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Challenges of education scenarios in primary care in the light of the Previne Brasil neoselectivity

Karina Magrini Carneiro Mendes[1*], Leonardo Carnut[2] and Lucia Dias da Silva Guerra[3] and Claudia Camilo[4]

[1]Universidade São Francisco, Av. São Francisco de Assis, 218, 12916-900, Bragança Paulista, São Paulo, Brazil. [2]Universidade Federal de São Paulo, São Paulo, São Paulo, Brazil. [3]Centro Universitário Anhanguera, São Paulo, São Paulo, Brazil. [4]Centro Universidade de São Paulo, São Paulo, São Paulo, Brazil. *Author for correspondence. E-mail: karinamagrini@yahoo.com.br

ABSTRACT. Primary Health Care (PHC) is considered a privileged space for the inclusion of students in the Unified Health System (UHS), which is most desirable the pedagogical scenario for the health course graduate education profile. However, its new financing model induces a neoselectivity that may mischaracterize UHS principles in primary care. This study is a qualitative meta-synthesis to understand the challenges of teaching practice scenarios in PHC, identified in the research, in order to discuss them in light of the limits imposed by the neoselectivity, induced by the Previne Brasil Program (Prevent Brazil Program). A search was conducted on the Virtual Health Library (VHL) portal. The search strategy was designed using the following keywords: 'practice scenarios in higher education' (object), 'challenges' (qualifier) and 'PHC' (amplitude/limit). The selection of publications was carried out using the PRISMA protocol by two independent reviewers, and data analysis was performed in the thematic modality. The quality analysis of the articles was based on the CASP protocol and the internal validation of the excerpts was done by a third evaluator. From the 17 articles included in the review, it was possible to extract 5 analytical dimensions of the scenarios' challenges, which are related to: 'care', 'teaching', 'management', 'health professionals' attitude', 'community attitude'. All dimensions presented several sub-themes, except for 'community attitude'. Given the existing challenges, the neoselectivity induced in PHC tends to intensify most of the problems. It is assumed that the impacts on PHC settings may, in the future, place it as a non-viable practice scenario.

Keywords:higher education; primary health care; professional training; faculty-care integration; health care financing.

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Introduction

Primary Health Care (PHC) is considered a privileged space for the insertion of students in the universal and public Unified Health System (UHS), which is the most desirable pedagogical scenario for shaping the professional profile of health course graduates. Although, historically, much progress has been made in the construction of the various forms of education-service-community integration[1] (ESCI) in the UHS, including the Organizational Contract for Public Education-Health Action[2] (OCPEHA), established by the National Policy for Permanent Education[3] (NPPE) (Contrato Organizativo de Ação Pública Ensino-Saúde [COAPES], 2015), many difficulties and conflicts in this integration are observed in practice.

It is important to emphasize that the UHS survives under a chronic process of underfunding which, after Constitutional Amendment 95, has become de-funding (Mendes & Carnut, 2020a). In this context, PHC has been the main target of several changes that alter the pillars that had been favoring institutional stability and the achievement of good health results, especially through the Family Health Strategy[4] (FHS).

Recently, this deconstruction was enhanced by Ordinance No. 2,979/2019, which instituted the Previne Brasil Program (Portaria nº 2.979, 2019) and delved into the ways of doing PHC. The program defeats the principle of universality, especially in its financing dimension, with concrete consequences for PHC, not only as a place of care production, but also as a setting for pedagogical practice.

[1]Integração ensino-serviço-comunidade (IESC).
[2]Contrato Organizativo da Ação Pública da saúde (COAPES).
[3]Política Nacional de Educação Permanente do SUS (PNEPS).
[4]Estratégia de Saúde da Família (ESF).

The 'Previne Brasil Program' (Portaria nº 2.979, 2019) implements the guidelines of the World Bank Report (World Bank Group, 2017), extinguishing the per capita Primary Care Floor (PCF-fixed) and replacing the former Variable Primary Care Floor for adherence to programs (PCF-variable) with a weighted capitation payment. This payment is calculated by the number of people registered in (vulnerable) health units and the amount transferred is variable depending on the achievement of performance metrics, generating a new type of selectivity (neoselectivity).

Selectivity in the context of policies, management and public administration can be thought of as an artifice, a path instituted within the Capitalist State, defined as an institutionalized form of public power deriving from social relations, supported by jurisdictional-legal protective barriers and related to material production, of which the ultimate content is private accumulation (Rodrigues, 1997). Through public policies, the Capitalist State enables, regulates, and establishes a functional complementarity between the system of political institutions and the economic system (Offe, 1984).

There isn't much doubt that the neoselectivity induced by the new PHC financing model will lead to a mischaracterization of the UHS principles in primary care (Mendes & Carnut, 2020b), such as a growing process of targeting care to the detriment of universal care access. It remains to be seen how PHC spaces will be reconfigured as an educational scenario for future health professionals in such adverse conditions for care, integrality, equity and with a real risk for interprofessionality. Therefore, this study aims to review what the scientific literature has to say about the challenges of practice scenarios for higher education in PHC, as already described, and to critically rethink them in the light of the neoselectivity induced by Previne Brasil.

Methodology

This study was the product of a master's thesis and was developed by means of a qualitative metasynthesis (Matheus, 2009). The review question was: 'What does the scientific literature say about the challenges of practice scenarios for higher education in PHC?'. The object of the review was 'practice scenarios in higher education' (object), qualified by 'challenges' (qualifier) and with a scope limited to 'Primary Health Care' (amplitude/limit).

The systematic search was carried out in the Virtual Health Library (VHL) on January 25th, 2021, using the descriptors identified in the Health Sciences Descriptors (DeCS). The descriptors were combined into pairs using the AND operator, and then the pairs were correlated using the OR operator, which resulted in the final syntax: mh:(mh:(mh:((mh:('atencao primaria a saude' AND 'educacao superior')) OR (mh:('atencao primaria a saude' AND 'formacao profissional')) OR (mh:('atencao primaria a saude' AND 'integracao docente assistencial')) OR (mh:('educacao superior' AND 'formacao profissional')) OR (mh:('educacao superior' AND 'integracao docente assistencial')) OR (mh:('formacao profissional' AND 'integracao docente assistencial')))) OR (tw:('cenario de pratica'))) AND (tw:('Sistema Único de Saúde')).

According to Figure 1, the PRISMA flowchart shows the process of identifying studies until they were eligible, which ended with 17 articles included. The following inclusion criteria were used in the research: studies in Portuguese, carried out using qualitative methodology or descriptive methods and/or reports, published between 2010 and 2020, which had the full text available and observed the key items of the research question. The exclusion criteria were: books or book chapters, dissertations, monographs, theses, ministerial documents, editorials, and annals.

To assess the quality of the articles included, the instrument adapted from the Critical Appraisal Skills Program (CASP) for qualitative research was used, which allows qualitative data to be assessed using ten questions (Hannes, 2011). It is applied independently by the two reviewers (K.M.C.M and L.C), with disagreements being discussed by a third (L.D.G). The studies reviewed were scored for each criterion to ensure transparency in the potential risk of bias, with the result shown in Table 1.

The papers were then categorized based on their objectives, methodology and results. In addition, the similarities, and dimensions of the practice scenario challenges in PHC higher education were identified.

Most of the studies reviewed used data collection methods in the concrete reality of services (testimonials, case studies, qualitative methods). Only two studies (out of seventeen) used the integrative review method; however, both reviewed practical teaching content in PHC and were therefore included.

From the data analysis standpoint in the studies reviewed, what guided it was the teaching problem in PHC that the article reported (either in the interviewees' statements, in the authors' comments or in the data included in the reviews). These problems were consolidated and organized into dimensions, as shown in Table 2, so that they could be better synthesized according to their similarities.

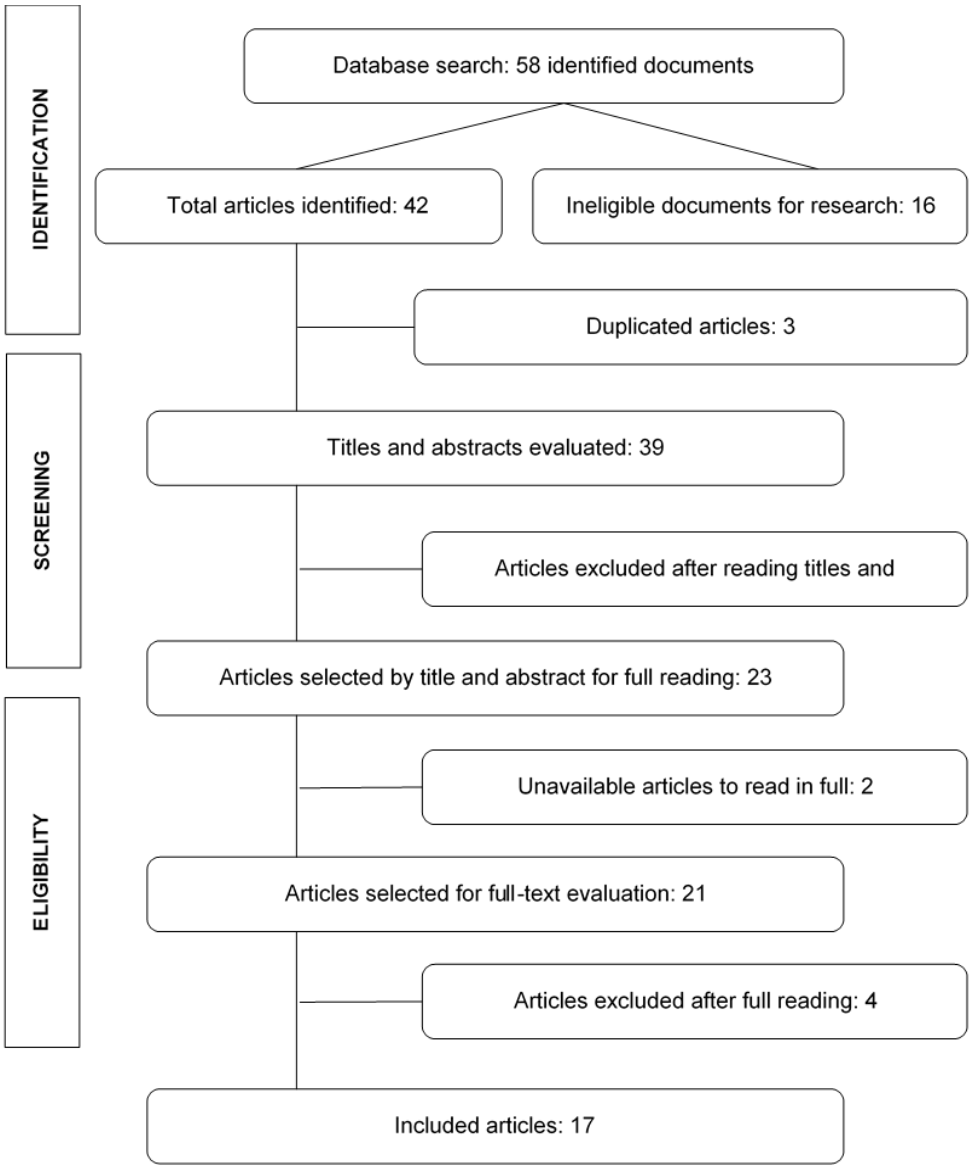

Figure 1. Flowchart of search, eligibility, and study inclusion. May 2021.

Table 1. Quality analysis of the articles included in the metasynthesis according to the Critical Appraisal Skills Program (CASP). May 2021.

Quality Analysis Criteria	Yes		Partial		No	
	N	%	N	%	N	%
Were the research objectives clearly reported?	16	94.2	1	5.8	0	0.0
Was the qualitative methodology appropriate?	16	94.2	1	5.8	0	0.0
Was the research design suitable for achieving the proposed objectives?	14	82.2	3	17.4	0	0.0
Was the recruitment strategy appropriate to the research objectives?	13	76.5	4	23.5	0	0.0
Was the data collected in a way that addressed the research question?	13	76.5	4	23.5	0	0.0
Was the relationship between the researcher and the participants properly considered?	8	47.1	2	11.8	7	41.1
Have ethical issues been considered?	17	100.0	0	0.0	0	0.0
Was the data analysis rigorous enough?	13	76.5	4	23.5	0	0.0
Were the results clearly reported?	15	88.3	2	11.7	0	0.0
Does the research make a contribution?	14	82.6	3	17.4	0	0.0

Source: Adapted from Critical Appraisal Skills Program (Hannes, 2011).

The selection of excerpts that best exemplify the content of each dimension was subject to qualitative validation by a third-party analyst to ensure greater quality control of the data used. The aim was to reduce the risk of a single content interpretation (Ollaik & Ziller, 2012; Pozzebon & Petrini, 2013). After this procedure, the interpretation of the metasynthesized content was rethought in the light of the neoselectivity induced by the Previne Brasil Program.

Results and discussion

Seventeen articles were included in this review. Table 2 shows the qualitative metasynthesis of the PHC practice scenario challenges, summarized in five dimensions related to: 'care', 'education', 'management', 'professional attitude' and 'community attitude'. Each of these dimensions was subcategorized according to its specific characteristics.

Each dimension brings together a summary of the challenges already reported in the literature (Table 2). These challenges already existed and are typical of education scenarios before Previne Brasil. Bringing these challenges together, metasynthesizing them, was necessary to understand how the neoselectivity induced by Previne Brasil intensifies (or not) these existing problems.

Table 2. Qualitative metasynthesis of the PHC practice scenario challenges by dimension according to the articles included. May 2021.

Dimension (related problems)	Challenges of the PHC teaching practice scenario
Care	Lack of longitudinality and continuity of care in the absence of the university
	Institutional arrangements do not promote accountability between education and service
Education	Distance between traditional curricula and the reality of the service
	Students' (in)comprehension of the UHS and PHC's importance
	Disproportionate education with reality
	Articulation of education and service work processes
	Theory-practice relationship
	Low involvement of students in primary care
	Student's passive attitude
Management	Unit infrastructure
	Scarcity of resources
	Space saturation
	Low representation of some professional categories in primary care
	Exhausting routines and precarious services
	Applying reductionist practices
	Devaluing teamwork
The attitude of health professionals	Interpersonal relationships
	Preceptorship profile
	Team(staff) resistance
The community's attitude	Community resistance

Source: Direct research.

Problems related to care

Two challenges need to be tackled here. The first deals with the 'lack of longitudinality and continuity of care during university absence', as identified: "One-off visits are no match for immersing students in the services' daily routine, which could lead to effective interventions and even their transformation" (Mira, Barreto, & Vasconcelos, 2016, p. 578).

The main way of getting students into PHC practice settings is still through one-off visits. Many of the demands generated by this integration remain in the services and are 'thrown' to the team, which must deal with the expectations of actions generated by the students during the school year. This way of integrating with the services does not build one of the essential attributes of PHC presented by Starfield (2002): longitudinality. Longitudinality implies a therapeutic relationship characterized by responsibility on the part of the health professional and trust on the part of the patient. When students enter the practice setting, the university (teachers and students) become co-responsible for longitudinality. This is something that, as reported in the studies, does not occur, compromising the production of more accurate diagnoses and treatments, as well as unnecessary referrals to other levels of complexity.

However, when the ESCI does not become a partner of the teams in the search for longitudinality and continuity of care, it demonstrates the lack of closer relations between education and the professional teams and the consequent loss of opportunity to enhance each other's communication and sharing of responsibilities.

In the scenario of neoselectivity induced by the Previne Brasil Program, considering the need for intense procedural production focused on individual and one-off care, the subjective and collective dimension of care

tends to be even more threatened. It is very likely that there will be an intensification of these one-off actions, which clash with the PHC's proposal of longitudinality, representing institutional barriers to the insertion of education into the service, in order to create and/or strengthen lasting bonds.

Another challenge related to the problems of care, which was metasynthesized from the studies, is the 'institutional arrangements that do not promote accountability between education and service'. According to Pires and Gomide (2014), institutional arrangements are understood as specific rules established for economic-political-social transactions and which define how processes are coordinated, delimiting the object and objectives of these processes, who is entitled to participate in them and the forms of relationship between the participants.

Despite the efforts to promote student integration in line with the demands of social reality, ESCI initiatives show asymmetries between Higher Education Institutions[5] (HEIs) and municipal public management. The municipalities are passive and need to be more proactive in the contractual agreement of actions, including their demands and needs, according to the excerpt: "The statements reveal the need for institutional arrangements, breaking with the culture of using the scenario only as a practice. This relationship between education and service can jeopardize both user care and professional training" (Silveira, Kremer, Silveira, & Schneider, 2020, p. 6).

There is a predominance of reports about the lack of articulation between academia and the service in relation to the organization of work processes, represented by the university's view that is distant from the local reality. Because it differs from the needs of the population it assists, this results in inefficient communication between HEIs and professionals. This leads to poorly articulated planning which highlights the differences in the expectations of managers, workers, teachers, and students.

This adjustment of expectations could be better achieved by breaking with the culture of 'using the scenario' in a pragmatic way. However, the studies report the weight of an institutional culture based on four visions. Managers see the insertion of academia into the service only as an opportunity to increase the workforce in public services that traditionally have no budget for it. In addition, workers perceive the presence of students as new demands for reorganization of the service that do not always correspond to learning opportunities, but rather to the feeling of 'more work'. For teachers, this relationship appears as the opportunity that the services have (and for which they should be grateful!) for academia to offer its systematized knowledge. For many teachers, even in a subliminal way, academia holds the 'true' knowledge and with this attitude they tend to disregard the knowledge produced in practice as legitimate. Finally, for the students, this appears yet another unnecessary obligation, if not an 'exotic' experience. Care in this situation fades away.

In the midst of the neoselectivity provided by Previne Brasil and with the advance of privatist interests in the health sector, it is assumed that this distancing of intentions will intensify, since the registration of users and the increase in the number of services will exacerbate the conflict of expectations between these parties and hinder a possible institutional arrangement that values health training more oriented towards adjusting expectations between these parties with a focus on care. This is because the PHC, as representatives of the state institution, are constantly trying to survive in a scenario of de-funding.

Problems related to education

Among the various problems catalogued about education, it was possible to synthesize them into seven challenges to overcome. The first is the "distance between traditional curricula and the reality of the service". It is important to remember that the development of the National Curriculum Guidelines[6] (NCG) for health courses, since 2001, states that the education of professionals must take the current health system in the country into account, and that the field of PHC is a privileged space for discussing the social relevance of the university (Carvalho & Ceccim, 2012). To achieve this goal, it is essential to implement curricula that are integrated into everyday practices, with the proper articulation.

However, the HEI curricula described in the studies reveal this distance as a challenge to overcome, as exemplified by Gauer, Ferretti and Teo (2018, p. 5): "Curricula aimed at education that does not value interdisciplinarity, [...] can hinder teamwork - aspects that do not promote education with a broader view of health care".

[5]Instituições de Ensino Superior (IES).
[6]Orientações Curriculares Nacionais (OCN).

The traditional curriculum, oriented towards the disciplinarization of knowledge, hinders the students' inclusion in the PHC logic as it should be: interdisciplinary, interprofessional and integral. Even though these three elements that constitute the PHC work are still under construction, Previne Brasil's neoselectivity will induce a regression in this field, leaving the 'construction site' today 'unfinished', but tomorrow non-existent. Sophisticated ways of extinguishing teamwork, which configures interprofessionality and interdisciplinarity, come from the restructuring of work processes that PHC will have to carry out in order to adapt to the race for financial subsistence, this time placed on service professionals. Even though PHC has been trying to overcome a still fragile, hierarchical and uncollaborative interprofessional logic for 33 years (Reuter, Santos, & Ramos, 2018), Previne Brasil's proposal, focused on the procedural and individual performance of the teams, interrupts, and makes it impossible to put these practices that were gradually being built into action. This means that the curricula, which are still disciplined today, gain from this measure, and it is possible that the traditional curricula will no longer be induced to change, since, as they stand, they adapt well to PHC reduced to procedures and actions 'funded' only for the vulnerable.

The second challenge is the '(in) comprehension by students of the UHS and PHC's importance'. The UHS and the PHC are still spaces for professional insertion that are poorly valued in health education, reinforcing the argument that there is a university culture that distances itself from the society's real needs (Tragtenberg, 2004). Work in the UHS is still colonized by a charitable vision derived from common sense. This view enters students' minds, causing them to disqualify the practice scenarios at PHC and corroborating the rejection of this educational space. As exemplified by Peixoto, Jesus, Carvalho and Assis (2019, p. 5) study: "The difficulties and tensions occur mainly in the students' comprehension of the UHS and PHC's importance for their education".

With neoselective practices, such as performance-based recruitment and production metrics, PHC will tend to be more de-funded and, possibly, this locus of practice will struggle to establish itself as a desirable place to work considering so many problems. It seems that the coming scenario will exacerbate this distancing of PHC as an important educational activity, reinforcing the widespread discredit that exists in the perception of students who don't know it.

A third challenge is related to the 'disproportion between education and reality'. The inclusion of students in practice settings allows them to encounter the reality of the UHS, a benefit cited by most of the articles studied, as well as breaking with paradigms and prejudices in relation to PHC (Silveira et al., 2020). However, this reality does not correspond to the expectations built up during undergraduate professional education, as mentioned in the excerpt: "[...] [There is] difficulty with some everyday situations, disconnected facts with the reality of the practice learned at university. [...] One of them] is based on the disproportionality between undergraduate education and the reality of the professional in the service" (Rodrigues et al., 2018, p. 4).

This disproportion appears in the contradictions between what is proposed by health policies and what is actually taught in academia. The 'encasement' of academia has generated in students this feeling of disconnection between what they learn at university and its 'inapplicability' in the services. Numerous public policies dedicated to the health-education interface: PET-Saúde (PET-Health), Provab, Pró-Saúde (Pro-Health), Pró-residências (Pro-residencies), etc. have led to successive rapprochements between academia and services in an attempt to resolve this disconnection (Batista, Jansen, Assis, Senna, & Cury, 2015). Even so, this is a reality that persists and is reported in the studies reviewed.

However, Previne's neoselective practices can contradictorily generate a double feeling about this disproportionality. On the one hand, it can create a feeling of greater disconnection, since the lack of funding for PHC worsens the material conditions of this care level (more frequent lack of inputs, more pressured and highly demotivated professionals), perpetuating the strangeness in students. On the other hand, this disproportionality can generate a feeling of greater operational adjustment (Mendes & Carnut, 2020a) between education and service, since the action selected by Previne Brasil is to induce professional behavior by making them exhaust their agenda in isolated practices in the individual clinical sphere, which is in line with the tradition of health education in the most conservative courses.

The fourth challenge proposed by the metasynthesized literature is the 'articulation of education and service work processes'. According to various studies, the articulation of work processes is the main setback of ESCI. Examples include: "Poor communication between HEI professionals and service professional-preceptors" (Rodrigues et al., 2018, p. 4); "Need for better coordination of activities between educational institutions and services, according to local singularities" (Bravo et al., 2018, p. 1488).

There are many elements mentioned in the studies that corroborate the disarticulation, such as poor planning, lack of building skills and competences for collective work, the mismatch between the actions proposed by academia and those carried out by the service, the unrealistic service expectations regarding the inclusion of students and the organization of student care independently from the service. All these factors create a conglomeration of actions that limit the link between education and the service, evidencing the distance between these entities, as has already been compiled in the literature.

In the scenario of neoselectivity, in which quantitative performance requirements are imposed on services that undermine individual, comprehensive, and person-centered care, as well as disregarding collective actions and health education, work processes begin to contradict the ideals of professional education for working in the UHS. This may limit interprofessional and health promotion proposals based on an emancipatory logic of building users' autonomy and participation, requiring academia to produce exclusively quantitative results when students join, thus making it impossible to critically reflect on learning actions.

The fifth challenge lies in the 'theory-practice relationship', which is still distant in these scenarios. As exemplified by Rodrigues et al. (2018, p. 2):

> The results of the study point to two challenges for the effectiveness of internship education in PHC: the relationship between theory and practice and education-service integration. The first has an educational connotation (in relation to teaching and learning) and the second is structural, involving aspects that transcend nursing education and encompass universities, health services and health management.

The study provides an interesting insight into the theory-practice relationship. The case presented regarding the students' insertion into services, when applied to residencies, highlights that even within university education, the theory-practice relationship seems to be pedagogically distanced, which is exacerbated when the resident is placed in the service (structurally). Bringing theory and practice closer together is the primary pedagogical foundation of any education (Freire, 2020), and in the health sector even more so, since, when it comes to residents, the problem takes on an inconceivable connotation.

Without the minimally technical requirements of the profession, students (whether undergraduates or residents) will have pedagogical difficulties (which precede the structural ones) when they enter the services. According to the synthesized data, it seems that the development of critical reflection on work (albeit 'technical-clinical' work and restricted to the practice completed at university) is a challenge that has not been overcome (Rodrigues et al., 2018).

It is hoped that the student's integration into the services will be an opportune moment for them to experience the reality of work and engage in real intervention situations, which requires them to understand more than just care practices, but also the principles, guidelines, policies, and rights surrounding the health system. In times of neoselectivity, it is possible that the new logic of work organization supports professional education aimed at meeting market demands, disregarding spaces for critical reflection and adjusting to the gap between theory (for PHC) and practice (for the market), as is often the case in some of the reviewed experiences (Kuabara, Sales, Marin, & Tonhom, 2014).

The sixth challenge imposed on education concerns the "low insertion of students in Primary Care", reported by some studies, as highlighted by Gauer et al. (2018, p. 2): "[...] among the obstacles identified are the low insertion of students in public health services [such as] the low number of physiotherapists in Primary Care [...]".

The FHS had been consolidated as a priority in the PHC aimed at reorganizing the healthcare model and work processes, especially in the pursuit of care integrality (Carnut, 2017). To achieve this, its minimum nucleus of general practitioners, nurses, nursing assistants or technicians and community health workers, with the possibility of adding an oral health team, needs to be expanded. After the Family Health Support Centers (NASF) were created in 2008 (Portaria nº 154, 2008), other professional categories were formally included in the strategy through matrix support, of which, as the excerpt mentions, physiotherapists were included.

However, the NASF was stripped of federal funding under the Previne Brasil Program, and the regulations for accrediting multi-professional teams were revoked in Technical Note 3/2020 (Nota Técnica nº 03, 2020). Regarding the argument of favoring the autonomy of the municipal manager to compose their teams according to their needs (something that was already possible previously) it can be said that it is, yet another selectivity created by public policy. This is a tactic to discourage the local manager (due to lack of financial incentive) from hiring other professionals who go beyond the minimum team, thus deconstructing care integrality.

Due to this low inclusion of various professional categories in PHC, it is assumed that the low inclusion of students in these settings will deepen, as there will be no professionals to precept their specific skills. Certainly, work in PHC will tend to offer minimum types of procedures, limited to the logic of the work carried out by this team. These, which correspond to the minimum team, will be able to offer, at most, preceptorship of common skills. It is therefore understood that this scenario will discourage changes in the curricula of the various courses that go beyond the minimum team, as they do not provide opportunities to exercise the technical-clinical skills of these categories.

The seventh educational challenge identified refers to the 'passive student attitude'. Codato, Garanhani and González (2017, p. 612) state that "[...] there are all kinds of students [but there are those who] simply want to get through here, to meet that deadline and only do what is determined".

Freire (2020) argues that learning is not limited to making the individual adapted to reality, but includes creating an active subject, capable of transforming it and intervening in it, recreating it. In ESCI, it is desirable that all participants (students, workers, and the community) take part in the learning process and that its articulation is not based on the presence of the student as a spectator, as studies have shown (De-Carli et al., 2019), but as an active subject of education. Even though PHC can promote a proactive culture in students, removing them from passivity, the neoselectivity induced by Previne Brasil tends to limit the possibilities of student involvement in this practice scenario, restricting them to what is offered in the clinical environment, requiring them to produce and replicate procedural actions, frustrating reflective and creative practices and failing to provide opportunities for scenarios beyond the unit's office. This situation can further reinforce the persistently passive role of students, as found in the experiences reviewed.

Problems related to management

Regarding the problems related to management, seven challenges were metasynthesized. The first concerns the 'infrastructure of the units'. Some studies evidenced a mostly negative assessment of the equipment and infrastructure of family health units by the Family Health Teams[7] (FHT), as exemplified in the study by Lima et al. (2019, p. 346): "[...] the problems originated from inadequate physical infrastructure are due to the fact that many of them operate in rented houses, adapted for operation as a health unit, without inspection of the risks and insalubrity for quality certification".

The limits of the primary care units' physical structure in Brazil have been reported in several studies (Nascimento, Santos, & Carnut, 2011). As a practice scenario, the situation of the units ranges from the mere lack of space - which generates conflicts between students and professionals (since the first occupy the space of the second), between professionals who dispute spaces when the units are full of students - to the very location of the units, since, located primarily in peripheral areas, they generate feelings of fear among students and professors.

The fragile infrastructure and insufficient material resources jeopardize the development and quality of the work processes at the PHC, generating dissatisfaction among professionals which, intensified by the inclusion of education, depletes its physical conditions. However, in a reality of de-funding, provided by neoselectivity, this structure tends to become even more precarious.

The second challenge for management is the 'scarcity of resources'. According to Rodrigues et al. (2018, p. 4), there is "[...] a persistent lack of the necessary inputs to carry out procedures in health services that corroborate quality and effective care".

From the student's perspective, the reality of practice should fully correspond to the theory learned, but when they are inserted into the services, students can observe and experience the difficulties arising from the management and financing models of the UHS, such as lack of inputs, lack of adequate infrastructure, shortage of professionals in some teams.

This repercussion on the quality of care and the dissatisfaction of family health team professionals, students and the community will certainly be intensified by the neoselectivity induced by Previne Brasil. The logic of this program leads to a lack of funding for this level of care, which could undoubtedly make PHC practices impossible due to the scarcity of supplies, equipment, and other structural aspects.

The third challenge for management refers to 'space saturation'. As the metasynthesized literature points out, the "[...] saturation of public health service spaces for practical activities [...]" is frequent (Gauer et al., 2018, p. 6). With the expansion of higher education institutions in health, many induced by market criteria

[7] Equipe de Saúde da Família (ESF).

and without appropriate supervision, the availability of practice scenarios is exhausted when it comes to large urban centers. Combined with the advance of management by Social Health Organizations[8] (SHO) and flexible contracting through the creation of the Agency for the Development of Primary Health Care[9] - ADPHC (Miranda, 2019), this saturation will take on even more severe contours of dispute between public and private HEIs. This is likely because there are already experiences in which private HEIs provide a financial incentive to professionals who take on the preceptorship of their students (Pereira et al., 2022), thus making this contribution a form of variable remuneration that adds to the logic installed in performance payments adopted by SHO models (Mendes & Carnut, 2018). Added to this, in the case of doctors, are the flexible contracts that do not require training in primary care advocated by the ADPHC. In this situation, the more institutions, the more money, the more salary increases, the more saturation and, of course, the more deprivation of students in public HEIs.

However, the OCPEHA has been shown to be an important instrument of articulation between HEIs and public services to avoid this type of dispute as far as possible (Nota Técnica nº 03, 2020). The intensification of individual and productivist work generated by neoselectivity may lead to a tendency for this saturation to be seen as an opportunity to produce more procedures, since the current logic, which follows the profusion of schools vying for practice settings, is merely to insert students into the PHC as a matter of protocol (to fulfill the formal requirements demanded by the NCG). It is in this context that management and workers can take advantage of this saturation to delegate responsibility for part of the productivity to the students who need this field of practice, as required by the norm.

The fourth management challenge concerns the "[...] low representation of some professional categories in primary care [...]", as summarized by Gauer et al. (2018, p. 6) regarding the "[...] low number of physiotherapists in primary care".

Some professions, which were not included in the FHT, find it difficult to recognize themselves in the PHC space, such as physiotherapists, nutritionists, psychologists, collective health bachelors and others previously included in the NASF. This selectivity, designed to exclude professionals who expanded care by integrating actions proposed by different perspectives, seems quite consistent with the intention of keeping other professionals' representation low. It is almost certain that management will not devote much effort to reconsidering this scenario and valuing interprofessionality with other categories when there is no financial inducement to do so.

The fifth management challenge refers to the "[...] exhausting routine and precariousness of the services" Mira et al. (2016, p. 522) summarized what most of the studies included on this topic: "[...] that the insertion and integration difficulties with the teams refer to the exhausting work routine and the precariousness of productive relationships" (Mira et al., 2016, p. 522).

Among the challenges for ESCI routines that will intensify under the new funding proposal is the prioritization of quantity over quality of care and procedures. This will compromise education and create an even more exhausting routine for health service professionals, making it impossible for them to reconcile care and preceptorship. Management is likely to discourage the inclusion of students to some extent, as they are seen as something that 'gets in the way' of professionals achieving their goals. However, students with clinical skills already well-developed at university may be welcomed by managers as another professional who 'performs procedures', a measure that is in line with the following category.

The sixth management challenge reaffirms the 'implementation of reductionist practices', which can be summarized as follows: "In fact, some dilemmas are present in the education-service articulation, especially regarding the competence of the FHS in establishing a mutual exchange relationship with students, due to the implementation of reductionist practices" (Madruga et al., 2015, p. 811).

According to Madruga et al. (2015), the lack of preparation by professionals in relation to practice and, consequently, to mediate students' experiences in the work settings, leads to the implementation of reductionist practices, which devalue teamwork and service in the territory, as a result of the vision influenced by the biomedical model, passivity in relation to integrated university activities, the distorted perception of the students' and professors' role in the services, sometimes seen as inspectors.

ESCI is a strategy that may contribute to reflections on the healthcare model, aiming its transformation, if so intended (Marin et al., 2013). However, the proposal to reorganize work processes, targeting the financial

[8]Organização Social de Saúde (OSS).
[9]Agência para o Desenvolvimento da Atenção Primária à Saúde (ADAPS).

transfer from Previne Brasil, emphasizes procedure monitoring and health action results restricted to individual care, not including evaluation of collective work processes, or focusing on the territory, restricting spaces for discussion and learning.

Finally, the seventh challenge synthesized for management is the 'devaluation of teamwork'. As can be identified in the study by Madruga et al. (2015, p. 810), "[...] teamwork is not valued, professionals resist education-service interaction, among other reasons". It is worth remembering that the model of care idealized by the FHS seeks to centralize the user and the community in the care process, which, strictly speaking, requires an intrinsic interaction between the different professional categories that constitute the teams (Barros, Spadacio, & Costa, 2018). Even though ESCI, in this environment, promotes Interprofessional Education[10] (IPE), a change in the model of care and the training of professionals from the perspective of integrality (Silva, Peduzzi, Orchad, & Leonello, 2015), studies report that teamwork is devalued, strengthening the lack of interprofessional communication and collaborative practices centered on the user and the community.

If this is already happening, as seen in the studies, with induced neoselectivity the search for productivity targets will lead to less communication and more practices focused on professional performance, inevitably reinforcing this devaluation and the breaking of bonds.

Problems related to health professionals' attitudes

A set of three challenges have been metasynthesized as the main problems related to health professionals' attitudes. The first is 'interpersonal relationships'.

> [...] although the team already knows they [the students] are going to arrive, nobody mistreats them at the reception, but the team remains at the rear. So: it depends greatly on how you treat me and the way I treat you [...] (Codato et al., 2017, p. 612).

As reported, there is tension among the preceptors, both in terms of expectations and in terms of the team's uncooperative manner. The quality of the preceptor-student relationship is essential for a good teaching-learning process. Preceptors' receptive attitude is crucial for students to have a successful experience at PHC (Luz & Toassi, 2016). In times of neoselectivity, when material conditions become more precarious, it is possible that their willingness to be empathetic and welcoming decreases, and it may be possible for raids and even disagreements to become more frequent.

The second challenge due to the professionals' attitude is the understanding of a certain 'preceptorship profile' that doesn't provide students with the opportunity to learn, either because the professional doesn't create the teaching conditions, doesn't have the skills to mediate the students' experiences in the work settings or hasn't had the pedagogical training to receive students. The following excerpt from the study summarizes the professionals' attitude in this regard: "If carried out without a preceptor present and without a solid scientific basis, it results in the mere reproduction of existing practices or their optimization within the narrow limits often found in the health system" (Mira et al., 2016, p. 424).

Even though this is not the ideal situation, there are two ways of organizing preceptorship in practice. One is when the preceptor is part of the health team (ideal situation) and the other is when the preceptor is a professor at the educational institution (possible situation). The first case facilitates the organization of activities, due to the proximity and freedom of the professional to make adjustments and manage agendas and proposals. With regard to the HEI's professor preceptor, it can be seen that sharing and participating in the planning of the service is non-existent, which promotes a dichotomy between the work offered by the local team and the university team, showing a mismatch of interests. While the university aims for pedagogical processes, the service seeks to resolve repressed and specialized demands, increase resolubility and qualify its human resources, which makes it difficult to share work processes, since only the physical space is common (Ceccim & Feuerwerker, 2004).

However, it is presumed that the neoselectivity induced by Previne will minimize or extinguish the availability for dialogue, since work in health units will be guided by individual production and focused on performance evaluations for financial transfers, where 'time' is a crucial factor in increasing productivity.

The third and final challenge synthesized about the professionals' attitude lies in 'team resistance'. Many PHC team members don't feel the need to join ESCI because they believe that integration is an activity restricted to programs like PET-Health, for example. Other professionals don't feel open or willing to

[10] Educação Interprofissional (EIP).

contribute to the team's demands, and it's difficult to find professionals who welcome students, as some feel that they ‘invade’ their spaces. Others feel that the large number of activities in the units prevents participation. All these arguments are reasons for resistance. As Madruga et al. (2015) point out:

> [...] there is a certain resistance from service professionals to include students in the teams' work process. This attitude is probably the result of the still biomedically influenced view that professionals are passive in relation to university-integrated activities, and the distorted perception of the students' and professors' role in the services as inspectors (Madruga et al., 2015, p. 812).

This resistance also stems from the professor's unwillingness to contribute to the unit's demands, coupled with poor communication between HEI professionals and service preceptors. This damages interpersonal relationships and results in the team's resistance to integrate with academia (Rodrigues et al., 2018; Codato et al., 2017). In times of neoselectivity, this resistance can result in the restriction or even extinction of practice scenarios in PHC, which can be demanded by the very professionals who were already resistant to the proposal. Everything indicates that the group of professionals who were already resistant to receiving students may chant a neoconservative discourse rejecting ESCI activities, setting back efforts to bring academia and services closer together.

Problems related to community attitude

Finally, with regard to problems related to community attitude, only one challenge is reported in the synthesized literature. The literature only presents one challenge in this category, which may reflect the extent to which the community has been invited to give its opinion and evaluate ESCI experiences. That said, the challenge in this category comes down to ‘community resistance’, as presented by Lima et al. (2019, p. 347): “[...] some resistance from some clients [...]. Sometimes it gets to the point where mothers say “oh, I don't want to let my child be seen by an academic” [...]. Women sometimes resist preventive examinations”.

Difficulties in the patient-student relationship naturally stem from the approach inexperience of the students, but this is overcome by building the bond between the academy and the community (Pereira et al., 2022). In the context of Previne's neoselectivity, which induces a more productivist behavior in the professional, there is a possibility that the students inserted in the PHC will adopt such attitudes, which, in terms of the community's view, may cause more fear of possible iatrogenies or even embarrassing situations. These situations will focus on haste and speed, generating less humanization. Of course, the patient feels this lack of care and therefore tends to be more suspicious of the student's ability, which leads to a fear of exposing their body and, therefore, greater resistance.

Despite the diverse challenges raised by this metasynthesis, it is essential to recognize the limitations of capturing and analyzing the object, including the lack of community participation in integration processes, as well as studies that demonstrate the opinion of these important participants. It is also notable that most literature is composed of experience reports, from the perspective of several scenarios, cultures, political and institutional organizations, and therefore presents different results, possibilities, and challenges.

The data compiled in this study helps to rethink new paths for public policies dedicated to ESCI, such as the establishment and valorization of collegiate spaces for deliberation and agreement. The aim is to strengthen OCPEHA and other policies that induce insertion in education, as well as those that provide for the innovation of curricula that promote critical education in health, responding to the care and political needs of the UHS.

Thus, this study provides an overview of practice scenarios in the light of the neoselectivity induced by Previne Brasil, which enables health service managers and educational institutions to organize themselves to minimize the impacts of this new policy on education and care activities. However, it highlights the need for studies that prioritize the community's perspective, encouraging social control and its inclusion in the management of ESCI actions, from the moment they are agreed upon and organized.

Final considerations

Health practice scenarios are an important educational space, but the pedagogical quality and integration between education, service, and community present challenges to overcome.

In relation to care, there is a lack of longitudinality and continuity in the absence of the university, due to the HEI's poor articulation and accountability with the service. This makes it difficult to forge closer relations

and bonds, as a result of poor planning and conflicts of interest, which converge with the challenges related to education, based on the distance between curricula and theory as well as work reality and student expectations. There are also difficulties with interpersonal relationships, the teams' resistance to receive students due to exhausting routines and the preceptorship profile, which is often not qualified to perform, hindering the development of pedagogical processes that respond to educational needs. Nor do these factors improve the quality of the services. In the uncertainty about the care quality, the community also resists integration, remaining apart from the articulation processes. Management-related challenges predominate, namely compatibility with PHC's underfunding, poor physical structure, lack of resources, understaffed teams, and insufficient settings for educational demand.

In the light of neoselectivity and the institution of Previne Brasil, PHC is expected to be immediately de-funded in most Brazilian municipalities and health care practices will regress, de-characterizing its actions, deprioritizing the FHS and fractionating its teams.

The reorganization of work processes could have a direct impact on educational actions, limiting interprofessional proposals, disregarding spaces for reflection, restricting students to the clinical environment, stimulating individual, specific and procedural practices, aimed at meeting market and performance demands, and resulting in the student's mere inclusion in the PHC and uncritical reproduction of practices and knowledge.

Beyond guaranteeing spaces and practice scenarios geared towards education and professional qualification, it is essential that managers, UHS workers, educational institutions and the community organize themselves in defense of a universal and comprehensive PHC, which coordinates and orders care, resolves problems and is committed to the real needs of the population.

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