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Family Health Strategy at 30: when care has something to say to policy

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The question that inspired the article submitted for debate – "What do we need after 30 years of the Family Health Strategy?" – could, in principle, suggest a generic and rhetorical answer: we need the Unified Health System (SUS) to be consolidated as a public, comprehensive, and universal health system.

If this is a premise for ensuring the conditions for the implementation of the guidelines that shape the Family Health Program (FHP), reiterated in the format of the Family Health Strategy (FHS) and in the first editions of the National Primary Health Care Policy (*Política Nacional de Atenção Básica em Saúde* - PNAB)[1], the discussion could shift to the major impasses of the SUS (underfunding, spurious public-private relations, underregulation, labor issues, among others) and, consequently, to its enormous political challenge. Indeed, the article, from its summary onwards, promises not to lose sight of the structural issues of SUS.

However, since the text under discussion prioritizes the dimension of care, particularly the attributes of coordination, integration, and continuity, it is imperative to recognize the focus on care and organizational models[2] as central components of a health system. From this perspective, even considering its relationships with administrative and political aspects, the FHS is treated in its specificity. This is one of the article's merits: without ignoring the distinct determinants of the effectiveness of Primary Health Care (PHC)[3], it strives to highlight what still needs to be done for its development after more than three decades of implementation, as one of Brazil's main health policies.

Another merit of the article is that it highlights the advances of the FHS during this period, without triumphalism, drawing on national and international publications. It recognizes the diversity of experiences within SUS and the PHC and highlights the persistence of problems related to the population's living and health conditions, inequalities, armed violence, outsourcing and precariousness of health workers, the lack of a career within SUS, regulation, among others. Furthermore, it inserts the discussion of PHC/FHS into the proposals for SUS networks and regions, broadly announcing possible developments in the current situation, given a "new and complex policy" for specialized care presented by the Ministry of Health (MS).

Finally, but no less important, the text lists proposals at the technical-administrative level for strengthening PHC/FHS/SUS, without prejudice to other policy proposals to be considered in analyses of coherence, feasibility, and viability, from the perspective of strategic thinking. The focus on a "set of technical-political strategies" can encourage readers of this publication and, ultimately, stakeholders to discuss a strategic design to implement the proposed proposals.

Using the conceptual framework systematized by Barbara Starfield, as well as doctrinal and normative documents produced in Brazil and international literature, allows us to examine notions, key elements, and the current situation regarding care, questioning a certain "mantra" used by technicians, managers, advisors, and academics, which affirms PHC as the "care coordinator and organizer" of the network. Exposing this ideological veil, which tends to obscure the contradictions of the health system and relegate the distribution of sectoral and societal power to a secondary role, represents a fundamental step toward political analysis in health, investigating and acting on reality as it is rather than as an object of beliefs and utopias. In this way, different spheres of power in health could be considered and processes could be triggered, producing new events through alliances and coalitions among stakeholders to alter the balance of power toward the consolidation of SUS/PHC/FHS. This could be a way to avoid subjecting the strategy to "a normative, idealized, and decontextualized logic".

Therefore, this is a thoughtful, well-argued text, grounded in current literature. Regarding care – that is, the content of the health system, rather than its organizational, administrative, and political dimensions – the article highlights five key elements for PHC: the ability to welcome and bond with users; the technical quality of professionals and health practices; coordination among professionals in work processes; "interorganizational collaboration"; and the integration of clinical information. Certainly, these elements, supported by care protocols and technical-ad-

ministrative standards, would tend to increase the quality, resolution, and effectiveness of care, reinvigorating a needs-centered care model.

Although managers, leaders, and politicians may display a magical or naive awareness of immediate changes in care models, it is the responsibility of science and technology in Policy, Planning, and Management to analyze concrete situations and identify alternatives for prioritizing quality of care through organization, management, resource acquisition, and policy. In the struggle for rationality (political, economic, bureaucratic, and technical-care) in the health decision-making process, PHC/FHS stakeholders should not compromise their defense of technical-care rationality, making a difference in care delivery.

In the mechanisms presented for the coordination, integration, and continuity of care, the article explains ideas and proposals developed by Brazilian Collective Health, including topics in mental health, without forgetting that specialized care in SUS represents a historically created bottleneck, as it is predominantly private[4]. Thus, PHC/SUS has been held hostage by the private sector, whose spurious relationship with SUS, both internally and externally, subjects them to market logic, compromising health as a right of all and a public good.

The text under discussion concludes with a list of proposals, considered preliminary, aimed at addressing the critical issues identified in PHC/FHS. Although most of these proposals are pertinent in terms of what should be done, it is necessary to discuss how, with whom, against whom, with what support, and the strategic design for building viability. Given these aspects, disagreements may arise depending on the debater's perspective, especially when considering the current situation, the current correlation of sectoral and societal forces, the urgency of the identified problems, and the federal government's proposal centered on the Now There's a Specialty Program (*Programa Agora tem Especialistas* - PATE), launched in May 2025.

Regarding the expansion of "clinical and care capacity," which is fundamental to quality care, the incorporation of new work methods based on knowledge derived from technological assessment in health, as well as the training, specialization, development, and certification of health professionals (not just physicians) for PHC, cannot depend exclusively on universities, colleges, and hospitals that are part of the so-called SUS Institutional Development Support Program (*Programa de Apoio ao Desenvolvimento Institucional do SUS* - Proadi-SUS). While the importance of public teaching and research facilities in advancing the quality of care is undeniable, it is impossible to ignore the significant growth of private institutions, insufficiently regulated by the State, whose trained professionals may be far removed from the priorities, principles, and guidelines of SUS. Furthermore, no matter how much investment can be made in technological incorporation, when professional qualifications depend on curricular changes, it is important to remember that the extensive training time (undergraduate, residency, specialization, and postgraduate) entails years of training, given the urgent problems that need to be addressed in the here and now. Therefore, without detracting from efforts focused on professional qualifications within academic institutions, new strategies for continuing health education must be implemented, coordinated by the Ministry of Health in partnership with state and municipal health departments, to ensure more timely responses to current problems[5].

Regarding the contribution of PHC to ensuring user access to specialized services – one of the major challenges facing SUS, stemming from public underfunding, the hegemonic medical-care model, and underregulation of the private sector – the notion of accountability should be present in the proposals. PHC healthcare would need to be responsible and accountable for this access, discussing and overcoming the obstacles and contradictions that increase the suffering of users in the ordeal they are forced to endure in the daily life of the SUS. Decentralizing parts of the "regulatory prerogatives and functions" under the control of "parameterized quotas," which translate to ordinary citizens and the media as "death lines," does not seem sufficient to reduce waiting times, even when clinical protocols or telehealth are implemented. The technical, administrative, and political powers of regulatory centers (RCs) can be transferred to PHC management bodies as an indicator of the democratization of the decision-making process, provided that the gray box of RCs can be opened to society, aiming for democratic control exercised by SUS councils. Simply transferring part of the regulation to PHC while maintaining bureaucratic secrecy, quotas for rationing supply, the opacity of technical-administrative mechanisms, the lack of transparency for users and their families, as well as authoritarian decisions lacking sufficient technical and scientific basis, in addition to failing to change the dynamics that produce waiting lists, fail to fulfill the right to health and dignified, quality care for SUS users. The burning question is who controls the RC controller, whether at the central, regional, and municipal levels, or at the PHC level?

Regarding the organization and operation of specialized care, unfortunately, the recommendations, while defendable, do not appear to achieve the purposes and pace outlined by PATE. Regulation of specialist training, changes to medical residency curricula to include experience in matrix support, establishment of waiting times, changes in financing to mandate in-person and/or virtual matrix support to reinforce PHC, and the strengthening of public specialized care appear to run counter to PATE's priorities and strategies, which deepen "SUS's dependence on the private market." The National Specialized Care Policy (*Política Nacional de Atenção Especializada* - PNAES) and the "Integrated Care Offers (ICO)" strategy, defined under Minister Nísia Trindade's administration, "require attention to the timing and direction of changes," as the text warns. Along with the PATE, they demand increased public funding, state intervention in regulating supply and demand[6], as well as the implementation and operation of democratic monitoring and evaluation mechanisms by technical and academic bodies and health councils.

Finally, regarding technical suggestions to overcome the multiplicity of information systems and their low interoperability, as they reveal a sensitive area with ethical, political, and economic dimensions, they require greater discussion with experts, given the interests of the "private market", which do not necessarily converge with the public interest.

While acknowledging that "each proposal requires an analysis of technical, political, and financial feasibility," as well as any necessary adjustments, the article emphasizes that "care coordination based on PHC" can only be fully achieved if changes are implemented in specialized care, as well as "in the organization and management of the network." This constraint, therefore, basically places a major part of the article's proposals on hold, as no "structuring policies" are foreseen in Brazil in the short or medium term.

Despite these restrictions, another merit of this publication is the potential to spark a broad debate in defense of the consolidation of a predominantly public, high-quality SUS, where the accumulated achievements of 30 years of implementation of the FHS play a significant role in the current political process. As the PHC Research Network warns, "strengthening specialized care, based on a public model, integrated and coordinated by PHC, is a crucial condition for guaranteeing the universal right to health and consolidating the principles that have guided SUS since its inception"[7] (p.2). From this perspective, the reconfiguration of care would have a lot to say to politics.

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