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Articles

Challenges for the expansion of Integrative and Complementary Health Practices in the care pathways of the Brazilian National Health System (SUS)

Desafios para a expansão das Práticas Integrativas e Complementares em Saúde nas linhas de cuidado do Sistema Único de Saúde (SUS) (resumo: p. 17)

Desafíos para la expansión de las Prácticas Integradoras y Complementarias en Salud en las líneas de cuidado del Sistema Brasileño de Salud (SUS)

(resumen: p. 17)

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The National Policy on Integrative and Complementary Practices (PNPIC) represented a milestone for the recognition of integrative practices in Brazil. However, almost 20 years later, challenges remain for its expansion in the Brazilian National Health System (SUS). This article proposes a critical analysis of the PNPIC, questioning the organizational mechanisms of care. It seeks to reflect on the influence that public health network references may have on the expansion of Integrative and Complementary Practices (PICS) in Brazil. The theoretical frameworks are linked to the critical study of the authors' accumulated experience in an institutional development project for the implementation of PICS in comprehensive care lines, carried out in 2024, with tripartite participation. As a contribution, some paths and methodological offerings are presented that aim to expand access and integrate PICS into comprehensive care for users.

Keywords: Complementary and integrative health practices. Community networks. Patient-centered care. Comprehensive health care. Health policy.

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Introduction

Integrative and Complementary Practices (PICs) include complex systems and therapeutic resources recognized for incorporating a broader view of the health-disease process and promoting comprehensive care. They consider approaches with special attention to establishing therapeutic bonds, humanized care, with space for perspectives on care that consider culture and spirituality in human health[1].

These aspects have been valued due to the growing recognition of the limitations of biomedicine and its association with the deterioration of care relationships in health services. They are presented as perspectives that contribute significantly to the qualification of comprehensive care in the context of the struggle for the right to health[2-5].

Brazil has participated in the global movement of Traditional, Complementary, and Integrative Medicines (TCIM), incorporating these practices as public policy through the Brazilian National Health System (SUS) to promote health and prevent and treat diseases and conditions. The National Policy on Integrative and Complementary Practices (PNPIC) represented a milestone for the official recognition of TCIM in Brazil, although it still has several weaknesses and gaps[5-7].

Established in Brazil in 2006, the PNPIC defined a set of guidelines whose purpose was to incorporate and implement PICS in the SUS, from the perspective of disease prevention and health promotion and recovery, with special emphasis on Primary Health Care (PHC). Its development process recognized the experiences of states and municipalities, the demands of civil society, and the guidelines of the World Health Organization (WHO)[6-9]. Since then, the policy has undergone expansion in 2017 and 2018, reaching 29 therapeutic practices offered by the SUS[10].

In 2024, the PNPIC celebrated its 18th anniversary, reaching all 27 federal units, with 13 formulating their own State PICS Policies (PEPIC). However, only seven have state funding. Nine others have PEPIC proposals in the works. A total of 4,640 municipalities (83%) registered PICS, covering 21,403 health teams (36%). From 2017 to 2023, 26.5 million people benefited from PICS carried out in the SUS. In 2023 alone, there were 5.7 million individual and collective therapeutic activities, encompassing all levels of care[10].

Despite advances in the implementation of PICS in the SUS, the expansion and consolidation of the PNPIC face significant challenges. The increase in supply does not necessarily reflect an improvement in the legitimacy of the policy among managers and hegemonic forces in the field of health[5].

The partial institutionalization of the PNPIC is revealed in the absence of specific financial incentives, which has been one of the main obstacles to its full implementation in the SUS[5,11].

The institutional position that the PNPIC occupies in the Ministry of Health, as a component of national PHC management, contributes to difficulties in mainstreaming it into the organizational structure and health policy agenda. This institutional position and the lack of financial mechanisms weaken its inducing capacity as a national policy[5].

The lack of funding results in inadequate infrastructure, lack of supplies, lack of professional training, and discontinuity of these services in the SUS. These conditions make the implementation of PICS dependent on the individual efforts of committed professionals. In addition, it compromises the expansion of scientific research and development, hindering the legitimization of these practices[5,12].

The qualification of health professionals for PICS in the SUS has shown some recent advances, especially with the expansion of continuing education programs promoted by states and municipalities[2]. Some government initiatives, such as training courses offered by the Ministry of Health, have contributed to disseminating knowledge about these practices and encouraging their implementation in PHC[10].

Universities and research centers have begun to offer specialization and continuing education courses in PICS, which represents an important step toward the inclusion of these practices in the academic curriculum and in the training of professionals to work in the SUS[13]. However, most undergraduate courses in the health field still do not include mandatory subjects on PICS, which results in the training of professionals who are unaware or poorly prepared[5].

Professional qualification in PICS is irregular and poorly distributed among Brazilian states and municipalities. Training opportunities are concentrated in large urban centers, most of them offered by private institutions unrelated to the SUS, with only a few opportunities for specialization courses financed with public funds[13,14]. This inequality compromises equity in access to PICS in the SUS, since the services offered vary according to the availability of qualified professionals in each region[4].

Another significant obstacle is the resistance of biomedical sectors to the implementation of PICS in the SUS. Many health professionals doubt the effectiveness of these practices and, due to a lack of adequate training, do not recommend them or even consider their use as part of treatment[7]. This resistance is also reflected in managers and decision-makers, who do not prioritize the allocation of resources for training and qualification in PICS within public health policies[11].

PICS occur unevenly across regions, with a higher concentration in large urban centers and lower coverage in inland municipalities and suburbs[15]. In São Paulo, Santa Catarina, and Rio Grande do Sul, the presence of PICS is more significant, while in the North and Northeast, their availability is limited and depends on isolated initiatives[14]. This disparity compromises the principle of equity in access to health, one of the pillars of the SUS, and reinforces the need for strategies to expand the presence of these practices throughout the national territory[4].

In the Brazilian context of the last 20 years, the expansion and qualification of Health Care have been influenced by the benchmark of Health Care Networks (RAS)[16]. The recent expansion of PICS in the SUS raises questions about how the interfaces between PICS and networks are developed and their implications.

In the first decade of the 2000s, the concept of networks was in vogue in Public Health. The emergence of the internet and digital social networks had a strong impact on the field and produced new theoretical and practical experiments[17,18].

The ramifications of these movements are broad, but we highlight two in particular, which bring elements to the current problem surrounding the concept of care pathways (CP), the focus of this article. First, the conceptual production surrounding the discussion on care technologies, comprehensive health care, and Health Production Networks (RPS). Second, the theoretical framework related to RAS, strongly based on PAHO recommendations, the precepts of Health Surveillance, Epidemiology, studies on epidemiological transition, American and British productions on primary care, and comparative studies of health systems.

The concept of RPS is derived from the set of conceptual works that emerged in Public Health in the 1970s, the problematization of health work, criticism of biomedicine, the defense of the right to health, health reform, and psychiatric reform.

This concept of a network implied broader definitions of what care technologies are, including their micro-political agencies. It required new theories about work, the organization of services, and their articulation for health production. This detailed journey is not the subject of this text, but this contextualization helps to explain the emergence and difference of the concept of CP that appears in the works of Merhy and Cecílio between 1996 and 2003, and is further developed by these and other authors[18-20].

CPs are dynamic arrangements of RPS, involving their macro and microinstitutional dimensions, which are articulated to constitute care processes centered on the health needs of the user[21]. It would therefore be an arrangement-effect mediated by the health needs of users, shaped from an individual care plan.

In this context, a normative CP is not in perspective, but rather the capacity for possible arrangements in an RPS. Its institutionalization could only constitute a delayed effect of the recurrence of arrangements in the networks, with its conformation and legitimacy constructed immanently to the networks themselves[22].

This concept did not remain merely a theoretical formulation, inspiring public policy arrangements and mechanisms such as the National Humanization Policy. Arrangements proposed by psychiatric reform in Brazil strongly included these references, as did popular health education movements, among others[23].

From another perspective, RAS gained ground, especially from 2006 onwards, with their implementation and experimentation in state health departments, with strong support from CONASS[16]. From 2011 onwards, they became the main guideline for the formulation of national health policies in the Dilma Rousseff government[24].

Within the scope of the RAS, CPs gained other aspects and consolidated themselves as organizational structures that aim to ensure continuity, comprehensiveness, and excellence in patient care, encompassing the entire care trajectory, from prevention to rehabilitation[16].

Clinical guidelines, care protocols, strategies for coordination between the various services in the network, logistics systems, governance processes, and coordination between the multiple levels of care constitute the main mechanisms of CPs. Their implementation requires investments in care regulation, team training, and information technologies to monitor and evaluate the services provided[25].

In the institutional space of SUS management, the concept of CP linked to the theoretical field of HCS has become predominant, due to promises such as predictability and cost-effectiveness, which are highly valued by managers[26].

However, the history of RAS policies also shows weaknesses and limitations in this concept of CP, stemming from its excessively normative and vertical perspective, especially the difficulties of coordination between services and levels of care, and progressively greater needs for information, regulation, and control systems, chronic underfunding, and the challenges of regional inter-managerial governance[24].

In this context, RPS concepts emerge expanded and reformulated, such as the *Redes Vivas*[27] proposal, with fragmentary and hypertextual attributes, circumstantial arrangements, which are linked to a multiplicity of other networks. As devices, they would have the potential to connect with institutionalized networks, achieving more stable designs, even assuming logics that do not serve a planned and standardized order.

Maximino et al.[28] observed in intervention research that care networks connect multiple vectors. They have formal and informal, visible and invisible, objective and subjective elements. These elements can facilitate or hinder the construction of points of articulation between services, people, and resources. These formulations are linked to a broad field of theoretical productions and experiences related to traditional care practices, popular practices, and the therapeutic itineraries of users and communities.

From this perspective, there is a growing number of studies that seek to give increasing visibility to the mediating elements of RPS that go beyond the margins of institutionalized care services and produce maps of their mediations[24].

This article proposes a critical analysis of the implementation of the PNPIC, with an emphasis on the need to problematize the organizational mechanisms of care. Considering the particularities of the PNPIC and the conditions historically established in the context of healthcare in Brazil, especially in relation to healthcare network policies over the last 20 years, we seek to problematize how the legacy of networks and lines of care can influence the consolidation and expansion of PICS in Brazil.

This analytical effort is relevant in the Brazilian context of PICS expansion, given the growing need to improve the quality of comprehensive care in various areas of healthcare. However, the insertion of PICS in the context of Care Networks seems to create tensions, both in relation to the legitimacy of non-biomedical rationalities and to the normative and organizational context, which is not very open to the singularization of care and the legitimization of community health production devices[6,11,12].

The theoretical and methodological subsidies are articulated based on the authors' accumulated experience in the project "*Implementação das Linhas de Cuidado em Dor Crônica e Saúde Mental com a oferta de Práticas Integrativas e Complementares para o cuidado integral*" carried out in 2024, in an institutional partnership financed by the Ministry of Health with the Oswaldo Cruz Foundation (Fiocruz).

We believe that the experiences produced in this project can shed light on the issue and contribute to the formulation of new operational devices for the expansion of

PICS in a qualified manner and across various public health policies in the Brazilian context.

Methodology

This article organizes the critical analyses produced during the execution of the project "*Implementação das Linhas de Cuidado em Dor Crônica e Saúde Mental com a oferta de Práticas Integrativas e Complementares para o cuidado integral*", based on the experience of the authors, who acted as coordinators and supporters in the field. These experiences of the project, combined with their own previous professional experience in management, health policy research, and dialogue with the literature in the field, gave rise to the analyses presented here. The information related to the project is public and not confidential.

The Institutional Analysis[29] tools provided the conceptual and technical support for conducting the meetings and working with the participants involved. This framework allows emerging analysts to engage in critical processes of institutional practices and subject-institution relationships, enabling, based on the delimitation of a field of intervention, the formation of a field of analysis of the relationships between the instituting and the instituted in organizational processes. In this sense, analysis is intervention, a clinic of institutional forces that allows the mobilization of the forces and subjects involved[29-31].

In this work, we seek to explain the main emerging analyzers and the processes triggered by them in the Project. In this effort, we aim to provoke critical reflection on the challenges imposed on the implementation and expansion of the PNPIC in the CP.

Results and discussion

The Project was coordinated by Fiocruz in conjunction with the National Coordination of the PNPIC, at the Ministry of Health. Carried out between March and December 2024, it sought to develop technology and knowledge production through the inclusion of PICS in the CP for Mental Health and Chronic Pain. It covered two states, one in the Northeast, with the participation of two municipalities, and another in the South of Brazil, with one municipality. These were indicated by the respective State Health Secretariats, with leadership from the PICS technical coordinators, constituting an interface between the federated entities. It is worth noting that the two states involved already had their PEPIC, including state funding. The Project also had two coordinators from Fiocruz and the support of two technicians from the National Coordination of PNPIC at the Ministry of Health.

In terms of population size, one of the municipalities had less than 30,000 inhabitants, 75% of the population in rural areas, with a strong presence of quilombola communities, 100% PHC coverage, and 34.5% of the population was a beneficiary of conditional cash transfer - *Bolsa Família* in 2024. Its health infrastructure included

a secondary hospital, a Psychosocial Care Center (CAPS) I, 11 Basic Health Units (UBS), 15 Family Health Teams (FHS), and 1 Multidisciplinary Team (e-Multi).

Another municipality was the headquarters of an inland health micro-region in the state. It had approximately 70,000 inhabitants, 50% of the population in rural areas, and 50% of the population benefited from Bolsa Família in 2024. It had 100% PHC coverage, with 18 UBS, 27 FHS, 1 e-Multi, two integrated centers (education, social assistance, and health), one for children and one for the elderly, a rehabilitation service, and a center for integrative and complementary practices.

And the third municipality, with just over 120,000 inhabitants, 92% living in urban areas, 81% PHC coverage, and 4.8% of the population benefiting from Bolsa Família in 2024. In this municipality, the health infrastructure consisted of 24 UBS, 16 FHS, 2 e-Multi, one CAPS II, one CAPS for children and adolescents (IJ), one CAPS for Drinking and Drug users (AD), one private hospital, one pain clinic, one high-risk pregnancy clinic, one Walk-in Clinic (UPA) one municipal emergency room, one Welcoming area, and one municipal therapeutic community.

The activities took place in a hybrid manner in two formats: 1) In-person workshops, using active methodologies to develop guidelines for organizing and monitoring the lines, and 2) Online educational meetings, focusing on the continuing education of all workers involved in the Care Pathways.

The local-regional management of the Project focused on the leadership and engagement of those directly involved in management and care. With the leadership of the municipalities and support from the states, as well as methodological support from the project's supporters, technicians and care professionals were mobilized and appointed to form a Working Group (WG) in each of the three municipal bases. This mechanism functioned as a management committee and aimed to promote the development and monitoring of a shared, longitudinal work plan, with the active involvement of individuals in the various aspects of the intervention[31].

These arrangements sought to promote joint responsibility for actions and ensure institutional sustainability for the agreements and outcomes produced from each Workshop and Pedagogical Meeting.

Nine Workshops were held with each WG, including moments of expansion for municipal network workers. The program was the same for the three WGs, with adaptations in emphasis according to the local context and the collective analysis of the emerging analysts at each meeting.

The workshops were organized around guiding themes, with the following program order: 1) Agreement and presentation of the project - discussion of local information and choice of municipalities; 2) Mapping and strengthening of networking - health production networks; 3) Work and care management (expanded clinic) - unique therapeutic project, Welcoming, and team meeting; 4) Clinical and care management; 5) Structuring the Care Line - agreement, local organization, and sustainability; 6) Presentation of the CP - co-management arrangements.

Shared Operational Plans were developed with actions and indicators formulated by the WGs themselves and agreed upon with the state secretariats and the Ministry of

Health, with monitoring by the technical areas. These plans were jointly reevaluated by facilitators and WGs and proved to be intervention tools that allowed for greater approximation of territorial contexts.

The work to structure the CPs was conducted based on a logical matrix to map the resources already existing in the municipalities. Next, it was necessary to correlate the practices with the best evidence in each theme - Mental Health and Chronic Pain. The next step was to agree on matrix support arrangements carried out by itinerant teams and/or e-Multi teams so that each health unit would include in its service portfolio at least one individual integrative practice and one collective activity for each of the themes. In this way, local arrangements were established with the reorganization of services connected in a network including PICS.

Starting with the fifth workshop, the tripartite composition in the training spaces and working groups was especially relevant, as it supported the mapping of needs and reinforced the legitimacy of the strategies adopted to expand PICS in the focused lines of care.

It was considered strategic to reinforce the inter-federative nature of the governance system, with the establishment of a tripartite collegiate body at the municipal level with strong mediation from the PICS technical area, articulating the PNPIC with the PEPIC in each state. This finding reinforces the idea that the structuring and financing of state policies are a good path for the implementation of the PNPIC in the SUS.

Regarding the organizational designs for local management of the Project, in two municipalities, the WGs were formed by a larger number of representatives from the UBS and e-Multi, offering greater interface with PHC. In another, it was decided to carry out a pilot project, with the presence of two UBS, investing in the participation of e-Multi and CAPS, focusing on institutional development for subsequent expansion to the network.

These differences show that the municipalities had room to recognize their needs and organized their management arrangements according to their contexts, negotiating interests with the state, with the support of Fiocruz coordinators.

As for the training-intervention mechanisms and their impacts on local and regional institutional development, the workshops became spaces for conceptual review and monitoring of the implementation of new forms of management that could promote and include PICS in the services.

The mechanisms worked on in the workshops sought to include PICS in a coordinated manner that was inseparable from the qualification of comprehensive care. This is demonstrated by the consistent methodological contribution to the qualification of the processes of situational planning, welcoming, team meetings, individual therapeutic projects, and reference matrices offered by the Project. It also reveals a clear link to the institutional support strategies carried out in the context of the National Humanization Policy and adherence to the RPS reference framework, even though the Project's task was to discuss and implement integrative practices in CPs related to the RAS, which had a strong normative and institutionalized component, such as the Psychosocial Care Network and services for the treatment of chronic pain.

Regarding the reference framework that underpinned the discussion process of the emerging analyzers, the conceptual framework of the Project adopted the proposals for lines of care from the perspective of Franco and Franco[17], centered on the needs of users. It affirms its link to the RPS paradigm, but does not deny the possibility of structured arrangements provided for in the RAS. It proposes a CP that goes beyond established protocols, but also recognizes that service managers can agree on flows, reorganizing the work process in order to facilitate user access to the units and service offerings they need.

The work process, viewed dynamically, and the protagonism of workers are key in this CP proposal. It understands that comprehensive care depends on the construction of maps of available services and offerings, in addition to coordination agreements between services, capable of qualifying the necessary flows for care. Its sustainability requires collegial management arrangements that can dynamically organize and update the institutionalized network agreements[17].

The project adopted a methodological approach that integrated training and intervention, seeking changes in the perceptions of the subjects involved and in health practices[30].

The methodological proposal paid attention to the emergence of analyzers on the lines, which arose from collective face-to-face and remote activities. These analyzers were developed in the Pedagogical Meetings and subsequent Workshops in order to feed and qualify the process of collective construction, collaboratively, at each meeting, varying, expanding, and deepening the analytical capacity and engagement of the subjects involved in the Project[30,31].

Regarding governance processes, the inter-federative relationship was fundamental to strengthening care networks and qualifying local teams. State technical support was important and necessary for the development of actions and the institutional agenda in the territories. It assumed a role of articulation with municipal management for the necessary institutional commitment and ensured the Project's developments with the teams. In addition, it played a leading role in PICS training actions based on the discussions and needs of the territory.

One of the major challenges for the PNPIC, as already mentioned[5,11,13], is tripartite governance, including representation from the areas of continuing education in states and municipalities and the distance learning training offered by the Ministry of Health. The state's coordination capacity helped in the composition of strategies that took advantage of existing resources, adapting them to the context of the territories.

An example of this was the composition of professional qualification itineraries in some PICS, such as auriculotherapy and aromatherapy, based on joint certification between the state and the Ministry of Health, comprising distance learning hours and practical hours in the municipalities/states participating in the Project. This type of strategy facilitated the training of new therapists. It allowed the participation of already qualified workers, in coordination with the PICS expansion strategies. This created the basis for matrix designs for care and continuing education, allowing for the continuous and qualified expansion of PICS offerings.

Regarding the quality of PICS implementation in the SUS, the scenario found, despite the relevant differences between territories, was the peripheral incorporation of PICS, which still did not correspond to viable therapeutic resources for the daily clinical demands of pain and mental suffering in PHC. The small number of trained professionals, the lack of necessary supplies, inadequate physical infrastructure, and dependence on individual initiative to carry out PICS were common problems in the three municipalities participating in the project. This situation corroborates the national scenario, confirming recent studies on the fragility of PNPIC implementation and the integration of PICS in PHC[4,5,11].

Regarding the PICS modalities identified in the three municipalities, auriculotherapy was the most commonly offered in PHC, followed by meditation and aromatherapy. The use of medicinal plants and acupuncture was offered in specialized services in two of the three territories. However, these practices were poorly coordinated with other offerings, so they did not constitute multimodal offerings for pain and mental health, as recommended. These findings reveal that the reality of PICS in these three municipalities was not very different from the rest of the country[5,12,13].

In terms of implementation strategies in healthcare services and networks, a study conducted in five large Brazilian urban centers revealed that the provision of PICS in the SUS varies between municipalities, with physical practices and Chinese medicine being more frequent. Based on qualitative research, the authors constructed four types of PICS integration in PHC. The research concluded that the best path to integration occurs when family health teams take on the qualified practice of PICS, based on training and continuing education actions, combined with arrangements in which already qualified professionals work in a matrix-like manner, forming support or multidisciplinary teams. This study suggests that this combination of strategies should be taken as a potential guideline for the insertion and expansion of PICS in the SUS, as it strengthens access to and the sustainability of these practices in services[14]. These indications seem to be in line with the analyses developed in the Project.

Regarding the potential for qualifying the comprehensive care of PICS, the problematization of PICS in comprehensive care lines has become a powerful tool for discussing the rationalities present in the daily routine of chronic pain and mental health care. It calls into question automated, ineffective, and even harmful practices that affect the lives of users and workers. The critical view of the processes of medicalization, the indiscriminate prescription of psychotropic drugs, and the almost complete absence of a collective and non-pharmacological perspective in these clinical approaches has been broadened. As a result, new clinical management practices have been developed and the range of services offered to users of the system has been expanded.

With regard to the differences in conception between RPS and RAS, for much of the academic literature, the defense of the centrality of the user as the organizer of CPs is opposed to the degree of institutionalization and predictability of the organizational arrangements of the networks. However, this perspective tends to ignore the *praxis* of health work, which requires constant mediation between the molar and the molecular[32].

In the context of the Project, the co-management methodology and the ability to include institutional analyzers, cross-cutting management and work vectors, facilitated the adequate treatment of problems that emerged when the demand for evidence-based clinical protocols crossed singular therapeutic care plans, allowing mutual mediations. This process, in a way, allowed for the articulation between the RPS and RAS references, creating mediations between algorithms and singularities, in the context of PICS.

The theoretical methodological challenge of a CP proposal that includes PICS needs to consider these accumulations and criticisms in order to delimit a logical model consistent with an integrative ethical, aesthetic, and political paradigm in health.

What we call na "integrative paradigm" refers to the possibility of a non-hierarchical composition between biomedicine and other medical rationalities or complex therapeutic systems, with a focus on the needs of users and collectives. In this sense, not only biomedical standards of clinical validation should be considered, but also other forms of knowledge production and social legitimation. Research analyzed together and composing evidence maps, considering ethnobotanical, ethnopharmacological, iatrogenic potential, health technology assessment studies, and scientific studies developed within the cosmologies of the various rationalities in health[33,34].

These evidence maps should be in dialogue with public policy agendas and debated in the public arena, both inside and outside academic spaces, avoiding their subordination to specific private interests. However, the discussion about the scientific legitimacy of rationalities other than biomedicine is still very much in dispute. In the Brazilian context, the translation expressed in the PNPIC, by reaffirming the health paradigm linked to the constitutional framework and integrality as a guideline, broadens the scope of the WHO recommendations for TCIM. This fuels disagreements between defenders of the biomedical health paradigm, such as the Federal Council of Medicine, and defenders of strict physicalism, such as the Brazilian Society of Physics[6].

These tensions revolve around the position that biomedicine should occupy in relation to other rationalities. According to Glass, Lima, and Nascimento[6], the WHO's initial proposal for TCIM does not address a comprehensive view of health, preserves the biomedical paradigm, and creates two categories of countries: those in which their populations have access to biomedicine and, in this case, Complementary and Alternative Medicine (CAM) should play a supporting role; and those in which their populations do not have access to scientific medicine, Traditional Medicine (TM) presents itself as a possibility for providing health care. However, the WHO proposal for the large-scale use of TM involves regulation, research, and exploration of its economic potential.

Thus, the Brazilian formulation for PICS has its merits, especially in opening up a field of dispute around the position occupied by biomedicine in relation to diverse rationalities. This allows for criticism of the biomedical health paradigm and resistance to forces that seek to position biomedicine in such a way that it exercises a kind of epistemological colonialism over all other rationalities[34]. These questions can

contribute to the treatment due to the substantial differences between the 29 practices included in the PNPIC. In particular, the necessary distinction between medical rationalities and integrative practices, as pointed out by Luz[33].

Final considerations

The analysis of the authors' experience with the Care Pathway Implementation Project noted the power of PICS in the SUS. It highlighted their ability to expand access and induce paradigmatic changes in clinical approaches, creating opportunities to improve listening, weCPome suffering, and make users' health needs visible. It reinforces the need for investment in a multi- and interdisciplinary integrative approach to health care.

On the other hand, critical analysis of this experience and the literature in the field reveals the need to overcome the still alternative and peripheral status of PICS in the SUS. The imminent risk of integrative practices becoming accessory therapeutic resources, offered within the same conventional procedural logic, reinforcing the centrality of the biomedical model, became evident. As a result, they lose their power to expand clinical practice and challenge the healthcare model.

Taken together, these reflections open up promising perspectives for other studies that can deepen the debate on the inclusion of PICS in lines of care. They also provide consistent support for a future reformulation of the PNPIC, with the prospect of investments in research, development, qualification, and financial induction of PICS in the SUS, contributing to overcoming recurring resistance and prejudice against PICS.

Data Availability

The contents underlying the research text are non-handwritten contents.

Authors' contribution

Oliveira GN, Nied CBF, Oliveira CF, participated the conception and design of the study; participation in the discussion of the results and writing of the manuscript. Neves F participated the conception and design of the study; participation in the discussion of the results and writing of the manuscript. All authors approved the final version of the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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A Política Nacional de Práticas Integrativas e Complementares (PNPIC) representou um marco para o reconhecimento das práticas integrativas no Brasil. No entanto, passados quase vinte anos, ainda apresenta desafios para a sua expansão no Sistema Único de Saúde. Este artigo propõe uma análise crítica da PNPIC, problematizando os dispositivos organizacionais do cuidado, e procura refletir sobre a influência que os referenciais de redes na Saúde Coletiva podem exercer sobre os caminhos de expansão das Práticas Integrativas e Complementares (PICs) no Brasil. Os marcos teóricos são articulados ao estudo crítico da experiência acumulada pelos autores em projeto de desenvolvimento institucional para implementação de PICs em linhas de cuidado integral, realizado em 2024, com participação tripartite. Como contribuição, são apresentados alguns caminhos e ofertas metodológicas que objetivam a ampliação do acesso e a integração das PICs no cuidado integral dos usuários.

Palavras-chave: Práticas de Saúde Complementares e Integrativas. Redes comunitárias. Cuidado centrado no paciente. Integralidade em saúde. Política de saúde.

La Política Nacional de Prácticas Integradoras y Complementarias (PNPIC) representó un marco para el reconocimiento de las prácticas integradoras en Brasil Sin embargo, trascurridos casi 20 años, todavía presenta desafíos para su expansión en el Sistema Brasileño de Salud (SUS). Este artículo propone un análisis crítico de la PNPIC, problematizando los dispositivos organizacionales del cuidado. Busca reflexionar sobre la influencia que los factores de referencia de redes de Salud Colectiva pueden ejercer sobre los caminos de expansión de las Prácticas Integradoras y Complementarias (PICS) en Brasil. Los marcos teóricos se articulan al estudio de la experiencia acumulada por los autores en un proyecto de desarrollo institucional para implementación de PICS en líneas de cuidado integral, realizado en 2024, con participación tripartita. Como contribución, se presentan algunos caminos y ofertas metodológicas cuyo objetivo es la ampliación del acceso y la integración de las PICS en el cuidado integral de los usuarios.

Palabras clave: Prácticas de salud complementarias e integradoras. Redes comunitarias. Cuidado enfocado en el paciente. Integralidad en salud. Política de salud.