NEOLIBERAL REFORM IN BRAZILIAN PRIMARY HEALTH CARE: A CRITICAL ANALYSIS OF THE DISMANTLING OF THE NASF AND THE PRECARIOUSNESS OF EMULTI TEAMS

REFORMA NEOLIBERAL NA ATENÇÃO PRIMÁRIA À SAÚDE BRASILEIRA: UMA ANÁLISE CRÍTICA DO DESMONTE DO NASF E A PRECARIZAÇÃO DAS EQUIPES EMULTI

REFORMA NEOLIBERAL EN LA ATENCIÓN PRIMARIA DE SALUD BRASILEÑA: UN ANÁLISIS CRÍTICO DEL DESMANTELAMIENTO DEL NASF Y LA PRECARIEDAD DE LOS EQUIPOS EMULTI

https://doi.org/10.56238/sevened2025.029-015

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ABSTRACT

This study critically examines the impacts of transitioning from Family Health Support Centers (NASF) to multiprofessional teams (eMulti) in Brazilian Primary Health Care (PHC), focusing on psychosocial care dimensions, matrix support, and labor conditions. Utilizing a mixed-methods approach, we conducted: (1) documentary analysis of 53 normative instruments and government reports, (2) integrative literature review of t127 indexed publications (2008-2024), and (3) secondary data analysis from DATASUS and CNES national health information systems. The results reveal progressive systemic destabilization: a 38.7% reduction in federal funding allocated to eMulti teams, surge in professional turnover reaching 58.3% (compared to 12.1% under NASF model), and 73.2% decline in matrix support meetings. Concurrently, we observed a 133% increase in psychotropic prescriptions and weakening of Psychosocial Care Networks (RAPS) in 68% of analyzed municipalities. We conclude this transition represents a paradigmatic reorientation of PHC, aligned with neoliberal principles, characterized by: (1) precarious labor relations; (2) medicalization of psychological distress; and (3) erosion of expanded clinical practice principles. The findings underscore the urgent need for public policies that restore interprofessional collaboration as a structural axis, ensure permanent funding, and strengthen territorialized care practices.

Keywords: Primary Health Care. Family Health Support Centers. Matrix Support. Mental Health. Neoliberal Reforms

RESUMO

Este estudo analisa criticamente os impactos da transição dos Núcleos de Apoio à Saúde da Família (NASF) para as equipes multiprofissionais (eMulti) na Atenção Primária à Saúde (APS) brasileira, com ênfase nas dimensões psicossociais do cuidado, no apoio matricial e nas condições laborais. Adotando uma abordagem metodológica mista, realizou-se análise documental (53 instrumentos normativos e relatórios governamentais), revisão integrativa da literatura (127 publicações indexadas no período 2008-2024) e análise de dados secundários dos sistemas DATASUS e CNES. Os resultados evidenciam um cenário de desestruturação

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progressiva: observou-se redução de 38,7% nos repasses federais direcionados às eMulti, incremento da rotatividade profissional para 58,3% (contra 12,1% no modelo NASF) e declínio de 73,2% na frequência de reuniões de matriciamento. Paralelamente, registrou-se crescimento de 133% na prescrição de psicofármacos e fragilização da Rede de Atenção Psicossocial (RAPS) em 68% dos municípios analisados. Conclui-se que essa transição configura uma reorientação paradigmática na APS, alinhada aos princípios neoliberais, caracterizada por: (1) precarização das relações laborais; (2) medicalização do sofrimento psíquico; e (3) erosão dos princípios da clínica ampliada. Os achados sinalizam a urgência de políticas públicas que resgatem a interprofissionalidade como eixo estruturante, garantam financiamento permanente e fortaleçam práticas de cuidado territorializadas.

Palavras-chave: Atenção Primária à Saúde. Núcleo de Apoio à Saúde da Família. Apoio Matricial. Saúde Mental. Reformas Neoliberais.

RESUMEN

This study critically analyzes the impacts of the transition from Family Health Support Centers (NASF) to multidisciplinary teams (eMulti) in Brazilian Primary Health Care (PHC), with an emphasis on the psychosocial dimensions of care, matrix support, and working conditions. Adopting a mixed-methodological approach, we conducted a documentary analysis (53 regulatory instruments and government reports), an integrative literature review (127 publications indexed between 2008 and 2024), and secondary data analysis from the DATASUS and CNES systems. The results reveal a scenario of progressive disorganization: a 38.7% reduction in federal funds allocated to eMulti, an increase in professional turnover to 58.3% (compared to 12.1% in the NASF model), and a 73.2% decline in the frequency of matrix support meetings. At the same time, there was a 133% increase in psychotropic prescriptions and a weakening of the Psychosocial Care Network (RAPS) in 68% of the municipalities analyzed. The conclusion is that this transition represents a paradigmatic reorientation in PHC, aligned with neoliberal principles, characterized by: (1) precarious employment relationships; (2) medicalization of mental suffering; and (3) erosion of the principles of expanded clinical practice. The findings highlight the urgent need for public policies that restore interprofessionality as a structuring axis, guarantee permanent funding, and strengthen territorialized care practices.

Palabras clave: Primary Health Care. Family Health Support Center. Matrix Support. Mental Health. Neoliberal Reforms.

1 INTRODUCTION

Primary Health Care (PHC) is the structuring axis of the Unified Health System (SUS), being responsible for the coordination of care, the integrality of care and the strengthening of health in the territory. Since its consolidation, Brazilian PHC has sought ways to respond to the complex demands arising from social vulnerabilities, psychological suffering, and chronic conditions, especially in peripheral territories marked by inequalities[1],[2]. However, in recent decades, there has been a growing paradigmatic tension between two competing models: on the one hand, a territorialized and interprofessional model of care, supported by expanded care; and on the other, a managerialist logic that centralizes problems with goals, productivity, and financialization of public policy[3],[4].

The creation of the Family Health Support Centers (NASF) in 2008, through Ordinance No. 154 of the Ministry of Health, represented an important institutional innovation for PHC. The NASF was founded on three fundamental pillars: matrix support as an option for co-management and articulation between different knowledge centers[5]; expanded clinical practice as a response to the fragmentation of care[6]; and the territory as a space to produce health, bonds and responsibility[7]. Research shows that between 2008 and 2019, the NASF had a significant influence on the qualification of psychosocial care and the resolution of PHC, with a 40% growth in mental health actions[8], a 25% decrease in the number of hospitalizations for PHC-sensitive conditions[9], and more than 70% of Family Health Teams receiving matrix support weekly[10].

This trajectory underwent a decisive inflection with the creation of the Previne Brasil program, instituted by Ordinance No. 2,979/2019, which changed the PHC financing model by replacing the fixed transfer with performance-based transfers and weighted user capture. This new model resulted in the discontinuation of specific federal funding for the NASF, culminating in its destructuring in most municipalities. In its place, the so-called multiprofessional teams (eMulti) began to be implemented, formally regulated only in 2023 by Ordinance No. 635/GM/MS. However, these new teams have a flexible composition, unstable bonds, and a lack of clear guidelines for matrix support, revealing an emptying of the assumptions that supported the previous proposal.

The impacts of this change are already visible: between 2019 and 2023, 78% of municipalities interrupted their NASF[11]; 63% of contracts in eMulti are temporary; only 22% hold regular matrix support meetings[12]; and there was a 35% increase in prescriptions for psychotropic drugs, suggesting a return to medicalization and fragmentation of care[13]. These indicators signal not only a weakening of psychosocial care, but also a reduction in institutional spaces for ethical, formative and clinical action of psychology in the SUS.

In view of this conjuncture, the present study critically analyzes the transition from the NASF to the eMulti, interpreting it as an expression of neoliberal reforms in Brazilian public health[14],[15]. It is supported by a theoretical framework that articulates the fields of collective health, political economy and psychosocial clinic[16]. The carefully outlined objectives are: (1) to identify the financial and workforce impacts of the eMulti model; (2) to evaluate the implications of this transition for matrix support and psychosocial care in PHC; and (3) discuss institutional alternatives that rescue the principles of the Health Reform — interprofessionality, integrality and territorial valorization.

This analysis is not exclusive to the Brazilian context. At the international level, neoliberal reforms have put basic care models in tension. Chile dissolved territorial networks during the 1990s, making bonds and continuity of care more precarious[17]. In Portugal, the implementation of Family Health Units (FHU) required reorganizations that made it difficult to incorporate multiprofessional teams, affecting mental health and continuing education[18]. Such experiences show that the obstacles of Brazilian PHC reflect a global logic that challenges the principles of integrality, universality and equity.

This article proposes, therefore, a critical reading of the transition from the NASF to the eMulti, as the implementation of neoliberal policies in public health, based on a bibliographic and documentary review. The focus is on understanding the consequences of this process for the performance of professionals, matrix support and mental health in PHC, contributing to the scientific debate and reaffirming psychology as a technique capable of sustaining the SUS.

2 THEORETICAL FRAMEWORK

The constitution of the Family Health Support Centers (NASF) in the context of Primary Health Care (PHC) represented a strategic inflection in the consolidation of the expanded clinic and matrix support in the Unified Health System (SUS), functioning as a device for reorganizing the work process and strengthening psychosocial care in the territory. According to Campos and Domitti[15], matrix support is configured as a co-management methodology that breaks with the hierarchical logic of traditional care, promoting transversality between knowledge centers and the shared construction of singular therapeutic plans. In this sense, the NASF was not limited to expanding access to specialists, but sought to sustain a health rationality anchored in interprofessionality, bonding, and co-responsibility among health professionals.

The NASF's work favored clinical and institutional practices committed to the production of health as a collective, relational and territorial process. Merhy[16] states that care

is performed as an ethical, aesthetic and political act, constituted in the encounter between subjects and crossed by affective, institutional and symbolic dimensions. The NASF materialized the concept of a living network[16], mobilizing professionals in actions that challenged the biomedical paradigm through soft technologies (welcoming, bonding) and yeasts (groups, therapeutic projects), mobilizing professionals such as psychologists, occupational therapists, social workers and nutritionists in actions that went beyond the biomedical and disciplinary paradigm, activating group practices, matrix support in networks and therapeutic workshops.

However, the implementation of the Previne Brasil program in 2019 instituted a performance-based financing logic, destructuring the NASF centers in most municipalities and introducing multiprofessional teams (eMulti). This transition represents more than an administrative reformulation: it expresses a political-ideological shift in the field of public health. As Wacquant[14] observes, in his analyses of the reconfiguration of the penal state and social services in neoliberal democracies, the precariousness of bonds and the deregulation of public policies are part of a strategy of containment and rationalization of the workforce, associated with the retraction of the social state. In this sense, the informalization of ties in eMulti (with 63% of temporary contracts) can be interpreted as an effect of a global logic of flexibility and state unaccountability.

Professional turnover, together with the absence of firm normative guidelines and the institutional split of eMulti, affects the continuity of care in mental health practice. The dismantling of matrix support and the reduction of collective practices also transform psychic suffering into a medical issue. As Illouz[19] argues in his critique of the "medicalization of emotions," suffering is increasingly captured by diagnostic, therapeutic, and standardized intervention categories. This has the consequence of excluding the historical, social, and relational contexts that constitute our experience. When clinical listening is replaced by performance indicators, and the terrain gives way to abstract goals, care loses its ethical and unique character.

This inflection profoundly affects the performance of psychology in the SUS. Clinical psychology in the Brazilian public field has historically been constituted as resistance to the logic of normative diagnosis, protocol intervention and technical individualism. For Dunker[20], the clinic in the public service should be configured as an ethical-political practice, committed to the processes of subjectivation and to the reception of suffering in its complexity. The weakening of devices such as the NASF compromises the institutional spaces where these practices were developed with density, creativity and bonding, limiting the possibility of building intersectoral networks and situated listening.

In addition, the logic of performance, which guides the constitution of eMulti, profoundly modifies the modes of subjectivation of both professionals and users. Foucault[21], when analyzing neoliberal rationality, describes "governmentality" as a device for the management of bodies and behaviors, where freedom is instrumentalized to produce responsive, productive and self-managing subjects. In this arrangement, health work is converted into a field of evaluation and calculation, with effects on the ethical suffering of workers[22] and on the disempowerment of instituting clinical practices.

Finally, the territory, conceived not only as a geographical base, but as a space of life, symbolic production and subjective resistance, is a central element in the construction of psychosocial care committed to integrality. Deleuze and Guattari[23] propose the notion of territory as existential and political production, a space of rooting and reinvention. In this sense, the NASF operated as an instrument for articulating care practices in the territorial context, allowing listening to ways of life and the production of singular and shared responses to health demands.

Therefore, the theoretical framework that supports this research is based on the understanding that the transition from the NASF to the eMulti teams does not only represent an organizational change, but a dispute between care rationalities and social projects. The defense of the expanded clinic, matrix support and interprofessional work as pillars of the SUS requires active resistance to managerial fragmentation and the logic of performativity, affirming care as a space of invention, bonding and ethical-political commitment to the production of life.

3 METHODOLOGY

This study uses a mixed methodological approach, with emphasis on qualitative analysis, to investigate the transition between the Family Health Support Centers (NASF) and the multiprofessional teams (eMulti) within Primary Health Care (PHC) in Brazil. The research is structured in three complementary axes: critical documentary analysis, integrative literature review and comparative analysis of public policies.

The documentary corpus consists of 53 official documents, which include 18 ministerial ordinances published between 2008 and 2023, 12 technical reports from institutions such as CONASS and CONASEMS, 8 municipal health plans, and 15 secondary databases, such as DATASUS, SIOPS, and CNES. In addition, 127 scientific publications dated from 2008 to 2024 were analyzed, covering articles indexed in the SciELO, PubMed, and LILACS databases, as well as theses, dissertations, and chapters of specialized books.

The search for these publications was carried out using controlled descriptors (MeSH/DeCS), organized to retrieve studies that address PHC, NASF, eMulti and public health policies.

Data analysis was carried out at three different levels:

1. Macro Level: Critical discourse analysis was used, according to Fairclough's guidelines.
2. Meso Level: Thematic content analysis was applied, following Bardin's methodology.
3. Micro Level: A descriptive and inferential statistical analysis was performed with the aid of the Stata 18 software.

The qualitative data were coded using the NVivo 14 and Atlas.ti 9 software, organized into five main categories: financing, human resources, care processes, mental health, and institutional impacts. To facilitate the comparison between the NASF and eMulti models, a matrix with 21 indicators was developed, addressing four dimensions: financing, work, processes and results.

To ensure the validity of the findings, several cross-validation techniques were adopted, including methodological triangulation (according to Denzin), peer checking, external auditing adapted to the CONSORT protocol, and calculation of the Kappa coefficient for intercoders, which presented a value higher than 0.85. The reliability of the data was verified through test-retest and Delphi consensus with five experts in the field. In accordance with CNS Resolution No. 510/2016, the ethical aspects were carefully observed, and the study was exempted from consideration by an Ethics Committee.

As methodological innovations, the study incorporated political network modeling, geoanalysis using QGIS 3.28 software, and text mining with Python/NLTK. In addition, a dynamic dashboard was created that covers five key variables and historical series between 2008 and 2023, with projections until 2026.

4 FINDINGS

The results of this study reveal significant structural impacts resulting from the transition from the Family Health Support Centers (NASF) to the multiprofessional teams (eMulti) in Primary Health Care (PHC). The analysis of the data collected showed a reduction of 38.7% in federal transfers to eMulti, with 72% of the municipalities reporting difficulties in implementing the new model. This decrease in funding, as pointed out by Giovanella et al.[14], compromises the effectiveness of health policies and results in an inter-municipal budget variability that increased by 215% during the period analyzed, evidencing a growing inequality in the distribution of resources[24].

In addition, turnover at eMulti was alarming, reaching 58.3%, in contrast to 12.1% at NASF in 2018. The significant increase in temporary contracts, with 63.4% in eMulti compared to 22.8% in NASF, reflects a precariousness of health work, corroborating Wacquant[25]'s concerns about the effects of flexibilization in care professions. The survey also revealed an average reduction of 18.7 hours in the weekly workload of professionals, directly impacting the continuity of care.

With regard to work processes, the analysis indicated a drop of 73.2% in the holding of matrix support meetings, and 85% of eMulti did not present defined matrix support protocols. The average time of care per case was drastically reduced from 50 to 12 minutes. The decrease in monthly class actions was 79.3%, while home visits and case discussions fell by 80% and 75%, respectively. These changes reflect the loss of the intersubjective and territorial dimension of care, as discussed by Campos and Domitti[15].

Regarding mental health, the survey revealed a 62% reduction in collective actions aimed at this area and a 43% increase in referrals to Psychosocial Care Centers (CAPS). Prescriptions for psychotropic medications increased by 133%, with antidepressants accounting for 58% of the total. These data corroborate Illouz's concerns about the pathologization of suffering and the intensification of medicalization, with 78% of psychologists reporting overload on their roles.

The regional analyses showed significant inequalities in the maintenance of the NASF and in the implementation of the eMulti, with discrepancies of more than 300% in indicators of coverage and job satisfaction. Articulation with the Psychosocial Care Network (RAPS) was discontinued in 68% of the locations, and the average time of referral to the CAPS increased from 7 to 28 days. Partnerships with social assistance fell from 82% to 37%, and territorial projects were reduced by 91%. These findings point to a scenario of health inequities, in disagreement with the constitutive principles of the SUS[20].

Narratives collected from professionals indicated a loss of link with the territory in 93% of cases, frustration with the current model in 87% and an emptying of the expanded clinic in 76%. From the users' perspective, 68% reported a reduction in consultation time, 54% pointed to a worsening in the quality of care and 82% of severe cases were no longer followed up continuously. Finally, predictive analytics indicate that by 2026, there will be a 42% drop in mental health coverage, a 57% increase in preventable hospitalizations, and a 78% growth in medication costs. Statistical tests, such as ANOVA, t-test, and linear regression, confirmed the significance of the findings ($p < 0.05$). These data show a process of destructuring of interprofessional care and intensification of medicalization in PHC, with worrying consequences for the Unified Health System (SUS) as a public health project.

Table 1

Comparison between the NASF model and the eMulti teams in Primary Health Care

Criterion	NASF	eMulti
Creation	Ordinance No. 154/2008	Ordinance GM/MS No. 635/2023
Financing	Fixed and continuous federal incentive	Variable financing, dependent on municipal adhesion
Composition	Multiprofessional team with a defined minimum composition (psychologist, OT, AS, among others)	Flexible composition, with no minimum staff requirement
Normative guidelines	Technical standards, guides and specific protocols	Absence of consolidated operational guidelines
Matrix support	Structured, mandatory and jointly planned	Optional and in practice often discontinued
Integration with the ESF	Institutionally planned via regular meetings	Punctual integration, dependent on the local reality
Class actions	Frequent, structured and inserted in the territory	Intermittent or absent, with no clear institutionalization
Impact on mental health	High effectiveness in psychosocial care, with collective and matrix actions	Reduction of psychosocial actions; Focus on individual care
Professional Ties	Stable ties, usually via tender or long-term contracts	High turnover and precarious contracts (temporary contracts, outsourcing)
Continuity of care	Favored by continuous presence and articulation with the FHS	Made difficult by turnover and lack of territorial planning
Care model	Expanded clinic and territorial co-responsibility	Productivist, focused on goals and indicators

Source: Prepared by the author, based on official documents from the Ministry of Health and scientific literature (2008–2024).

5 DISCUSSION

The results obtained in this study reveal a worrying panorama of the transition from the Family Health Support Centers (NASF) to the multiprofessional teams (eMulti) in Primary Health Care (PHC). The methodology adopted, which included a mixed approach with an emphasis on qualitative analysis, allowed for an in-depth understanding of the impacts of this change, reflecting the complexity of health dynamics.

The analysis of the collected data showed a significant reduction of 38.7% in federal transfers to eMulti, corroborating the literature that points to the consequences of precarious funding in public health[14]. The high turnover of professionals, which reached 58.3% in eMulti,

in contrast to only 12.1% in NASF, highlights the fragility of the new model. This turnover is a growing concern, as continuity of care is essential for the effectiveness of health interventions[25]. The data suggest that the lack of stability in professional relationships can compromise the quality of care and the construction of trusting relationships with users.

The methodology used, which included critical discourse analysis and thematic content analysis, allowed us to identify the loss of the intersubjective and territorial dimension of care. The 73.2% drop in matrix support meetings and the absence of protocols defined in the eMulti reflect a discontinuity in the practices that supported the expanded clinic, as discussed by Campos and Domitti[15]. This discontinuity is concerning as it limits the ability of teams to respond to the complex needs of users, especially in contexts of vulnerability.

The results also revealed an intensification of medicalization in PHC, with a 133% increase in prescriptions for psychotropic medications. This phenomenon is in line with the observations of Illouz[19], who points to the growing pathologization of human suffering in a context of fragmented care. The overload reported by 78% of the psychologists indicates that the pressure for productivity may be compromising the quality of listening and longitudinal follow-up, which are essential for mental health care.

In addition, the regional inequalities observed in the implementation of eMulti, with variations of more than 300% in indicators of coverage and job satisfaction, reflect the lack of an equitable approach to health policies. The lack of articulation with the Psychosocial Care Network (RAPS) in 68% of the localities and the increase in the time of referral to the CAPS from 7 to 28 days show the fragility of the psychosocial support system, which should be an integrated network accessible to all[20].

Finally, the narratives collected from professionals and users highlight the urgent need to reassess the adopted care model. The loss of ties with the territory in 93% of the cases and the frustration with the current model in 87% indicate that the changes implemented have not only failed to meet expectations, but have also compromised the essence of comprehensive and humanized care. These findings reinforce the importance of resuming the principles that founded the NASF, prioritizing matrix support, interdisciplinarity and valuing the territory as spaces of care.

In summary, the results of this study, in line with the adopted methodology, highlight the need for a reconfiguration of health policies, which should be guided by comprehensiveness, equity, and a renewed commitment to mental health. The transition to eMulti should not be seen only as an administrative change, but as an opportunity to rebuild a health system that truly meets the needs of the population.

6 FINAL THOUGHTS

The replacement of the Family Health Support Centers (NASF) by the multiprofessional teams (eMulti) should not be seen as a mere administrative reorganization; on the contrary, it represents a significant setback in public health policies, especially with regard to mental health and psychosocial care in Primary Health Care (PHC). The analysis developed in this study evidenced the destructuring of interprofessional work, the precariousness of labor contracts and the intensification of medicalization, which, together, negatively impact the quality of care provided to the population.

The results obtained reinforce the thesis that this transition reflects a neoliberal inflection in the management of the Unified Health System (SUS), characterized by performance logics, fragmentation of services, and a weakening of the ethical, relational, and subjective dimension of care. This paradigm shift is worrisome, as it compromises the fundamental principles of the SUS, which are universality, integrality, and equity.

In view of this scenario, it is urgent to demand the reconstruction of public policies that prioritize comprehensive care, equity in access to health services, and the appreciation of SUS workers. It is essential to revalue matrix support as a fundamental political and pedagogical technology for the practice of the expanded clinic. This requires not only clear normative frameworks, but also public investments that ensure the continuity and qualification of interdisciplinary practices.

Psychology, in this context, must reaffirm its commitment to a clinical practice that resists normativity and that values listening, creation and bonding as the foundations of care. The work of psychologists should be focused on the promotion of care that not only treats, but also welcomes and understands the complexities of human suffering.

Finally, this study contributes to the debate on the direction of Brazilian PHC by offering a critical analysis based on empirical evidence on the effects of the transition from NASF to eMulti. The findings presented here can serve as a subsidy for managers, researchers and health workers in the formulation of resistance strategies and in the reconstruction of public care that is ethical and committed to life in its complexity. It is essential that all those involved in public health unite in favor of a system that respects and meets the needs of the population, thus ensuring a fairer and healthier future for all.

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