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Primary health care and matrix support: challenges and limitations of cooperative work

Atenção primária à saúde e apoio matricial: desafios e limites do trabalho compartilhado

Atención primaria de salud e matriz de apoyo: retos e límites del trabajo compartido

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ABSTRACT: The Basic Health Care Unities (UAPS) are, nowadays, the main access to Health Care Network. In UAPS, Family Health Care Strategy suggests actions through interdisciplinary work as a way to redirect health practices. The Matrix Support, which happens in UAPS with Family Health Care Teams and Family Health Care Support Teams (NASF), has searched the strengthening of interdisciplinary health care practices. However, these practices' consolidation still has many challenges. This study presents a research developed during the Multiprofessional Residency in Family Health in Betim/MG. This study wanted to find out the limitations and challenges that Matrix Support faces in an UAPS of this city. The research used the Focal Group to produce empirical facts. The data analyses was made through Content Analysis has shown that Matrix Support has allowed health knowledge confluence, building a shared work, and workload reduction. Nevertheless, professionals' practices and discourses still keep a strong influence from the biomedical model. We observed a disagreement between the user's expectations and the acts thought by the servers, highlighting a weakness in the bound between users and servers. The research has also shown disagreements among the professional about the dynamics for Matrix Support working.

Keywords: Primary Health Care; Matrix Support; Family Health Strategy; Nucleus of Support for Family Health; Multiprofessional Residency in Family Health.

RESUMO: As Unidades de Atenção Primária à Saúde (UAPS) são, hoje, a principal porta de entrada na Rede de Atenção à Saúde. Nas UAPS, a Estratégia Saúde da Família propõe ações

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pautadas pelo trabalho interdisciplinar como ferramenta para o redirecionamento das práticas em saúde. O Apoio Matricial, realizado nas UAPS entre as Equipes de Saúde da Família e o Núcleo de Apoio à Saúde da Família (NASF), tem buscado o fortalecimento de práticas de cuidado interdisciplinares. Contudo, a consolidação dessas práticas ainda encontra desafios. Este estudo apresenta uma pesquisa realizada durante a Residência Multiprofissional em Saúde da Família em Betim/MG. Essa pesquisa buscou conhecer os limites e desafios do Apoio Matricial em uma UAPS desse município. A pesquisa utilizou o Grupo Focal para a produção de dados empíricos. A análise dos dados, realizada pela Análise de Conteúdo, mostrou que o Apoio Matricial tem permitido o encontro de saberes em saúde, a construção do trabalho compartilhado e a redução da sobrecarga de trabalho. Porém, as práticas e discursos dos profissionais ainda têm forte influência do modelo biomédico. Observou-se ainda um desencontro entre a expectativa dos usuários e a conduta pensada pelo serviço, evidenciando fragilidade no vínculo trabalhador-usuário. A pesquisa revelou, ademais, divergências entre os profissionais acerca da dinâmica de funcionamento do Apoio Matricial.

Palavras-chave: Atenção Primária à Saúde; Apoio Matricial; Estratégia Saúde da Família; Núcleo de Apoio à Saúde da Família; Residência Multiprofissional em Saúde da Família.

RESUMEN: Las Unidades de Atención Primaria de Salud (UAPS) son, hoy por hoy, la principal puerta de entrada a la Red de Atención en Salud. En las UAPS, la Estrategia Salud de la Familia propone acciones guiadas por el trabajo interdisciplinario como herramienta para la reorientación de las prácticas de salud. El Apoyo Matricial, realizado en las UAPS entre los Equipos de Salud de la Familia y el Centro de Apoyo en Salud de la Familia (NASF), ha tratado de fortalecer prácticas de cuidado interdisciplinarios. Sin embargo, la consolidación de esas prácticas todavía encuentra dificultades. Este estudio presenta una investigación realizada durante la Residencia Multidisciplinaria en Salud de la Familia en Betim/MG. Esta investigación trató de conocer las limitaciones y retos del Apoyo Matricial en una UAPS de ese municipio. La investigación utilizó el Grupo Focal para la producción de datos empíricos. El análisis de los datos realizado por el Análisis de Contenido, señaló que el Apoyo Matricial ha permitido el encuentro de saberes en salud, la construcción del trabajo compartido y la reducción de la sobrecarga de trabajo. Sin embargo, las prácticas y discursos de los profesionales todavía tienen una fuerte influencia del modelo biomédico. También se observó un desencuentro entre la expectativa de los usuarios y la conducta planteada por el servicio, evidenciando debilidad en el vínculo trabajador-usuario. La investigación reveló, además, divergencias entre los profesionales acerca de la dinámica de funcionamiento del Apoyo Matricial.

Palabras clave: Atención Primaria de Salud; Apoyo Matricial; Estrategia Salud de la Familia; Centro de Apoyo en Salud de la Familia; Residencia Multidisciplinaria en Salud de la Familia.

INTRODUCTION

This study presents research done as the final paper for the Multiprofessional Residency in Family Health Care (Residência Multiprofissional em Saúde da Família - RMSF). It was conducted in a Basic Health Care Unit (Unidade de Atenção Primária à Saúde - UAPS), in Betim, a city located in the state of Minas Gerais, Brazil. It happened between April 2014 and March 2016.

The Multiprofessional Residency in Health Care Program, created by the Law 11.129, 2005, aims at the creation of permanent educational spaces, into the Family Health Care Strategy. Those spaces should allow workers to think about the new ways of caring and alternatives for strengthening interdisciplinary actions.

Therefore, the Multiprofessional Residency done in Betim, through a partnership between the City's Hall, Health Ministry, and The Pontifical Catholic University of Minas Gerais, involves a range of professionals such as nurses, physiotherapists, odontologists, psychologists, and social service workers. The residents worked in two Basic Health Care Units, having 5,760 working hours distributed in 1,160 hours in activities dedicated to theory, and 4,600 working hours in the Health Units, summing up to 60 working hours a week, based o the idea of learning through work[1].

The research hereby presented was carried out by a resident psychologist, under the advisement of a professor from the Pontifical Catholic University of Minas Gerais, tutor of the psychology team in the Multiprofessional Residency.

While this study was conducted, there was an increasing interest in the Matrix Support meetings, due to the potential this arrangement brings to the practice of Primary Health Attention, and because of the problems observed in the relations among workers, users, and institution. Thus, the following question: What are the limits and challenges that the Family Health Care Support Teams (NASF) and the Family Health Care Teams face during Matrix Support Practices?

Analyzing this question, this study has not intended to present a single truth about the phenomenon, but to describe "a point of view of a viewpoint" from a singular perspective, as explained by Pierre Bourdieu[2]. Moreover, we try to think about new possibilities to develop work and knowledge in the health field.

Understanding health care's complexity for different populations in Brazil has allowed the development of studies and practices that tackle the factors which influence the process of health-disease. Primary Attention Services (Serviços de Atenção Primária à Saúde- APS) are an important alternative to grant and strength democratic and participative practices, allowing for the autonomy of the people cared for by the health care services[3].

The National Policy for Primary Attention to Health, approved by the Act 2488/GM/MS, on October 21, 2011, considers the Basic Health Care Unities (Unidades de Atenção Primária à Saúde - UAPS) as the first contact with the Health Care Network (Rede de Atenção à Saúde - RAS), and the responsible for coordinating health care. This policy also claims Family Health Care Strategy (Estratégia Saúde da Família) as the priority to ensure its expansion, qualification, and consolidation. In order to improve problem-solving measures and the impact on people's and collective health, this model suggests the use of complex care technology and interdisciplinary actions[3].

Multi-professional work is an important tool to promote and redirect health practices. Therefore, working in a Basic Health Care Unity (UAPS) is characterized by having diversified ways of knowledge coming together, and organizing themselves into acting teams, among which we highlight the Family Health Care Teams (Equipes de Saúde da Família) and the Family Health Care Support Teams (Núcleo de Apoio à Saúde da Família - NASF).

Family Health Care Teams are composed by a doctor, who can be a General practitioner, a specialist in Family Health or a Family and Community doctor, a nurse, who also can be a General Practitioner (GP) or specialized in Family Health, an auxiliary or nurse technician, and community health agents (Agentes Comunitários de Saúde - ACS). These professionals have the responsibility to attend clinic appointments, group activities, and home visits, they have planned actions and spontaneous demand, and they need to create ways to have permanent education for health. On top of that, they must develop interventions to promote health and prevent diseases and aggravation of them[3].

Considering Family Health Care Support Teams (NASF), which was created by the Act 154/GM/2008, published on January 24, 2008, and republished on March 4, 2008, it is composed by professionals from different areas of knowledge who must work articulating and integrating their actions to the ones of Family Health Care Teams. In order to effect the principles of universality and comprehensiveness, NASF must structure spaces to strengthen amplified clinic practices, ensuring a shared construction for the Singular Therapeutic Project (Projeto Terapêutico Singular - PTS), forming education in health groups, and, when needed, having individual appointments[3].

However, despite the insertion of different sets of knowledge and practices in primary attention to health, Gastão Campos and Gustavo Cunha[5] argue that the fragmentation of care is still a tendency that is present in the daily life in health services. As a result, health care has been organized by hierarchical relations and practices, fragmented and isolated, which has reinforced, according to Dulce Chiaverini, "a difference between the authority of who refers and of the one who receives the patient, since there is a transference of responsibility when referring"[6].

In this scenario, it is psychologists' job to "fix" mental health cases, physiotherapists must tackle cases of chronic pain and physical rehabilitation, dentists have to take care of teeth full of cavities, social workers need to see to the countless socio-economic problems of the population, and nurses and doctors care for the spontaneous demands, chronic diseases, among others.

Matrix Support is a proposition to break this fragmented model, making it possible to build and strengthen care practices that follow an interdisciplinary model, integrating Family Health Care Teams and NASF.

The concept of Matrix Support is the result of a proposition developed by Gastão Campos[7,8], which presents a new methodology to manage work in health, promoting specialized support, technical and pedagogical support, and interdisciplinarity among health professionals. The expression Matrix Support is related to the word *matr(i)*, from the Latin "mother", "origin" or "the place where something is created". Thus, this proposition aims at creating horizontal dialogues among different areas of knowledge in health.

Moreover, according to Gastão Campos[7], Matrix Support tries to strengthen the amplified clinic perspective, encourage shared responsibility and the formulation of a Singular Therapeutic Project (PTS). Meanwhile, Matrix Support urges workers to think twice about the process of health and disease, since it takes the disease away from the center of the individual's life, and shows other aspects that are paramount to promote integrated health care.

Before continuing our analysis, it is important to explain how Matrix Support was built historically. Many studies claim that Campinas/SP was one of the first cities to use Matrix Support in mental health, articulating it with the primary attention[9,10, 11]. This articulation was thought because of the need to break the fragmented view of the work, which strengthened the logic of referring the patient to a specialist; and due to the necessity to subvert the biomedical model logic.

Therefore, according to Edilane Bezerra and Magda Dimenstein[12], the Paideia Program, an adaptation of the Family Health Care Strategy from the Health Ministry and done in Campinas, was a driving factor to the organization of a healthcare network in the city. This enterprise has tried to monitor patients in their family context, basing their care in the reception, responsibilization, clients' adscrition, social control, participative management, amplified clinic, and territorialization. In order to make this model effective, it was important to integrate different care networks. Thus, Matrix Support was indicated as the path to articulate the different levels of assistance.

According to Gastão Campos and Gustavo Cunha[5], the first experiences of Matrix Support happened around 1989, in two Mental Health Reference Centers, in Campinas. The working process in them was structured in traditional models of healthcare, where the individual clinic was predominant, with no interlocution with the territory. Besides, the weak dialogue between Mental

Health Services and Basic Health Care Unities (UAPS) reinforced the logic of fragmented and uniprofessional care, through referring and referring back. From this point, there was a growing need to expand and decentralize healthcare services' actions, through the creation of multi-professional teams, which supported the primary attention teams:

Matrix Support in mental health would be the specialist technical support, where knowledge and actions, historically understood as belonging to the "psy" area, are offered to the other mental health professionals and the interdisciplinary health team, composing a space to exchange knowledge, inventions, and experiments that help the team to broaden its clinic and listening, to welcome cries, psychic pain, and deal with users subjectivity[13].

We understand that, initially, Matrix Support proposed itself as a bridge to integrating practices and care offered by mental health services and primary attention. This experience was consolidated in 2003, through the directives that included mental health in Primary Attention to Health, through Matrix Support[14].

However, we highlight that the funding for Matrix Support only started in 2008, when the Family Health Care Support Teams (NASF) were institutionalized nationally[11]. NASF is an experience that starts having Matrix Support as an important tool to organize and develop its working process. The constitution of directives for NASF's work was conceived according to Matrix Support's logic because it was being developed by Mental Health in Primary Attention[5].

In order to explain Matrix Support, Gastão Campos7 presents an organizational matrix for that system, structured in two axes: the vertical, where we find the reference teams, and the horizontal, where the matrix supporters offer a range of activities which can be used in a triple agreement: reference team, matrix supporter, and user.

The reference team is the one responsible for conducting the case, be it individual, familiar, or a community case. Its responsibility is to ensure longitudinal follow-up and to create the bond between professional and user[7]. Meanwhile, matrix supporter is a specialist or a team of specialists whose function is to boost the actions taken by the reference team, concerning themselves with questions and problems related to health.

Gastão Campos and Ana Carla Domitti8 suggest three ways to integrate matrix supporter and reference team: shared care, shared scheduling of appointments or specialized interventions, and spaces for education or sharing knowledge, to guide the paths chosen by the teams.

Analyzing the organizational matrix presented by Gastão Campos[7], we realize that, in Basic Health Care Units (UAPS), the Family Health Care Teams take the place of reference, meaning it is responsible for coordinating the cases. On the other hand, NASF is in charge of matrix supporter

activities. They should work in an articulated way, considering the creation of integrated actions for health, and that care should be committed to the users. However, many obstacles are in the way of Matrix Support's consolidation in Basic Health Care Units (UAPS), such as care fragmentation, power concentration, absence of collective spaces, and the excessive valorization of biomedical rationality[8].

Considering this scenario, this research has had the goal to learn the limits and challenges that NASF and Family Health Care Teams face while practicing Matrix Support in a Basic Health Care Unity (UAPS). The demand for this research came from the need to know and analyze the organizational obstacles that lead to the production and reproductions of practices base in rigid, fragmented, and uniprofessional models, as explained by Campos and Domitti8. The authors also consider that the obstacles must be understood, analyzed, and solved or weakened, whenever it is possible, making it possible for the work to happen in an interdisciplinary base, with co-management systems[8].

RESEARCH SCOPE

It is important to describe some characteristics of the Basic Health Care Unite where this research happened. It is located in Betim/MG, as stated before, and it is organized according to Family Health Care Strategy's requirements. During the research period, there were five Family Health Care Teams, with a General Practitioner Doctor, a nurse, a nurse technician, five or six Community Health Agents (ACS), who tried to use practices to promote health, prevent aggravation of diseases, and assist the patients.

The Basic Health Care Unit teams had the support of professionals from different areas of knowledge. There were three gynecologists, two social workers, a pediatrician, and a Family Health Care Support Team (NASF), composed of two psychologists, a physiotherapist, and a nutritionist. There was also a Mental Health Team, with a psychologist, a psychiatrist, and a psychiatry resident. Moreover, the team counted with an odontology team, organized in different specialities, and the residents in Family Health Care.

There was not a single and established way to refer patients to different professionals. Therefore, scheduling an appointment with the pediatrician or gynecologist was something people did through the unity's reception. On the other hand, social service was organized through spontaneous demand. As for oral health, there was a predetermined hour to receive new cases, and from that first contact, patients would be evaluated and referred to oral treatment, if it were possible to book a time for them with the professionals. In contrast, Mental Health and NASF organized themselves differently. Referring happened during Matrix Support meetings, when the reference team presented cases where they had difficulties to create the Therapeutic Project.

As explained before, this research focused on Family Health Care Support Teams (NASF) and the Matrix Support they offer to the reference teams in the Basic Health Care Unit (UAPS) studied. We have tried to understand the limits and challenges these professionals, both from NASF and from Family Health Care Teams, face when using Matrix Support.

We have used the focal group technique, since it promotes the arising of different conceptions and beliefs about the researched theme, allowing us to understand the meaning of experiences to the study subjects, besides enabling the analysis about social, cultural, and historical elements in the conception of the research object[15].

The focal group was done with six professionals, who were part of Matrix Support in the Basic Health Care Unit studied. We have chosen the participants trying to understand a range of workers, from those who were part of the Basic Health Care Teams, meaning the reference teams, and those who worked in Matrix Support. Thus, this focal group had a nurse, a doctor, three Community Health Agents, representing Family Health Care Teams, and a Basic Health Care Support Team psychologist.

The data collected was analyzed according to Thematic Content Analysis[16, 17]. This method has allowed the systematic organization of data and the elaboration of descriptions and inferences about the researched phenomenon. We have used three stages to operate the analysis: (1) pre-analysis, (2) material familiarization, and (3) reviewing results and interpreting them.

This research was approved by the Ethics Committee of Betim's Health Municipal Office and by the Ethics Committee of the Pontifical Catholic University of Minas Gerais, following, throughout its development, the ethical recommendations from the 196/96 resolution of the National Health Council.

DATA ANALYSIS

The empirical material produced during field research was organized in three categories for analysis: (1) Matrix Support's goals from the Basic Health Care Unit workers' perspective; (2) user's role and 'banking clinic' challenges; (3) Matrix Support's dynamics and the referring logic. We are going to present the reflections about each of these analysis axes hereinafter.

Matrix Support's goals in the Basic Health Care Unit workers perspective

Analyzing the data, we realize that workers had different expectations and understandings about Matrix Support. In the focal group, there were presented varied ideas about Matrix Support, such as a moment to build the case collectively; a space to learn and investigate the user's history; a permanent education space, where it is possible to share knowledge horizontally; a strategy to stop

outpatient care, the medicalization of bodies, and the specialisms (the idea that specialists should focus only on their field) in public health. According to one of the workers:

The reason is that sometimes we go (to the meeting) with the idea to schedule an appointment, but then we discuss the case and, many times, we do not even need to schedule with the psychiatrist or psychologist, the GP is able to conduct the case, sometimes talking about a case with a person that is inserted in the case of someone else. That is why this is a very enriching meeting. (Reference Team Nurse)

These remarks agree with the literature that understands Matrix Support as an institutional arrangement, adopted by the Health Ministry, aiming at qualifying of cases' management by health services. Concurrently, it stops indiscriminate referring because of shared responsibility[7].

We have also observed that some speeches express the understanding or expectation that Matrix Support will enable professionals to "look for a solution for the case" or to "solve the user's issue" These ideas are fostered by the rationalist paradigm, which understands health from the binomial problem-solution. According to Flávia Freire[18], this paradigm is based on the need to define and explain a problem to create an answer or rational solution for it. However, we have observed a fragility in this attitude. Considering the complexity of factors that lead people to disease (economic, socio-political, cultural, among others), it is fundamental to break and or question the belief that health care is built through a single path.

Gastão Campos and Gustavo Cunha[5] argue that there is a strong organizational culture, within the Primary Care services, of making invisible or denying the uncertainties which are inherent to the complex problems that are taken care of by the health sector. It leads to a weakness in the interdisciplinary bonds and the user's experience. Because of this, the authors emphasize the need to change this uncritical relationship with the "truth" and the "solution", and it is important to consider a balance that amplifies the object and goal of the work, and the view of the disease for the person under care. This transformation allows the professional to deal with the existing boundaries between the specialist's knowledge and the limits of knowledge and intervention. Then, we see that diagnoses and therapeutic procedures can be valued as working tools and not as undeniable dogmas[5].

Flavia Freire[18] alerted that health interventions should be thought about from the perspective of technical knowledge, related to territory and social spaces. The author affirms that:

All natural-scientific knowledge is social-scientific - it refers to the overcoming of binomial dichotomies of knowledge, abolishing statistical interpretations: health/disease, nature/cultural, natural/artificial, reason/unreason. All knowledge is local and total - this refers to developing interdisciplinary knowledge, which perceives the totality of specific phenomenon, making them

more complex and richer[19].

Similarly, Magda Dimenstein[10]. has alerted to naïve universalism which upholds and follows certain practices in health. This attitude generalizes the clinic interventions in a strict and unlimited way, with no questions about people's reality in their territories.

Matrix Support has allowed import developments, especially when it comes to having different knowledge fields in health working together, building shared work, and reducing work overload. However, we realize that professionals, moved by the wish to find solutions, tend to reinforce the cure logic. In other words, they reduce users' experience and perceptions, reinforcing the centrality of the biomedical speech in health practices.

User's role: the challenge to break the "Banking Clinic" logic

Access to the services provided by the Family Health Care Support Teams (NASF) happens through the Matrix Support meetings. In the daily life of the service studied, this meeting is called "matrixing" or "NASF's meeting". For instance, if a user wants to be assisted by a nutritionist, they must go to their team's reception and explain their problems and demands to their reference nurse. Then, they will have an appointment with the GP and the nurse will communicate to the user that their case will be "discussed" and analyzed during the matrixing meeting, which happens monthly with each Family Health Care Team. After this meeting, the community health agent (ACS) explains what was agreed by the reference team with the matrix support from NASF.

We have observed that the flow organization in the Basic Health Care Unit reveals a curious and strange relation between user and worker. In many moments, we realized that the user understands that health attention is a service provided by specialists, and the workers take the place of offering this product (health). This attitude reinforces a prescriptive position, where the professionals "take the floor" and solely produce knowledge about the person being cared for, which makes the user a mere recipient of the professional knowledge and certainties.

It can be understood when a user asks the nurse to have an appointment with the nutritionist. That professional discusses the best way to deal with the case with the other members of the Family Health Care Team and NASF. Thus, according to the data gathered by the matrixing participants, the user may be referred to the nutritionist or a health promotion group, or to other options that the territory might offer.

In this case, the right to have a voice is denied to the users. They have to adapt to the prescriptions of the legitimated knowledge. This mechanism, so common in Basic Health Care Units, is called the "Banking Clinic" in this paper. This expression is a reference to the concept of "Banking Education" proposed by Paulo Freire in the book "Pedagogy of the Oppressed". This idea can be

understood through the author's reflections about education:

Education that is imposed to those truly committed with the liberation cannot be founded on an understanding of humans as empty beings who are going to be filled by the world with content; it cannot be based on a specialized awareness, mechanically divided, but intended to the world in people with "conscience bodies". It cannot be based on content deposit, but on the problem-posing relation humans have towards the world[20].

We believe that "Banking Clinic" strengthens the idea that the user is an empty being, with no intentionality, while the professional is a "banking" educator, responsible for disciplining and "filling" the users with the adequate determinations for their cases, according to technic-scientific knowledge, taken separately from the person's reality. This affirmative can be summarized by the following speech:

When we bring in a case, for example, the person wants an answer, and sometimes the answer you have is not the one the person wants, because it is the one we agreed in the matrixing meeting. For example, the person wants an appointment with the psychiatrist, but then we take the case to matrixing, and what we have is a GP appointment, because there was the conclusion that the case didn't neet… and the GP can medicate, orient. So, it is difficult for us, because we have to tell the person the answer and it is not the one they want. We need to be flexible and patient. (ACS1 - Reference Team)

We believe that the user's discomfort towards the answer given by the Community Health Agent explains their peripheral role when building their Singular Therapeutic Project. The "quest for a solution" tends to disregard the user's experience and knowledge. Therefore, we realize that, in spite of the interdisciplinary approaches present in Matrix Support, the user is still in a peripheral role when compared to the specialist, considering that "answer and solution" are thought about without that person's participation.

Paulo Freire[21] invites, by discussing the banking logic, to question the oppressive relations which are present in Brazil's social structure. It is possible to understand the relevance and dialogue between the author's remarks and the relationship between health care workers and users. Despite the developments reached by Matrix Support's implementation, especially when it comes to horizontalizing knowledge and health practices among professionals, we still need to think about how to build the Singular Therapeutic Program with the user as an actor of this process.

In the situation presented previously, we can perceive that there is a difference between the Singular Therapeutic Program proposed by Matrix Support and the one expected by the user.

Inspired by Paulo Freire[21], we need to consider that the banking attitude, here analyzed through "Banking Clinic", has the goal to immobilize and silence the users, since they have to accept passively the specialists' decisions. However, the authors state that, in face of the inhibition of their creational potential, there is an emerging feeling of frustration and unbalance, which is soon refused through the search of and return to the "transforming potential". This inhibition and this feeling of frustration on the part of the user can appear in various ways in their relationship with the health services. Here we highlight the absenteeism and treatments' evasion.

Magda Dimenstein[22] considers that facing 'the incompatibility of therapeutic projects between professionals and users, or simply due to the inexistence of a project on the part of the user', there will be an active attitude from the user. This attitude may be called 'a rebel act', considering Paulo Freire's ideas, reflected on the user's absenteeism in scheduled appointments and treatments' evasion. We have realized, during the focal group, that the professionals think that the absenteeism is a limit to the effectiveness of Matrix Support, which can be summarized by the following quote:

The patient is the one who schedules the appointment and doesn't show up. There is no commitment. (DOCTOR - REFERENCE TEAM)

The authors quoted before have a new comprehension about the absence of patients in scheduled appointments. Beyond "lack of commitment", this behavior shows the ability the user had to act and transform the banking position which is given to him. Therefore, there is a fragility between the workers' and Gastão Campos and Gustavo Cunha's[5] perceptions. These authors understand matrix strategy as an instrument to strengthen the bond between professionals and users since it decentralizes attention practices and affirms the shared responsibility of all the actors involved in the process of managing health care. Despite the developments observed in public health, we believe that health care's shared responsibility and building users' autonomy are issues that still need to be thoroughly considered.

Mariana Figueiredo explains how important it is to amplify the notion of the clinic:

Amplifying the clinic also means that the professionals may, at some point, withdraw their previous knowledge, which is taken for granted with the techniques, as a standard procedure, to open up to intersubjective contact, which happens in the relationship between professionals and patients, to ask themselves what is the best intervention in each situation[23].

In the context of Primary Attention, we have observed that the amplified clinic presents itself as a tool to be strengthened. The accelerated dynamics of services, the strong biomedical and ambulatory posture, productivity, and technicalism are factors that lead to the fragility of dialogues and meetings in the professional/user relationship. For this reason, it becomes a challenge to be thought about, aiming at overcoming the barriers imposed by the banking model of health care.

Matrix Support meetings dynamics versus referring logic

Another problem posed by the data produced was the organization and dynamics of Matrix Support meetings. Analyzing the professionals' speech, we realize that there is nothing clear about how the meeting should happen in terms of structure and conduction.

In the Basic Health Care Unit we studied, Matrix Support meetings with the Family Health Care Support Team happens with each of the five Family Health Care Teams once a month, meaning that every week one or two teams go through that process. In the meeting, the nurse is in charge of presenting the cases that were previously discussed in the Family Health Care Team's meeting. After the case and the problems to build a Singular Therapeutic Program are explained, the reference team and the matrix supporters have a dialogue trying to think about the best path for the case. However, there are some barriers to the process:

I'll tell you a little about what [the nurse] said… there are too many questions for us, for God's sake! (laughs) I can't stand it! So, there is no need for the person to have an appointment, I have an appointment for the person. I believe that the professional should at least see the citizen's face too! If you have given, at least, half of the answers they need, it is a big deal to have an appointment. It upsets me! (ACS2 - Reference Team)

In the situation presented, we observe the dissatisfaction from the reference team towards the number of questions posed by matrix supporters from NASF (two psychologists, a physiotherapist, and a nutritionist). For NASF, those questions allow them to understand the case and the user's history better, but for the Family Health Care Team, those questions are seen as a way created by NASF to refer the case. This attitude has been named "nasfering" by the professionals in the reference team. It means that these professionals deal in a derogatory way with the lack of readiness from NASF to answer the latter's expectations. We have observed that there is no clear idea about NASF's position and the way the meeting should be conducted. This problem may be understood from Gastão Campos and Gustavo Cunha's observation:

NASF is an experience using the concepts of Reference Team and Matrix Support. There are, obviously, structural problems, such as lacking specialized services, which induce to the wrongful use of NASF in an attempt to substitute other services (for instance, the support of a physiotherapist to a health care center does not substitute a physical rehabilitation center), impoverishing health care and impairing the understanding of how it should work. Besides, since other specialized services do not practice Matrix Support, NASF's teams work is harder, both because they cannot learn from each other and because of the isolation primary attention faces when related to the whole assistance network[24].

At this point, it is important to reflect on the attributions of the reference team and the matrix

supporter, because it is possible to identify this polarity. On the one hand, the reference team is overloaded with several cases of users requesting individual appointments. On the other hand, the matrix supporters seeking to question, using several inquiries, the clinical picture and the socioeconomic context of the user, to build care strategies that go beyond the outpatient model. We have, thus, observed the practical challenge: how to implement shared responsibility?

In order to think about these problems, it is important to consider the responsibilities attributed to all the actors present in Matrix Support. According to the Act 154, January 24, 2008, which legislates on NASF, it 'does not represent the first contact people have with the health system and must act in integration with the health services network, from demands that are identified while working together with Family Health Care Teams.'[24] Therefore, the work developed by Family Health Care Teams and NASF is expected to be organized through the shared work axis.

The shared responsibility between family health care teams and NASF in the community foresees the review of the referral practice based on the reference and counter-reference processes, extending it to a longitudinal follow-up process of responsibility of the Basic Care/Family Health Care, acting in the strengthening of its attributes and the role of coordinating care in SUS[24].

It is also worth mentioning that, for Gastão Campos[7], the matrix supporter should advise the reference teams through specialized knowledge and offer assistance and technical-pedagogical support, but should not assume the reference of the case. For this author, the reference should be the responsibility of the Family Health Care Team. The Matrix Support team does not assume the reference and should not be understood as a second level of health care attention.

From the points raised, we note that the reality of primary attention reveals some impasses for the consolidation of the matrix system. Thus, we question: Doesn't the reference team understand NASF's place? How can we break with the logic of referral in a participatory way and without causing polarities? How to conduct Matrix Support meeting beyond questions, to consolidate resolution in user's care?

These questions highlight the complexity of the structural problems present in the dynamics of Matrix Support, which in turn make it difficult to disseminate this proposal. For this reason, Gastão Campos[7] points to the importance of reflecting on the structural and ideological logics that still sustain traditional practices present in primary care devices. It is known that institutional contexts are structured through organizational arrangements that have multiple determinations, such as culture, the subjectivity of the actors involved, economy, politics, and history of the territory of action. Therefore, the construction and insertion of new models must be thought out from a careful analysis of power relations and the socio-cultural elements that sustain health care practices in each context.

CONCLUSION

Throughout the study, we have observed that Matrix Support is a powerful proposal for primary attention services. For the workers, this practice guarantees a moment for the collective construction of the case; a space to learn and investigate the user's history; a space for permanent education, in which it is possible to share knowledge horizontally; and, finally, a strategy to break with the ambulatory model, with the medicalization of the bodies and with the specialties in the field of public health.

However, during our analyses, we have noticed disagreements in the discourses stated by the workers, regarding the challenges/limits they point to the practice of Matrix Support and, on the other hand, the contributions that Matrix Support brings to the health teams. For the workers, Matrix Support contributes to overcoming the outpatient model and specialism, but, at the same time, we observe a strong presence of the biomedical discourse. It was also stated that the matrix arrangement makes it possible to: improve the ability to discuss a case; learn to listen better; promote the creation of the Singular Therapeutic Program in a shared way. Nevertheless, such aspects come up against the logic of the "Banking Clinic" concerning the user, as indicated by this study.

Regarding the dynamics of Matrix Support meetings, it is noticeable from the professionals' speeches that there is no clarity about how the meeting should be structured and conducted. Therefore, throughout the research, it was possible to observe a divergence between the expectations of NASF and those of the Family Health Team, especially regarding how referrals should be made.

Therefore, it is not enough to have policies and guidelines that foster the implementation of Matrix Support in health units and create Matrix Support teams to work with other services. It is also necessary to break away from the rigid frontiers of knowledge in health formation spaces and encourage ongoing formation programs that value interdisciplinarity and also the different types of knowledge involved (not only those related to techno-scientific formation). Also, it is essential to bring about changes in the power relations present in organizations, to seek more democratic ways of working and relationships with users, as well as a break with neoliberal logic that alienate health care processes.

After two years in the Multiprofessional Residency Program in Family Health and during the construction of this research, some concerns remain: How to promote user co-participation in the construction of the Singular Therapeutic Program, in a context marked by great demand and productivity requirements? What is the potential of the shared construction of the Singular Therapeutic Program for the creation of autonomous and political subjects? How to break with the "Banking Clinic"?

Faced with the proposals of the new devices present in the Basic Health Care Unit field, which point to co-responsibility and the construction of autonomy as paths for the construction of the expanded clinic, we think that it is necessary to meet with the subjects with whom we act daily. It is fundamental to think not only about the history of the subjects but to think, with the subjects, about their history. We need to break with the lenses of technicalism, which aims to organize health care from consultations, medications, groups, finally, from the long menu that we, health professionals, offer to the "passive" subject and his "strange and unknown" community.

Considering the naturalization of silence and even more of oppressions, it is necessary to rethink the models and practices of care. As citizens and health care professionals, we have to allow ourselves a closer encounter with the different subjects involved in health care to elaborate not only the other's exit but our exits.

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