

The health care model: concepts and challenges for primary health care in Brazil

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Abstract *This is a theoretical reflection aiming to highlight the conceptual debate about the health care model and the challenges for primary health care in Brazil. The study characterizes different concepts and terminologies relating to the expression 'care model' and shows that the Family Health Strategy has improved access to health care, and also including user reception and humanization perspectives in health practices. However, one still sees: a centralizing attitude in the treatment of pathologies, and care focused on the biological body; difficulties in implementing comprehensive care; and deficits in training of teams, and in working conditions and relations. The study concludes that the term 'care model' is interpreted as polysemic and that, although there are structuring proposals and policies for a model that can make progress in relation to the biomedical paradigm, the difficulties for its implementation are significant.*

Key words *Family health, Public health policies, Primary healthcare, Health systems*

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Introduction

There is an intense debate about the forms of health practice organizations, both in the political and the academic spheres. The debate has centered on two principal points: on the one side, the conceptual understanding and terminologies of the expression ‘care model’; and on the other, the characteristics of what could be a new model oriented by the principles and guidelines of the Brazilian Unified Health System (SUS), and the difficulties presented in the structuring proposals and policies that are being implemented in Brazil, following the 1990 Health Laws 8080¹ and 8142², which instituted the SUS and social auditing of the health system.

The so-called ‘biomedical model’ has influenced professional training, the organization of services and the production of knowledge in health care. The emergence of this model is frequently associated with the publication of the Flexner Report, in 1910, in the USA, which criticized the situation of the medical schools in the US and Canada. The guidelines of the report gave orientation in the direction of a break with the science based on metaphysics in favor of one that was sustained on the Cartesian paradigm^{3,4} – which took over the highlight position and establish itself in the field of health.

The hegemony of the biomedical model generated a movement of criticism gaining international importance starting in the 1970s. In Brazil, this movement was expressed with more intensity in the second half of the 1980s^{5,6}. This model was recognized and incorporated by the health services, because of its benefits in providing relief from pain and treatment of various diseases that afflict humanity. On the other hand, its limits in care for people’s health are widely recognized, for example: the focus on the non-differentiated individual; predominant interventions on the body, and on the affected part or ‘non-functioning part of the body-machine’; the emphasis on curative action and on treatment of diseases, injuries and damage; medicalization; and the emphasis on hospital care, with intensive use of the material technological apparatus. It is also significant that little emphasis is placed on the analysis of the determining factors of the health-disease process, the orientation toward spontaneous demand, the distancing from the cultural and ethical aspects implied in subjects’ choices and experiences, and the incapacity to understand the multi-dimensionality of the human being⁷⁻¹¹.

In the 1980s, faced with growing costs to the health sector and in the context of the struggles to end the Brazilian military dictatorship, to achieve democracy and citizenship rights, criticism of the current health care model gained strength¹². This debate was expressed fundamentality in the Eighth National Health Conference¹³, and in the 1988 Constitution¹⁴, which culminated in the achievement of the SUS, in 1990^{1,2}.

Among the subjects under discussion in that period were the concept of health, which began to be understood as the result of social and life conditions, and the themes of the right to health and to access to the health services – both recognized as rights of citizenship. The principles of the SUS became an axis of orientation for care practices, aiming to provide: universal and equal access to health services; a health care system regionalized, hierarchized and decentralized with popular participation; and care in terms of comprehensiveness^{1,2,7,15}.

However, in the process of construction and implementation of the principles of the SUS, there were various challenges in creating a care model that complied with what was specified in the legal framework^{7,12,15-18}. Teixeira and Paim¹⁹ refer to “the need to translate the principles laid out in the health reform and the Eighth National Health Conference into the organization of the health services”.

The dispute between the hegemonic biomedical model and the alternative models proposed¹², which began in the 1980s, continued in the 1990s and the beginning of the 2000s. The debate widened in the National Health Conferences (CNS). In the Tenth CNS (in 1996), the need to build a model of care for quality of life was put on the agenda; and at the Eleventh CNS (2000), “this question reappeared as one of the sub-themes of debate: healthcare models centered on quality, effectiveness, equity and priority health needs”¹². The themes and resolutions of the Twelfth CNS (2003), the Thirteenth CNS (2008) and the Fourteenth CNS (2012) dealt with issues relating to making the right to health and to access to services, and aspects relating to the need for reorganization of healthcare, practices and the ways of giving care, which are the elements constituting the care model²⁰⁻²², into a concrete reality.

In this scenario, it is important to highlight the year 1994 when the Family Health Program emerges, and is later called the Family Health Strategy (FHS)²³ by the Ministry of Health. The FHS has represented one of the principal at-

tempts at overcoming the problems arising from the biomedical model and also to implement the principles of the SUS. The FHS presents itself as a structuring axis for the process of reorganization of the health system, based on Primary Health Care (PHC).

The guidelines prescribed in the FHS set out a 'new' care model, in which the practices were to be oriented by the determining characteristics of the health-disease process, concerning the individual in his family context, as part of socio-cultural groups and communities, and including important actions in the field of Health Surveillance and Health Promotion²³.

In 2012 the FHS and Primary Health Care, including the ordination of the care networks, were strengthened by the national health policy. "The new policy strengthens ties between Primary Health Care and important initiatives of the SUS, such as the expansion of intersectorial actions and promotion of health, with the universalization of the Health in the School Program"²⁴.

Primary Health Care was to be the preferred contact for users, the principal entry to the Healthcare Network, and the center of its communication. In the Brazilian health policy the terms 'Basic Healthcare' and 'Primary Healthcare' are equivalent²⁴.

The Brazilian Primary Health Care Policy reaffirmed that Family Health is the priority strategy for expansion and consolidation of care, and the Health Ministry and the State health secretariats were made responsible for support to healthcare and stimulus for adoption of the FHS as a structuring factor for the organization of the municipal health systems²⁴.

However, studies showed fragilities in the potential of the Brazilian Primary Health Care Policy to motivate changes in care practices, evidencing that actions continued to be predominantly centered on the doctor, on treatment of and rehabilitation from diseases, and to have some deficiencies in the teamwork^{18,25,26}.

Also, it was found that there was not uniformity in the employment of the term 'care model'. In this context, two points stand out: the multiple meanings attributed to the expression 'care model' and its variations, and the challenges of the movements that criticize the hegemonic paradigm.

This article aims to highlight the debate about the concepts of the health care model and the challenges for primary health care in Brazil.

Health Care Model: names and concepts

The term 'health care model' is used with various terminological variations: 'health care modalities or technological models'^{27,28}, 'means of producing health'¹⁶, 'health care models'^{12,16,28}, 'technical or technocare model, and techno-care model'^{17,28}, 'means of intervention'¹², 'models of health care'²⁹⁻³¹, or 'models for care'³². The diversity of names and approaches makes it a complex task to place a precise concept on the expression 'health care model'.

Merhy¹⁷ uses the name 'technocare model' to refer to a process made up of "health work technologies" and health care is understood as a "technology of care" operated by three types of technological arrangements: the soft, soft-hard and hard technologies. This author contributes to the debate about the need to change the hegemonic care model, arguing that for this it is necessary to have an impact on the nucleus of care, an impact of "the living labour on the dead labour". In this sense, it is necessary to invest in soft technologies, in the relationships-technologies, centered on users' needs, inverting the investment in hard or soft-hard technologies (as rules, equipment and materials).

Health care models, models or modes of intervention in health care are understood by Paim¹² as different technological combinations for different purposes. They have the purpose of solving problems and health needs, in a given reality and population (individuals, groups or communities), and to organize health services depending on the epidemiological profile and the investigation of the damage and risks to health¹².

In the view of Campos^{16,27}, health care model, technological model or health care modality should not be understood only as the organizational and technical design of the services, but including the way in which the assistential actions are produced and how the state organizes itself to achieve this process.

Mendes¹¹, analyzing the Brazilian Health System in a dialogue with international precepts and dealing with the challenges of implementation of the principles of the SUS, says that 'the healthcare models are logical systems that organize the functioning of the Healthcare Networks, articulating, in a singular fashion, the relationships between the components of the network and the health interventions taken, which are decided as a function of the prevailing view of health, of the

demographic and epidemiological situations, and of the social determinants of health, that are in place at a given time in a given society⁷¹¹. However, ‘in the SUS, although the official discourse is that Primary Health Care is the health family strategy, in reality it still mixes cultural, technical and operational elements of two other interpretations that are more restricted: the selective PHC, and the PHC as a primary level of health care⁷¹¹. In spite of the importance of the semantic change from Family Health Program to Family Health Strategy, there is a need “to go more deeply into the transformation for a change of paradigm to be achieved⁷¹¹. According to the author, the new paradigm incorporates precepts of Primary Health Care, reporting back to the resolution of the Alma-Ata Conference (1978) and the definition of Primary Health Care. He argues that “the institutionalization of the PHC of the SUS as a family health strategy (FHS) will mean two major movements of changes: replacement of the cycle of basic healthcare by the cycle of primary healthcare, and the consequent replacement of the Family Health Program (FHP) by the consolidation of the Family Health Strategy (FHS)⁷¹¹.

Rosa and Labate³¹, based on one of the first documents of the Health Ministry, published in 1997, about the FHS, say that its objective is to reorganize care practice, widening the focus to the family and its social relations and conditions of life, articulating a group of actions promoting, protecting and recovering health. They also say, based on Levcovitz and Garrido³², that the FHS consists of “a care model that presupposes recognition of health as a right of citizenship, expressed in improvement of conditions of life⁷, with services that are more problem-solving, more integrated, and, principally, more humanized.

Lucena *et al.*³³ and Mendes³⁴ say that the concept and shape of the care model are strongly associated with the social-historical scenario of interests of classes, and with the evolution of health systems and health policies. In Brazil, starting in the 20th Century, four care models^{16,34} can be identified: the health-campaign model of the beginning of the century; the professional-clinician, or private-medical-care model (based on the concepts of health as a merchandise and not oriented by the population’s health needs); the rationalizing/reformist model (which aims to reorganize and rationalize the services, without changing the conception of health and the manner of intervention in the health-disease pro-

cess); and the model that is still under construction, which brings to life the inventory of ideas from the Eighth National Health Conference, of 1986, and from the SUS, of 1990.

Considering the theoretical formulations that have been put forward, it can be concluded that the ‘health care model’ is a polysemic term used to describe different aspects of a complex phenomenon. However, all of them refer to the way in which, given historic-social contexts, these health services are organized, how the practices are carried out, the values that guide how each society defines health, and the rights of human beings in relation to life. In our understanding, in the process of configuration of a ‘health care model’, various elements interact with each other, influencing and defining different care practices, articulated to different historical and cultural contexts³⁵. This is characterized in Figure 1.

Challenges for the construction of a Care model in Primary Healthcare

The FHS can be understood as a formulation that indicates problems and solutions for a community of practitioners, “in the sense of renewing and producing new instruments, alternative to those existing, which are able to solve the health problems of the Brazilian population, which apparently have not had sufficient responses from the Flexnerian biomedical model⁷³⁶. However, the legitimacy and the reach of the condition of hegemony of the new paradigm depends on strong social support, and the resolution of the problems which it is proposed should not be limited to the sphere of the FHS, but cover the whole health system, in its different levels of complexity, and the carrying out of intersectorial actions³⁷.

The Family Health (FH) or Family Health Strategy (FHS) model is a benchmark proposal that emerged in the 1990s, in Brazil, to motivate changes in the healthcare model^{31,38}, with a view to complying with the requirements in the 1998 Constitution, and with the principles of the SUS. Thus, in the political-legal and political-institutional dimensions, the SUS already constitutes a new paradigm. However, it is in the political-operational dimension, that is to say, at the level of care practices – where the FHS is situated – that the great challenge is found^{36,39}.

At present, the FHS is incorporated in the Brazilian Primary Health Care policy²⁴ and its content includes international references, such as the development of the concept of Primary

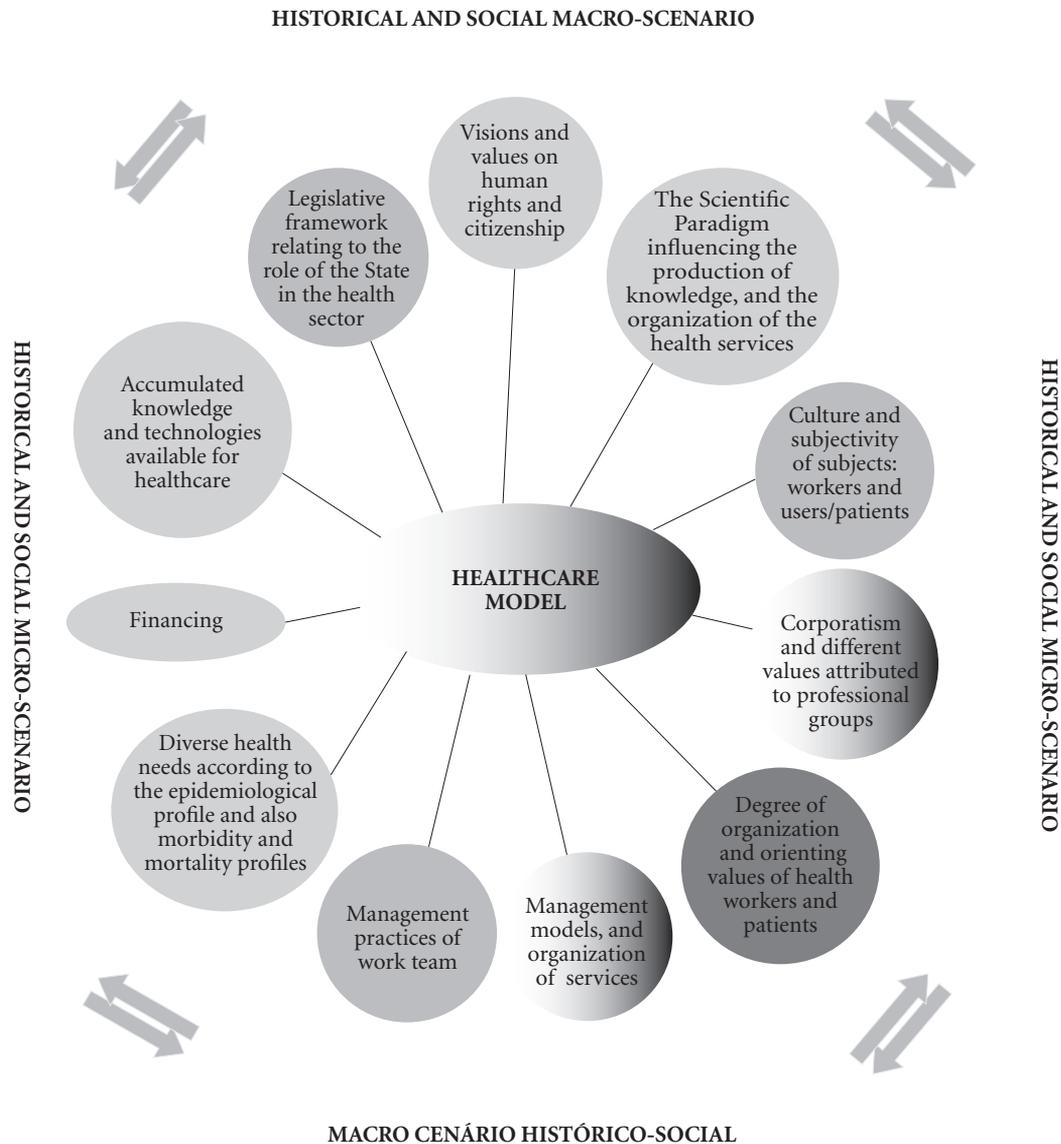


Figure 1. Elements that interfere in the formation of a care model, from the formulations of Campos^{16,27}, Paim³⁰ and Pires³⁵.

Fonte: Constructed by the authors, 2014.

Health Care, and the ideals and experiences of family medicine accumulated in countries such as Canada, Cuba, Sweden and England³¹.

Primary Health Care consists of a group of strategies formulated at the international Alma-Ata Conference, in the Russian city of that name, in 1978. Primary Health Care was assumed by the World Health Organization (WHO), as a

strategy for achieving the target of 'health for all', considering the recognition of the importance of cultural practices in health and the use of problem-solving modes of care and costs that could be supported by the countries⁴⁰.

The FHS is inspired on the resolutions of Alma-Ata and reaffirms the principles and guidelines of the SUS, prescribing full and continuous

care for families and communities, in their social space, understood and served as from the place where they live, work and relate to each other. It also includes multi-professional actions in an interdisciplinary perspective, the construction of improved user reception, and bonding of a commitment and co-responsibility between health professionals and the population of the region

covered by the health unit, also intervening on risk factors²³, with emphasis on Health Surveillance and Health Promotion.

The Chart 1 presents the characteristics of the biomedical model and of the model prescribed in the FHS and the National Primary Health Care Policy, of 2012, highlighting the elements that point toward the construction of a new para-

Chart 1. Characteristics to the biomedical model and ESF/PNAB as main changes strategies in the care model after the implantation of SUS.

	Biomedical model	Family Health model
Characteristics	Currently this model is hegemonic in health services. The health care practices focus on patients' complaints, and on diagnoses and treatment of diseases. Health promotion is not a priority.	The Family Health Program emerged in 1994. After it became a priority strategy for overcoming the problems that arise from the biomedical model and for putting the principles of the SUS into action. It lays out a "New Healthcare Model", inspired on Primary Health Care (APS), expanding the approach of health problems, and articulating actions for health promotion, prevention and treatment of diseases, and rehabilitation.
	It gives priority to individual care, with emphasis on specialization and the use of technologies, specially the material ones. Organizes care based on spontaneous demand.	It proposes healthcare focused on the family, groups and communities. The individual is seen as a historical and social being, who is part of a family and of a specific culture. It considers the determinant factors of health and diseases for health care planning and proposes the promotion of autonomy and quality of life.
	Work takes place in a fragmented fashion, with predominance of hierarchically-organized practices and inequality between the different professional categories.	It proposes healthcare provided by multi-professional teams, operating with an interdisciplinary approach.
	Biomedical model presents difficulties for apply the comprehensiveness approach, both in terms of understanding of the multi-dimensional nature of the human being, and also in terms of integration between levels of care. There is lack of communication and integration between the services that comprise the health networks.	The Family Health model assumes the concept of comprehensiveness including the primary health care as the first level of care, but also integrated into the network of the health system. The health system has to be able to care the population health needs. The relationships between their levels of complexity includes reference/couter reference system.
	The health care professional education and knowledge are based on the principles of the 1910 Flexner Report. Health professionals are trained in curricula that give little value to the Unified Health System (SUS) and the Family Health model.	Recognizes the importance of training human resources for the Unified Health System (SUS).
	Health planning is little used as a management tool, and themes such as bonding, and user embracement, are not given priority.	Assumes, as one of the central axes of health practices, the user embracement perspective and the construction of relationships including a bond of commitment and co-responsibility, between health professionals, managers and the population.

digm for thinking about and producing health, oriented by the principles of the SUS. In the process of construction of this 'new' care model in basic healthcare, after 20 years of implementation, it is seen that the principal strategies are found in the political-operational dimension⁴¹. The first relates to the teamwork that is considered essential⁴² for achieving the objectives of the FHS. However, the work continues to be in general fragmented, with hierarchal practices persisting, and an inequality between the various professional categories, usually with various professions being subordinated to the knowledge and practices of medicine⁴²⁻⁴⁴. Opposed to this reality is the view of a multi-professional team that should act from an interdisciplinary point of view, integrating different areas of knowledge with a view to providing a care that is more qualified to the needs of the users. Further, in this point of view, one can mention the central position occupied by actions on care for the biological body, on diagnosis and treatment of pathologies, and on medicalization^{8,25,45}. Although these aspects constitute a great challenge, it should be recognized that there is a heterogeneity of configurations in the work of the Family Health (FH) teams, which vary according to the social context and the region where they are developed⁴⁶.

The second challenge referred to in the literature is about the difficulties in establishing an integrated health service^{14,45}, whether from the point of view of understanding of the multi-dimensionality of the human being, or whether in relation to the relationship of reference and counter-reference inside the SUS and integration between the levels of care. In this context, the recent implementation of care networks has been a positive highlight: they are organizing arrangements of actions and services that seek to ensure integrated healthcare. The networks aim to provide actions oriented to meet the health needs of the population, provided in a continuous and integrated way by multi-professional teams that share objectives and commitments to the best health and economic results⁴⁷.

Third, there is the problem of inadequate or insufficient training for work in Family Health, whether due to a question of professional education, or because of the deficits in permanent education^{36,48,49}.

Another important challenge is the need to overcome the significant deficits in working conditions, including instability in labor relations, precariously paid wages, and excessive working hours, problems in the teams/population ratio,

and shortcomings in terms of instruments and work environment²⁶.

A fifth challenge is the importance of facing the problem of the asymmetrical relationship between professionals and health users: the difficulties in the involvement of professionals with the community, establishment of the link of mutual respect and correspondence between professionals and users of the health services^{46,49}.

Lack of understanding about what inter-sectoriality is, the problems in the structure of the services and in the processes of management are also major challenges in the construction of the prescribed new model for healthcare. The spaces for collective construction of new health practices are still incipient, since the formal instances of agreement between managers, workers and users are still more dedicated to the debate about organization and financing of the system than to the debate about the organization of care itself³⁷.

Final considerations

The quest for a health care model oriented towards comprehensive care and a wider view of health needs in harmony with the principles of the SUS, and able to overcome the problems arising from the hegemony of the biomedicine paradigm, is one of the great challenges of the Brazilian health system today. This scenario is strongly reflected in academic work, policies, conferences and congresses both in Brazil and internationally.

The literature shows that 'health care model' is a polysemic term used with various terminological variations, and referring to different aspects of a complex phenomenon. However, based on the research work and published matter on the subject, it is possible to state that the shape of a specific health care model results in an historic-social process which is dynamic and multi-factorial and which undergoes influences from a network of factors from the macro and micro-social spheres, of a given society. This 'shaping' involves values that orient the concept of health and the right to health. It is also influenced by accumulated knowledge and by the hegemonic paradigm of science, in such a way that different models consist of political responses produced in answer to the health problems of a given society, taking into account costs, demands and the capacity of the various agents to press for their interests and rights.

The movements for definition of one or other model may go, sometimes, in the direction of conservation of the traditional model; at other

times, in the direction of a new model – and at other times indicate a co-existence, with conflict, or with complementation, between them. In this process the day-to-day movements in the health labor, such as the relationships between people, are highlighted; the involvement and co-accountability (of the managers, health professionals and users) in healthcare; and also the bonding, user reception and humanization of the care practices.

In the micro-scenario of work, disputes arise between interests of different subjects. Thus, for construction of a new health model with potential to make a break with the biomedicine paradigm, it is necessary to consider two principal aspects: the day-to-day routine of the care practices, and the health needs of the users. The different theoretical contributions on the subject of this study lead to the view that it is the arena of

interests, built on the daily routine of the health services, that will define the design for care.

Positive advances in the consolidation of the FHS can be seen, principally in relation to the broadening of access, in relation to home care, care for women, particularly pre-natal of low risk, childcare, and in the special care for the elderly and chronic diseases. However, a significant influence can also be seen from the hegemonic biomedical model in the care practices, and although there are structuring proposals and policies of a model that would make a break with the biomedical paradigm, the difficulties for its implementation are significant. The theoretical and political outlooks for implementation of a new care model, in Brazil, are challenges that need to be assimilated in the day-to-day work of the health services, by the health professionals and teams, by the users and their instances of social control, and by the managers of health.

Collaborations

HP Fertonani and DEP Pires were responsible for the article design and write-up. HP Fertonani, DEP Pires, D Biff and MDA Scherer participated in the write-up of the article, critical review and approval of the final version for publication.

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