro que é complexo para mim[40]	Baduy et al.	2016	Avaliação compartilhada do cuidado em saúde (V.1)	Empirical research
E22. Arranjos regulatórios como dispositivos para o cuidado compartilhado em saúde[41]	Bertussi et al.	2016	Avaliação compartilhada do cuidado em saúde (V.1)	Empirical research

To be continued

Chart 1 (concluded)

TITLE	AUTHORS	YEAR	SOURCES	TYPES OF STUDY
E23. Micro-regulatory processes in a Primary Health Care Service and the production of health care[42]	Oliveira et al.	2016	Saúde em Debate	Empirical research
E24. Vínculo e responsabilização: Como estamos engravidando esses conceitos na produção do cuidado na Atenção Básica?[5]	Seixas et al.	2016	Avaliação compartilhada do cuidado em saúde (V.1)	Empirical research
E25. Mental health care in the family health strategy: the experience of matrix support[43]	Gurgel et al.	2017	Revista de Enfermagem da UERJ	Empirical research
E26. Professionals as network producers: compositions and connections in health care[44]	Maximino et al.	2017	Saúde e Sociedade	Empirical research
E27. Production of care for resolubility of the Family Health Strategy: knowledge and dilemmas[45]	Rios; Nascimento	2017	Revista de Enfermagem UFPE Online	Empirical research
E28. Perceptions of users about humanization in family health strategy: a study based on the Theory of Gift[6]	Cunha et al.	2017	Ciência Plural	Empirical research
E29. Health care production focused on the Expanded Clinic: a necessary debate in dental education[46]	Graff; Toassi	2017	Revista ABENO	Theoretical essay
E30. The production of care in the routine of Family Health Teams[47]	Agonigi et al.	2018	Revista Brasileira de Enfermagem	Empirical research
E31. Redesigning pathways towards the expanded oral health clinic[48]	Fonsêca et al.	2018	Saúde e Sociedade	Empirical research
E32. Oral health clinic as a space for the production dialogue, connection and subjectivity among users and dentists of Primary Care[49]	Graff; Toassi	2018	Physis – Revista de Saúde Coletiva	Empirical research
E33. User embracement as a surveillance strategy in health care production: an epistemological reflection[50]	Silva et al.	2018	Saúde em Debate	Theoretical essay

Taking into account the thematic categories listed to facilitate the organization and synthesis of evidence, considering the "Relational dimension between health professionals and users", aspects that favor intersubjective meetings (E1, E2, E3, E5, E7, E8, E11, E20, E24, E26, E27, E28, E29, E30, E31, E32, E33) and mismatches between subjects (E2, E3, E5, E6, E18, E19, E24, E26) were found. Regarding the "Interactive dimension of the teamwork process", openings (E2, E6, E10, E13, E11, E16, E17, E18, E23, E25, E28, E33) and resistance to interprofessional collaboration (E2, E8, E9, E11, E16, E20, E21, E25, E29) were identified. In the "Organizational dimension and articulation in networks", favorable flows (E4, E12, E16, E22, E26, E30, E31) and access barriers (E6, E8, E12, E13, E14, E15, E20, E27, E28) were mapped.

DISCUSSION

Relational dimension between health professionals and users: meetings and mismatches

The work process and the production of care in the hegemonic health care model are health practices that are not centered on the users' singular needs or on the resolution of their demands at a specific time[28]. The time is linked to subjective criteria based on the user's suffering during their search for health care and to the predominant mode of subjectivation and sociability in contemporary times[25].

In the context of PHC, welcoming the user with qualified listening as a care technology is a potential tool for consolidating comprehensiveness. Based on relational technologies, it mobilizes the sensitivity, reflective action, and an ethical stance of health workers permeable to active listening and dialogue. This welcoming is fundamental to guarantee accessibility and the establishment of a trusting relationship between health professional and user, which allows the manifestation of the subjectivity of the other through a communicational process of qualified listening and adequate responses to the identified demands. This has the potential for strengthening interpersonal bonds, reorienting health practices, and producing comprehensive care, based on co-responsibility, respect and human dignity[2,24,27,29-30,32,46,50].

Still, in this intense and complex intersubjective situation, the different institutional regimes and the existence of complex cases directly affect the possibilities of care production[44]. When faced with challenging cases of resistant users and who do not adhere to the therapeutic plan unilaterally designed by those who believe they know "what is the best" for them, health professionals can renounce the ideal type of submissive users and experience a shared and co-responsible care process. This often leads to discomfort and inconveniences those who insist on operating in a protocolar logic and in the attempt to control the situations. However, it is in this resistance of the users that the expression of their power and the desire to keep control over themselves can be found, not to mention it can be possible for health professionals to go into a process of leaving their comfort zone and reframing their way of producing care[5,40].

In this sense, a production of care based on dialogue, on respectful, welcoming and resolutive professional performance, provides the strengthening of bonds of trust[25,45], enabling an expanded approach to health, contextualized with the territory and its social determinants[46]. From the perspective of the expanded clinic, it fosters greater diagnostic capabilities and the effectiveness of the therapeutic act[24]. However, health professionals often perceive embracement as a relational technology, but in practice, what is evident in several settings, is that users endure a veritable pilgrimage in search of care and there is a fragile teamwork in the welcoming design proposed by the service[39].

In addition, sometimes listening is limited to complaints, due to the high demand for activities, weakening the bond between professionals and users. In this complaint-conduct logic, prescriptions and standards provide little space for the creativity and autonomy

of subjects[4]. Even the accumulation of knowledge and experience of community health agents, in relation to the community context and the conditions of risk and vulnerabilities of the territory covered by the team, are little valued, and all of this ends up negatively impacting the care production processes[25]. What predominates in the daily routine of services are bureaucratic relations from the reception to consultations or making referrals[27].

This review found that the breadth of actions that seek to address the entire life cycle, longer professional experience, a reception with qualified listening, the mediation of community health agents, and home visits that bring teams closer to the community context and family dynamics, are aspects that favor and strengthen the bond between the teams and the people under their responsibility[6,18]. This is how relationships of affection and trust between workers and users are constructed[5-6].

It is noteworthy that a bond presupposes a relationship. Therefore, it is not possible to build it unilaterally. For this particular relationship to be strengthened, there must be a mutual recognition of "valid interlocutors". It is an ethical posture that makes it possible to agree and accept needs, desires and expectations that are different between the subjects, since in these intervening meetings, processes of deterritorialization unfold[5,44].

Thus, the production of symmetrical relationships capable of generating bonding and accountability makes it possible to face a tendency to rival these notions, which, in addition to producing more barriers than inclusion, still acts in the production of subjectivity that generates "blaming" the user instead of accepting their demands, needs and desires[5]. As a result, it is necessary to question how these relations are being established in daily work, reflecting on the extent to which teams trust users and value their voice, thus understanding the production of care as a relationship to be built[44].

When health professionals use creativity and innovation to share the therapeutic plan with users, it is possible to enrich the dialogue and expand the autonomy of the subjects involved. These initiatives, although seemingly strange, are innovative practices in the production of care and are based on relational technologies, expanded clinic and on a person-centered approach[46-49].

Interactive dimensions of the teamwork process: openings and resistances

The work process centered on clinical and prescriptive acts leads to a model that is not very capable of problem solving, in which individualized professional postures[30] and health practices establish cold, bureaucratic, impoverished relationships[31] and are decontextualized from the needs and particularities of the problems presented by users. This work process is commonly criticized by users, managers and the health workers themselves[32], resulting in a production of care that is not compromised with life and with the constitution of active subjects[43].

In this context, a good reception of the patient is the first step in the internal micro-regulation process of a health unit[50], as a mechanism for inclusion and attention to spontaneous demand with qualified listening[42]. It is an element for assessing the quality of the health service, capable of triggering reflections and changes in the organization of the work process, either by altering flows or enhancing teamwork, enabling an alignment between users' health needs and the capacities the service has to solve problems and show more accountability[34].

In addition, when the focus of care is shifted towards the production of procedures, there is a risk of reproducing biomedical rationality in the work process[40], which is often supported by a market logic, where corporate disputes over the monopoly of diagnoses and prescriptions occur. Users are seen as consumers of health products and there is an incentive to fragment work in stages with little problem-solving capabilities[2].

This situation is pointed out because of professional training in dissonance with a care model centered on PHC and the user, mainly focusing on technical procedures and fragmented health practices[18], since the incorporation of relational technologies in clinical practice is still challenging and is in discussion in the field of health education[46].

It has become evident that the negotiations established in these processes can reduce tensions and prioritize demands, making longitudinal care feasible, since the production of subjectivities in the territory allows for greater complicity between the community and the team[32]. Receiving the patient with qualified listening, affection, respect, honesty, quality of communication and dialogue are highlighted by users as indicators of humanized care[6]. This implies in greater adherence by users to the care plan, because they feel safe and heard, due to the configuration of a network of responsibilities for the therapeutic projects built, in addition to work processes that excel by creativity and dialogue[4].

This shared and co-responsible coordination to produce care is aligned with the perspective of "interprofessional collaboration", a term used to describe the interactive processes between professionals from different fields of knowledge, with participatory practices and strengthened interpersonal relationships. Such collaboration provides health care implied by comprehensive care and involves intensifying communication and shared decision-making[37].

Inter-professional collaboration is considered a complex process, as it includes sharing, as the division of responsibilities and sharing of decisions; partnership, with the cultivation of relationships of affinity, open communication, mutual respect, and trust; interdependence, which requires the participation of each core of knowledge in therapeutic projects; and power, expressed as the empowerment of each member of the team, whose importance is recognized[3].

The existence of tensions between traditional professional logic and collaborative practice presents itself as another challenge for comprehensive care. Professionals who operate in the traditional managerial logic of referral end up resorting to external services without first seeking the multiprofessional support team, in addition to focusing their practices on specialized procedures[37]. In some contexts, the act of meeting to discuss and get to know the cases better can be considered a "waste of time", whose apparatuses, such as support from central management, are delegitimized in the production of comprehensive care[31].

In the context of the FHS, interprofessional collaboration between members of the reference teams and NASF teams can be achieved through support from central management, that is, technical, pedagogical, and care-related support received from a specialized team working in the back ranks of the operation. This organizational arrangement makes it possible to expand the clinic in a dialogical way, promoting the production of care

through the discussion of cases and the shared, co-responsible and contextualized construction of singular therapeutic project (PTS), in a movement that breaks with traditional practices based on medicalization, referral and treatment and knowledge hierarchy[31,37]. Thus, central-management support enables the overcoming of a fragmented work logic that is still prevalent in the daily routine of services, and the user can count on the articulation of knowledge and actions capable of giving more resolute answers in face of their diverse demands to the service[43].

Collaborative practices are intent on focusing on the health needs of the families and the community. However, they have to deal with the obstacle that is fulfilling the goals of producing consultations as required by management. This adds to the difficulty of working according to the difficulties of the reference teams and to clinical, epidemiological, and sanitary parameters found in the territory[37]. The team's planning process is also limited by the lack of records with useful information, the underutilization of available information systems, and the lack of monitoring[18].

In this context, the groups organized as co-management, which are devices for organizing the work process and production of care, have the potential to induce more complex approaches to produce comprehensive care through meetings and exchanges, giving space to the alterity in the relationships established by the collective work. This configures "a teamwork that is necessarily co-managed, co-responsible and open to processes that institute new ways of producing care"[2](p.218), which operate according to ethical and political commitments to the defense of life, constituting spaces for problematization and agreement of work processes and production of comprehensive care[28].

When teams recognize themselves as collectives that share responsibilities and practices, willing to discuss, plan and deliberate their actions in a more horizontal and dialogical way, teamwork is strengthened, allowing greater integration between the subjects. This becomes an interesting interprofessional process[37], through which they articulate their knowledge and form a common field of work in health, with the appreciation of intersubjectivities and catalyzing different subjects' interests[32], expanding the capacity to solve the problems in a contextualized and responsible way[4].

Based on the premise that no single professional category has all the tools to provide comprehensive care, the practice of interprofessional collaboration requires willingness, flexibility, and openness from health professionals to put subjectively shared interests into action. The work becomes organized by the principle of shared responsibility for health between the reference team and the support team, favoring exchanges and expanded care[37,42]. Without disregarding the importance of clinical protocols in the organization or work processes, the determining criteria for the quality of the relationships produced in the meeting between health workers and users are openness to dialogue and the interest in building shared work[38].

Organizational dimension and network articulation: flow and barriers to access

Disarticulation between services at different levels of care is an important challenge for comprehensive care, since it results in limited problem-solving capabilities, discontinuity of care, unaccountability, repeated work, and loss of quality of care provided to the user[28]. The problems involved in the process of integrating the FHS into the care network are linked both to the insufficiency of specialized services that form long queues and to the communication difficulties between professionals in the network and even between members of the reference teams and NASF teams in the context of PHC[18].

Users are often lost in the threads of health care networks, resorting to other forms of entry, such as urgent and emergency services, as a strategy for accessing the health system and solving their demands[6]. This is at the heart of the issue related to the valorization of these services by the users, despite the criticism made of the "complaint-conduct" model, the lack of bond and empathy and the curative and fragmented approach that prevails at this point in the network[33].

Recognizing that users compete for meanings and create loopholes in their "lay action", producing "care maps" and other possible arrangements of health systems and ways of thinking and organizing care, requires professionals to change their crystallized way of acting: it is necessary to brave other paths that take into account the real movement of users in search of care, well-being and mitigation of pain, once users are touched by suffering, illness and/or feelings of fragility, all of which are inherent to the human condition[33].

It is interesting to note that users actively participate in the regulation of the system, even though they are not recognized and valued as a co-management strategy for care, since some managers and workers have difficulty in recognizing them as active producers. This is because they perceive services as "barrier producers", though some users create access possibilities and are not subordinate to the logic of a single form of assistance. Certainly, they will not stop looking for alternatives of bonding, of care, producing informal networks while the services offer options that involve the pilgrimage in an "analogue" network, since regulation only becomes meaningful in defense of life if it is worked to produce connections in networks based on shared care[41,44].

Another example from a care network, identified in the publications, was provided by an experimentation with participatory planning, based on the premises of permanent health education and co-management, transforming relationships of intense conflict between health professionals and users into compromising devices of the community, as well as strengthening bonds and establishing co-responsibilities. Thus, "this whole process provided a change in attitude in the process of production of care and enhanced the development of the autonomy of the subjects involved"[26](p.677).

With regard to the organizational barriers that affect the production of "carelessness", challenges were identified due to the little political autonomy of the FHS teams, the overvaluation of technicality and the distance from the theory to the real practice in health[45]. Supply and demand are disproportional, and there is a deficit in the technical composition of the work that burdens health professionals and an absence of planning centered on the needs of users and in the territorial context. These aspects contribute to the formation of repressed demands, to a crystallized work process and to fragmented care practices[18,34].

Still, there are other limitations: inadequate infrastructure, restriction of supply inputs, obstacles in the adoption of embracement as a management device for organizing access and the work process, fragmented care focused on medicalization, problems in communication between workers, disarticulation between workers of different levels of attention and fragmentation

of information systems[30]. Many services still maintain medical-centered care standards, with excessive referrals and a PHC that depends on the support of specialized care[35].

In the meantime, it has been highlighted that the discussion of cases and the joint construction of PTS as the guiding thread of the care production process expresses a resolutive work and, commonly, results in the satisfaction of both users and health workers[37]. However, for this restructuring to take place in a fluid way in the daily life of the service, it is necessary to reorganize the work process of the teams and the joint programming of the activities agreed upon, demanding the construction of a shared agenda, aligned with the meeting spaces of the team. Such movement is not always easy to happen due to the resistance on the part of some professionals, a consequence of the lack of integration and coordination in the team[36], as well as the way in which the services are organized, which may or may not favor these meetings.

The production of care mediated by light technologies allows the PTS to be proposed based on a mediation and negotiation with the user, requiring the displacement of prescriptive, imposing, and homogenizing actions, for the assumption of interactive, dialogical, and problem-solving postures, which take into account the needs of users and the specificities of the territory in which they operate[47]. Shared and particular therapeutic projects can be proposed through the exercise of an expanded clinic, and it is possible to find answers to the health needs of the subjects in a more assertive and problem-solving way[48].

Study limitations

One of the limitations of this review is the restricted character of one of the eligibility criteria, since it included only national journals. Another limitation lies in the temporal dimension, which only included publications until 2018, a period that did not include more recent publications, which would express the unfolding of the socio-health crisis that is the COVID-19 pandemic, which directly affects the way in which care is provided in the PHC.

Contributions to the area of Nursing, Health or Public Policies

The panorama of challenges faced in the routine of PHC services and the processes that induce good practices represented by the strategies and tools that have been identified require greater investment from policies and decision makers, to facilitate ethically and politically compromised decisions with an integral care with problem-solving capabilities.

Furthermore, these processes are in dispute in the teams' daily work and in the way they relate to users who are monitored in health units, especially in the current context of systematic attempts to dismantle Brazilian public health policies.

FINAL CONSIDERATIONS

The production of care is linked to the micropolitics of the health work process, demanding collaborative integration committed to the production of shared and unique therapeutic plans and integral practices inside services or in the territory. Among the challenging situations identified, some stand out, including the health practices that do not consider the unique needs of users in a timely manner; the crystallized work processes focused on bureaucratic, medicalizing and procedural logic; and the obstacles related to the ways in which the services are organized, which end up producing barriers to access, establishing distant and noisy relationships between users, health professionals and managers.

In response to these challenges, strategies and devices that favor the production of comprehensive care were mapped, such as welcoming with qualified listening, the use of interprofessional tools and practices as conditions for collaborative teamwork, and the care networks coproduced by subjects. These devices have in common the openness of the subjects to active listening, the strengthening of intersubjective bonds, the valorization of existential territories and the collaborative work.

Therefore, the implementation of other ways of acting in health – centered around the needs and singularities of the subjects, guided by relational technologies and by the broad and shared clinical practices –, despite facing adversities and contradictory situations, many successful experiences have taken place in many varied contexts of Brazilian PHC, as could be evidenced in the publications that comprised this review. Thus, these good results have the potential for strengthening interpersonal bonds and reorienting the process of organizing health practices and producing comprehensive and contextualized care, based on co-responsibility, respect and human dignity.

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