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PREVENTION OR MEDICALIZATION? THE CHALLENGES OF PRIMARY HEALTH CARE (PHC) IN THE ERA OF POPULATION SCREENING AND RISK MANAGEMENT

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ABSTRACT

In recent decades, the field of public health has been crossed by an intense debate about the limits and possibilities of prevention within public health policies. Especially in Primary Health Care (PHC), recognized as a preferential gateway and a privileged space for bonding, listening, and comprehensive care, there is a growing emphasis on the technical rationality of risk management and the systematic adoption of population screening strategies. Such practices, although legitimized by the discourse of health promotion and system efficiency, have been criticized for promoting a subtle, but profound, medicalization of daily life, shifting the focus from the expanded clinic to a model centered on surveillance and standardization of conducts. In this context, we ask: How has the centrality of risk management and screening strategies in Primary Health Care contributed to the medicalization of daily life and to the emptying of the expanded clinic in care practices? For this, we used as theoretical support the studies of Szasz (1974), Illich (1975), Foucault (2001; 2014), Han (2010), Löwy (2010), Starfield (2002), Armstrong (2002), Kidd, Heath & Howe (2013), Rose (2013), Merhy (2007), Diniz (2007), Conrad (2007), Mol (2008), Rose (2008), Ahlzén et. al. (2017), Agamben (2018), Young (1997), Silva & Hortale (2012), Starfield (2002), Mol (2008), Merhy (2007), Rose (2008; 2013), among others. The methodology used is qualitative (Minayo, 2007), bibliographic and descriptive (Gil, 2008)

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and with a comprehensive analytical bias based on Weber (1949). The research revealed that the centrality of population screening and risk management in PHC has intensified the medicalization of daily life, reducing care in the application of protocols and weakening listening and bonding. It was evidenced that this technocratic rationality displaces the expanded clinic to a normative model, marked by surveillance and standardization of conducts. On the other hand, paths of resistance anchored in the ethics of care, in the valorization of the knowledge of the territory and in the critical training of professionals were pointed out.

Keywords: Population Screening. Risk Management. Medicalization. Prevention. APS.

INTRODUCTION

BETWEEN HEALTH PROMOTION AND RISK SURVEILLANCE: CONTEMPORARY TENSIONS IN PRIMARY CARE – INTRODUCING

Primary Health Care (PHC) occupies a[17] central place in the Unified Health System (SUS),[18] being responsible for the articulation of actions that promote health, prevent diseases and ensure comprehensive, problem-solving and humanized care. As Starfield (2002) points out, "[...] PHC should be the starting point, coordinator and regulator of health care, structured on the principles of accessibility, continuity, integrality and coordination" (p. 19). In the same direction, Mendes (2012) states that "[...] PHC is the structuring axis of the Health Care Networks, articulating the different levels of care and promoting person-centered care" (p. 55).

> Primary health care addresses the most common problems in the community by offering prevention, cure, and rehabilitation services to maximize health and well-being. It integrates care when there is more than one health problem and deals with the context in which the disease exists and influences people's response to their health problems. It is attention that organizes and rationalizes the use of all resources, both basic and specialized, directed to the promotion, maintenance and improvement of health (Starfield, 2002, p. 28).

However, despite its commitment to strengthening health promotion and the autonomy of the subjects, there is a growing incorporation of technocratic practices centered on population control and risk anticipation. As Rose (2008) points out, "[...] the public health discourse has increasingly turned to the early identification of risks, even

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[17] Primary Health Care (PHC) is the structuring level of the health system, being responsible for coordinating care, promoting equity, and ensuring universal and continuous access to health services. It is characterized by being the preferred gateway to the Unified Health System (SUS), articulating actions of promotion, prevention, treatment, rehabilitation and palliative care in an integral and humanized way. Based on territorialization, the allocation of clientele and the accountability of teams, PHC seeks to build lasting bonds with users, valuing the social, cultural and family context of the subjects. According to Barbara Starfield, PHC should be understood as "[...] the starting point, coordinator and regulator of health care, structured on the principles of accessibility, continuity, integrality and coordination" (Starfield, 2002, p. 19). See: Starfield, B. *Primary care: balance between health needs, services and technology*. Brasília: UNESCO, Ministry of Health, 2002.

[18] The Unified Health System (SUS) is a fundamental public policy for guaranteeing the right to health in Brazil, consolidated from the Federal Constitution of 1988. It is based on the principles of universality, integrality and equity, structuring itself as a decentralized system, with tripartite management and shared financing between the Union, states and municipalities. The SUS seeks to overcome the exclusionary logic of the old care models, promoting the democratization of access, social participation and the intersectoral articulation of public policies. As stated by the Ministry of Health, "[...] the SUS is a heritage of the Brazilian people, supported by principles that express a broad conception of health and require the construction of problem-solving, continuous, comprehensive, humanized health care, with sanitary responsibility and social participation" (Brasil, 2012, p. 13). See: Brazil. Ministry of Health. *Care of Chronic Conditions in Primary Health Care: the imperative of consolidating the Family Health Strategy*. Brasília: Ministry of Health, 2012.

before the appearance of any symptom" (p. 22). Similarly, Illich (1975) already warned that "[...] the medicalization of daily life transforms health into a state of constant surveillance, in which the pathological future is brought to the present" (p. 37).

Now, if health promotion aims to expand capacities and reduce vulnerabilities, how can we understand the current emphasis on practices of mass population screening and risk management, which often act as disease anticipators? According to Lowy (2010), "[...] screening tends to medicalize healthy bodies by transforming them into carriers of latent risks" (p. 91). And, for Conrad (2007), "[...] the expansion of medicalization is driven not only by the pharmaceutical industry, but also by public health policies centered on epidemiological data and numerical targets" (p. 10).

> The excesses of preventivism in clinical practice are explained by some main reasons: the search for impossible perfection, the medicalization of life, the emergence and development of the concept of risk factor, the belief in zero risk, the imposition of mandatory health, economic interests and the inevitable damage produced by preventive activities [...]. By tracking health conditions, apparently beneficial actions can determine iatrogenic problems. [...] An illustrious American onco-epidemiologist showed that, in his hospital, every thousand prostate cancer screenings through PSA generated financial revenues of 4.9 million dollars in medical interventions, such as biopsies, tests, surgeries, and others (Mendes, 2018, p. 241).

Therefore, the present research is justified by its potential to shed critical light on the effects of this logic on the conformation of PHC services, especially in view of the advancement of practices based on risk indicators. According to Mol (2008): "[...] care is not a simple response to protocols, but a situated practice, sensitive to the context, history and uniqueness of the patients" (p. 32). Likewise, Han (2010) warns that "[...] the logic of performance and efficiency fragments care and transforms the subject into a carrier of anticipated symptoms" (p. 27).

As a consequence, there is a risk that PHC will be displaced from its historical role of welcoming, bonding, and accountability to operate as a mechanism for the standardization and control of bodies[19]. According to Foucault (2001), "[...] disciplinary

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[19] With the advance of technocratic rationality and the centrality given to risk management and population tracking, there is a risk that Primary Health Care (PHC) will be displaced from its historical role of welcoming, bonding, and accountability to operate as a mechanism for standardizing and controlling bodies. When reduced to the application of protocols and epidemiological surveillance, PHC runs the risk of reproducing disciplinary practices that prioritize the anticipation of health problems to the detriment of individualized care. In this logic, the subject is conceived as a permanent bearer of risks, being constantly monitored and classified, which empties the relational power of care and strengthens the clinic as an instrument of social regulation. As Foucault states, "[...] Disciplinary power is exercised over bodies through surveillance, normalization and hierarchization. The body is invested by a political technology that makes it productive and

power is exercised over bodies through surveillance, normalization and hierarchization" (p. 184). In addition, Agamben (2018) argues that "[...] contemporary politics is increasingly defined as biopolitics[20], that is, as the government of bare life, devoid of singularity" (p. 58).

> We are witnessing the emergence of new ideas of what human beings are, what they should do, and what they can expect. New conceptions of 'biological citizenship' have taken forms that recode the duties, rights and expectations of human beings in relation to their illness, as well as their own lives, reorganize the relations between individuals and their biomedical authorities, and transform the ways in which human beings relate to themselves as 'somatic individuals'. This is linked to the emergence of what I call 'somatic ethics' – ethics not in the sense of moral principles, but rather as the values for the conduct of a life – which assigns a central place to bodily, physical existence (Rose, 2013, p. 19).

However, the logic of prevention, when perverted by biomedical and statistical rationality, tends to colonize care with algorithms and checklists that exclude listening and negotiation of care. As Barbara Starfield (2002) explains: "[...] person-centered care requires attentive listening to the needs experienced, not just the presumed diagnoses" (p. 133). For Szasz (1974), "[...] modern medicine transforms human suffering into a technical problem, the answer to which is control" (p. 25).

Therefore, the objective of this research is to critically analyze the challenges involving the prevention and risk of medicalization within PHC, especially in the context of population screening and risk management policies. As Padula & Rodrigues (undated) argues, "[...] PHC must overcome the Flexnerian logic[21], centered on disease, to build an

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submissive" (Foucault, 2014, p. 34). See: Foucault, M. *Watching and punishing: birth of prison* (40th ed.). Petrópolis: Vozes, 2014.

[20] Biopolitics in health is particularly strongly manifested in population screening and risk management strategies, which shift the focus from care to the statistical anticipation of future diseases. In this logic, the body is no longer just an object of therapeutic intervention and becomes a constant target of surveillance, becoming a "body at risk" to be permanently monitored. It is a regime of power that manages life through population categories, using biomedical knowledge to classify, standardize and intervene preventively on subjects, who are often still asymptomatic. As Rose points out, "[...] biomedical governmentality is based on the anticipation of future threats, even if they never materialize, and our bodies and brains become sites of risk management, both through biomedical techniques and through our own conduct as prudent citizens" (Rose, 2013, p. 20). See: Rose, N. *Politics of life: biomedicine, power and subjectivity in the twenty-first century*. São Paulo: Paulus, 2013.

[21] The Flexnerian logic, consolidated from the Flexner Report of 1910, structured modern medical education based on a biomedical model centered on disease, specialization, and technical rationality. This paradigm fragmented care into disciplines and procedures, prioritizing pathology and curative intervention, to the detriment of a broader view of health and comprehensive care for the subject. Even today, the influence of this logic persists in the organization of health services, making it difficult to build interdisciplinary and humanized practices, especially in Primary Health Care (PHC). As Padula and Rodrigues point out, "[...] overcoming the Flexnerian logic implies shifting the focus from the disease to the subject, from the hospital to the territory, from the specialty to shared care, and from fragmentation to comprehensiveness" (Padula & Rodrigues, undated, p. 2). See: Padula, A., & Rodrigues, P. H. A. *Overcoming the Flexnerian logic: challenges for the consolidation of primary care in Brazil*. Unpublished text provided in the research collection, (undated).

integrated and humanized practice" (p. 2). In addition, Diniz (2007) reinforces that "[...] medicalization hides the social determinations of health by reducing suffering to organic failure" (p. 4).

Not only can epidemiological protocols and goals generate perverse effects, but they also reinforce inequalities by standardizing subjects and practices. According to Fanon (2008), "[...] the medical gaze colonizes bodies by disregarding their cultural and social trajectories" (p. 91). And as Foucault (2014) warns: "[...] the modern clinic is organized by the visibility, control and objectification of the body" (p. 91).

Although health surveillance is important to monitor health problems and protect vulnerable populations, it becomes problematic when it replaces singularized care with risk algorithms. According to Mendes (2011), "[...] clinical risk should be interpreted in dialogue with the context of life, and not as an inevitable destiny" (p. 103). And as Mol (2008) reminds us, "[...] clinical decisions should be made with, and not about, the patients" (p. 76).

> Medicalization describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of diseases and disorders. Some analysts have suggested that the growth of medical jurisdiction is 'one of the most potent transformations of the second half of the twentieth century in the West'. [...] The concept came to be applicable to a wide range of human problems that entered medical jurisdiction. In sociology, there are dozens of case studies on medicalization; the corresponding body of literature has been called, broadly, the 'medicalization thesis' (Conrad, 2007, p. 4).

While screening can identify early conditions, it is necessary to question the extent to which it promotes health or manufactures potential patients. For Armstrong (2002), "[...] screening constructs risk identities and creates a new category of patients without symptoms" (p. 45). Rose (2013) points out that "[...] biomedical governmentality is based on the anticipation of future threats, even if these never materialize" (p. 109).

Thus, this research intends to problematize the tension between health promotion and medicalization in PHC, illuminating the ethical, political and clinical implications of this process. According to Illich (1975), "[...] cultural iatrogenic[22] events occur when society

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[22] Cultural iatrogenic refers to the negative effects caused by medicine on ways of life and perception of human suffering, by replacing popular knowledge and autonomous forms of care with exclusively technical explanations and interventions. This form of iatrogenic disease is not limited to the physical or psychological damage caused by medical procedures, but acts profoundly on the symbolic and cultural dimension of health, promoting the dependence of individuals on specialists and delegitimizing their own experiences and narratives about becoming ill. As Ivan Illich warns, "[...] Cultural iatrogenesis sets in when society loses the ability to deal with suffering without the mediation of technical knowledge. The medicalization of life transforms the individual into a permanent patient, alienated from his own pain and unable to face it through

loses the ability to deal with suffering without the mediation of technical knowledge" (p. 41). And as Vilaça Mendes (2012) summarizes, "[...] PHC should be the place of listening, bonding and the shared construction of care" (p. 60).

COMPREHENSIVE PATHS: ANALYTICAL WRITING AS A METHOD OF APPROACHING MEDICALIZATION IN PHC – THE METHODOLOGY

The present research used a qualitative approach according to Minayo (2007), guided by the comprehensive perspective of Weber (1949), which favored the interpretation of the meanings attributed to discursive and institutional practices in the field of public health. Instead of seeking causal or quantifiable relationships, the investigation focused on unraveling the ways in which prevention and screening strategies were produced, legitimized and incorporated into the routine of Primary Health Care (PHC). As Minayao warns: "[...] it is not a matter of verifying 'reality in itself', but of seeking the meanings that the subjects socially construct about it" (2007, p. 24). And, as the author points out, "[...] qualitative analysis involves an interpretative process, which starts from the reading of empirical and theoretical data and aims to build a critical understanding" (Minayo, 2007, p. 25).

> The data collected in these studies are descriptive, portraying the largest possible number of elements existing in the reality studied. It cares much more about the process than the product. In the analysis of the collected data, there is no concern to prove previously established hypotheses, but these do not eliminate the existence of a theoretical framework that directs the collection, analysis and interpretation of data (Lakatos & Marconi, 2010, p. 71).

The nature of the research was bibliographic and descriptive, according to Gil's (2008) guidelines, allowing a dive into the theoretical debates that support the criticism of the medicalization of life and risk-centered preventive strategies. The analysis was based on a careful reading of classic and contemporary works in the areas of public health, philosophy, sociology of medicine and human sciences. According to Gil, "[...] bibliographic research is developed based on material already prepared, consisting mainly of books and scientific articles" (2008, p. 44). And, he adds, "[...] this type of research is particularly indicated when one wishes to analyze theoretical positions and construct conceptual interpretations" (Gil, 2008, p. 45).

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non-institutional resources" (Illich, 1975, p. 41). See: Illich, I. *The expropriation of health: nemesis of medicine*. Rio de Janeiro: Nova Fronteira, 1975.

> The main advantage of literature search lies in the fact that it allows the researcher to cover a much wider range of phenomena than he could research directly. [...] Bibliographic research is also indispensable in historical studies. In many situations, there is no other way to know past events than on the basis of secondary data. [...] To reduce this possibility, it is convenient for researchers to be sure of the conditions under which the data were obtained, to analyze each piece of information in depth to discover possible inconsistencies or contradictions, and to use different sources, carefully comparing themselves (Gil, 2008, p. 51).

As a methodological path, the research was structured in the reading and extraction of significant excerpts from the selected texts, which allowed to illuminate emerging concepts and tensions. Next, a cross-section was carried out between the authors and theoretical currents, revealing counterpoints and convergences around the themes of prevention, medicalization and expanded clinic. This strategy allowed not only to illustrate positions, but, above all, to build a critical understanding of the effects of biomedical rationalities on PHC. As Rose (2013) states:

> “[...] Technologies embody controversial visions of what, in individual or collective human life, can in fact be an excellent state. [...] These rationalities implied a growing emphasis on the responsibility of individuals in the management of their own affairs, in the provision of their own security with a prudent eye to the future" (p. 19).

The theoretical framework articulated fundamental authors for the critique of technocracy and normalization in the field of health. The contributions of Michel Foucault (2001; 2014) were mobilized, especially the concepts of biopower, surveillance, and political technology of the body; Ivan Illich (1975), with his critique of iatrogenic and the expropriation of autonomy; Thomas Szasz (1974), when denouncing the use of psychiatry as social control; and Peter Conrad (2007), who problematized the expansion of medicalization as a cultural phenomenon. As Conrad stated: "[...] Medicalization describes a process by which non-medical problems become defined and treated as medical problems. [...] The concept has come to be applicable to a wide range of human problems that have entered the medical jurisdiction" (2007, p. 4).

In addition, the analysis dialogued with the contributions of Barbara Starfield (2002), whose reflections on the limits of population strategies supported the criticism of the standardization of PHC; Nikolas Rose (2008; 2013), with the notion of the politics of life and the governmentality of risk; and Annemarie Mol (2008), when contrasting the logic of choice with the ethics of care. Also noteworthy were the contributions of Byung-Chul Han (2015), Ilana Löwy (2010), Emerson Merhy (2007), Débora Diniz (2007), Armstrong (2002), Ahlzén et. al. (2017), Agamben (2018), Young (1997), and Silva & Hortale (2012), composing a critical and plural mosaic on contemporary disputes around care. As Merhy summarized: "[...] The live work in action reorganizes the ways of doing health, activating listening, bonding and the shared construction of the therapeutic project. [...] Expanded clinical practice implies recognizing the senses and meanings of daily life in health acts" (2007, p. 87).

The methodological path also included the description, analysis and interpretation of the main concepts related to the theme: population screening, risk management, medicalization and expanded clinic. These elements were analyzed in the light of the effects they produce on PHC subjects and workers, with special attention to the ethical and political implications of preventive practices. As Starfield (2002) pointed out: "[...] Primary care should be oriented to the needs of communities, not just biomedical demands. [...] not everyone wants to engage in prevention when it is imposed by a visible bureaucracy" (p. 319).

The methodological objective was to investigate how the centrality of risk management and screening strategies has contributed to the emptying of singular care and the intensification of the medicalization of daily life. The analysis aimed to shed light on the subjective, institutional and epistemological effects of this displacement, questioning the limits and possibilities of PHC as a space for the production of life. As Illich (1975) pointed out: "[...] Early diagnosis turns people who feel well into anxious patients. [...] people who are not sick will submit to the medical institution for the sake of their future health" (p. 195).

Finally, the methodology sought not only to describe, but to propose ways to rescue the ethical dimension of care, valuing the bond, qualified listening, the territory and the uniqueness of the subjects. The investigation started from the premise that resisting technocratic logic is also affirming a political project of care committed to autonomy and emancipation. As Foucault argued: "[...] The birth of the clinic is linked to a new configuration of the gaze and language. The examination combines the techniques of the hierarchy that monitors and those of the sanction that normalizes. It is a normalizing look, a surveillance that allows qualifying, classifying and punishing" (2001, p. 121).

PREVENTION OR MEDICALIZATION? THE CHALLENGES OF PRIMARY HEALTH CARE (PHC) IN THE ERA OF POPULATION SCREENING AND RISK MANAGEMENT

The trajectory of Primary Health Care (PHC) in Brazil is marked by historical processes of transformation and consolidation within the Unified Health System (SUS), especially since the 1988 Constitution, which enshrined the universal right to health. As the Ministry of Health points out: "[...] the institution of the SUS led to a sixth cycle that took place through the municipalization of the PHC units of the states that passed to the management of the municipalities" (Brasil, 2018, p. 72). This municipalization expanded access and stimulated the reorganization of the care model, because "[...] it was no longer possible to continue to offer PHC as a selective primary care program and it was required to strengthen this level of care" (Brasil, 2018, p. 72).

However, the expansion of PHC in Brazil was not only administrative, but conceptual and political, marked by the incorporation of attributes such as comprehensiveness, bonding, and teamwork. According to Starfield (2002): "[...] primary care is oriented towards meeting people's needs, it must provide a variety of services aimed at these needs and achieve a high level of performance" (p. 315). Furthermore, she emphasizes that "[...] as primary care deals with a larger set of health concerns and does so within a broader social context, it must have a wide range of resource types at its disposal" (2002, p. 316). For Mendes (2018: 59):

> There will only be a quality PHC when its seven attributes are being operationalized, in their entirety. The first four are the essential attributes and the last three are the derived attributes. [...] Comprehensiveness means the provision by the health team of a set of services that meet the needs of the population enrolled in the fields of promotion, prevention, cure, care, rehabilitation and palliation, responsibility for the provision of services at other health care points and the adequate recognition of biological problems. psychological and social factors that cause diseases. [...] Community orientation means the recognition of the needs of families according to the physical, economic and social context in which they live, which requires a situational analysis of the health needs of families from a population perspective and their integration into intersectoral programs to cope with the proximal and intermediate social determinants of health.

And, along this path, the Family Health Strategy (FHS) emerges as a decisive milestone in the reconfiguration of PHC, by proposing territorialized care centered on multiprofessional teams. According to the Ministry of Health (2006), "[...] the EqSF[23] is

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[23] The Family Health Team (EqSF) is the operational unit of the Family Health Strategy (FHS), composed of a multidisciplinary team responsible for a defined population in a given territory. Its minimum composition includes a general practitioner or specialist in Family and Community Medicine, a nurse, a nursing assistant or technician and community health agents (CHA). The EqSF's main function is to carry out health promotion,

multiprofessional, composed of a general practitioner, a nurse, one or two nursing assistants/technicians and five to six community health agents" (p. 521). This team must "[...] to develop a program of activities to face the determinants of the health/disease process, to develop educational and intersectoral actions [...] and to provide comprehensive care to the families under their responsibility" (Brasil, 2006, p. 520).

Thus, territorialization and family assignment transform the way care is organized and reinforce the accountability of the teams. According to Mendes (2012), "[...] the family registry aims to know the families enrolled in the FHS teams [...], an important basis for the construction of bonding relationships between the population and health professionals" (p. 754). And, as a complement, "[...] the territorialization process involves the survey of the territorial-environmental, demographic, socioeconomic and institutional profile", which allows planning contextualized actions (Mendes, 2012, p. 754).

> The territorialization process is based on the construction of territories-processes that are defined by geographical, political, economic, social and cultural criteria, with a dynamic vision that accompanies the permanent changes in the territory. They are territories of life that are rebuilt all the time, in their various dimensions. [...] The focus of territorialization in the FHS is to establish two fundamental health territories: the area territory, which is the space of responsibility of an FHS team, and the micro-area territory, which is the territory of responsibility of an CHA. [...] The function of accountability is attributed to each team in relation to the families enrolled (Mendes, 2018, p. 753).

Therefore, the expanded conception of care implies recognizing that health is produced in social relations and that social determinants need to be faced collectively. According to the National Commission on SDH[24], "[...] addressing the causes of the causes

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prevention, recovery and rehabilitation actions, focusing on comprehensive care, bonding with users and co-responsibility for the health results of the enrolled community. As established by the Ministry of Health, "[...] the EqSF is multiprofessional, composed of a general practitioner, a nurse, one or two nursing assistants/technicians and five to six community health agents. This team must develop a program of activities to face the determinants of the health/disease process, develop educational and intersectoral actions [...] and provide comprehensive care to the families under its responsibility" (Brasil, 2006, p. 520). See: Brazil. Ministry of Health. *National Policy of Primary Care*. Brasília: Ministry of Health, 2006.

[24] The National Commission on Social Determinants of Health (SDH) was established with the objective of deepening the debate on the structural causes of health inequities in Brazil, recognizing that the process of illness is directly related to the social, economic, environmental and cultural conditions in which individuals live. The Commission's mission was to subsidize intersectoral public policies that address the "causes of the causes" of diseases, promoting social justice and equity in health. According to the final report, "[...] addressing the causes of the causes involves interventions in socioeconomic, environmental and cultural conditions through intersectoral public policies that reduce the vulnerabilities of the population" (Brasil, 2008, p. 136). Thus, the Commission contributed to consolidating a broader conception of health within the scope of the SUS, strengthening the perspective of health promotion and equity as fundamental pillars of Primary Care. See: Brazil. National Commission on Social Determinants of Health. *The social causes of health*

[...] involves interventions in socioeconomic, environmental and cultural conditions through intersectoral public policies" (Brasil, 2012, p. 136). And, as the Ministry of Health itself states, "[...] developing comprehensive care impacts people's autonomy and the determinants and conditioning factors of health in the collectivities" (Brasil, 2012, p. 13).

As can be seen, comprehensive care requires breaking with technical fragmentation and building continuous bonds between professionals and users. Starfield (2002) observes that "[...] the continuity of the relationship over time allows for a humanized relationship and more comprehensive care" (p. 503). And he adds: "[...] the bond is established in the health team-user relationship, built over time based on the user's trust in the professionals and the team's responsibility for care" (2002, p. 504).

> Try to know what the user's projects and desires are. Cravings agglutinate a huge amount of people's energy and may or may not be extremely therapeutic. They just can't be ignored; [...] Knowing the leisure activities (present and past) is very important. The mere presence or absence of pleasurable activities is quite indicative of the user's situation; On the other hand, knowing the factors that most trigger disorders in the user can also be decisive in a therapeutic project. These are issues that in a very reasonable number of times point the way, if not for therapeutic projects, at least for the deepening of the bond and understanding of the subject (Ministério da Saúde, 2007, p. 53).

But it is also essential to consider that care cannot be reduced to specific clinical interventions, as it demands listening, welcoming, and co-responsibility. According to Giovanella et. al. (2012), "[...] primary care should be the organizing center of the health care network [...], and should play a key role in the ordering of the RAS[25]" (p. 528). To this end, "[...] it is necessary to welcome, listen, offer protection and provide a response capable of solving the problem presented by the user" (Brasil, 2012, p. 504).

Although the presence of multiple professionals makes up the team, the challenge is to build a truly integrated and collaborative practice. For Mendes (2012), "[...]

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inequities in Brazil: final report of the National Commission on Social Determinants of Health – CNDSS. Rio de Janeiro: Fiocruz, 2008.

[25] The Health Care Networks (RAS) were conceived as an organizational strategy of the Unified Health System (SUS), with the objective of overcoming the fragmentation of services and ensuring the integrality of care through the articulation between the different levels of care. The RAS are composed of a set of health actions and services, organized in a regionalized and hierarchical manner, which operate in a cooperative and continuous manner to meet the health needs of the population. In this context, Primary Health Care (PHC) is recognized as the organizer of networks and coordinator of care, being responsible for ensuring access and longitudinality of care. As established by the Ministry of Health, "[...] the RAS are organizational arrangements of health actions and services, with different technological densities, which, integrated through support, logistical and governance systems, seek to guarantee the integrality of care" (Brasil, 2010, p. 11). See: Brazil. Ministry of Health. *Ordinance No. 4,279, of December 30, 2010. Establishes guidelines for the organization of the Health Care Network within the scope of the SUS.* Official Gazette of the Union, Brasília, 2010.

multiprofessional work distributes tasks according to the foundations of population-based health care" (p. 846). And he adds: "[...] members of health teams assume functions and responsibilities compatible with their professional capacities and strengths" (2012, p. 308).

Therefore, the multiprofessional team must operate with horizontality and dialogue, overcoming hierarchical logic and incorporating different knowledge. Mendes (2012) points out that "[...] a team spirit must be created, which implies that the different professionals must share a common vision and learn to solve problems through communication" (p. 308). In addition, "[...] multiprofessional work is important because there is an added value of more eyes and more ears, insights from different bodies of knowledge and a broader spectrum of skills" (Mendes, 2012, p. 308).

> Multiprofessional work must be carried out by teams. Health team members assume roles and responsibilities to perform tasks compatible with their professional capabilities and strengths. The hierarchical relationship in the conventional work mode, with strong medical mastery, is replaced by horizontal relationships, since each member of the team is valued for his or her condition as a provider of significant and essential services for improving the health of patients with chronic conditions. In a true team, there is a clear understanding of everyone that, even if the functions are differentiated, there will be no added value for the users of the ESF if everyone does not participate in an integrated and cooperative way (Pan American Health Organization, 2012, p. 308).

Not only the organization of work must be transformed, but also the way in which the health-disease process and health care are understood. According to the Ministry of Health (2012), "[...] intersectoral action is an attribution of the Family Health teams, which must promote partnerships with community organizations to jointly confront risk factors" (p. 521). And, as the same document reinforces, "[...] intersectoriality is a condition for primary care to contemplate not only biological aspects, but also psychological and social aspects" (Brasil, 2012, p. 521).

Thus, the Collective Health perspective reinforces that PHC should not only respond to spontaneous demand, but also promote autonomy and protagonism. According to the Ministry of Health (2012): "[...] better knowledge of local and global problems [...] strengthens the organization and participation in collective actions, to become active social actors" (p. 135). And, as the WHO report (2008) concludes: "[...] the promotion of equity in health requires addressing social inequities through structural policies and active social participation" (Brasil, 2012, p. 136).

That said, Primary Health Care (PHC) in Brazil has faced, in recent decades, a silent transformation, driven by the progressive centrality of the notion of risk in public health policies. The logic of population stratification, previously focused on the identification of social vulnerabilities, has been replaced by clinical and epidemiological classification models that organize services based on risk categories. As stated by the Pan American Health Organization (2012), "[...] the stratification of the population requires their in-depth knowledge by the health care system [...], classifying each family by socio-sanitary risk and having a record with information on all patients with each health condition, stratified by risks" (p. 254). Thus, "[...] without the stratification of the population into subpopulations at risk, it is impossible to provide the right care, in the right place, at the right cost and with the right quality" (PAHO, 2012, p. 254).

However, the rise of the discourse of risk in PHC is not limited to a technical reorganization. It involves a profound change in the rationality of care, shifting the focus from listening and comprehensiveness to the anticipation of possible problems. Illich (1975) already warned that "[...] Modern medicine initially controlled the size of its market and now it no longer has limits. People who are not sick will submit to the medical institution for the sake of their future health" (p. 193). And he adds: "[...] Early diagnosis turns people who feel well into anxious patients. To begin with, some of these tests are not without risk" (1975, p. 195).

> Nowhere have transformations in government technologies been more eloquent than in the field of health care, where patients are increasingly encouraged to become active and responsible consumers of medical services and products ranging from medicinal drugs to reproductive technologies and genetic testing. [...] Currently, it is at the molecular level that human life is understood, [...] and it is at this level that life can now be manipulated. [...] Since human beings come to experience themselves in new ways as biological creatures, as biological themselves, their vital existence becomes the focus of government, the target of new forms of authority and expertise (Rose, 2013, p. 17).

Therefore, the practice of large-scale population screening, anchored in the logic of early detection, has gained momentum as a supposedly rational and efficient strategy for organizing services. However, it tends to standardize conducts and transform subjects into carriers of statistical risks, even if they are asymptomatic. As the Ministry of Health (2012) warns, "[...] The aim of the operation is to offer countless millions a detection of their hidden therapeutic needs [...]. The absence of serious studies at the beginning of this operation allowed the prevention markets to give rise to unfounded expectations" (p. 147). For Illich (1975), "[...] the truth is that early diagnosis transforms people who feel well into anxious patients" (p. 195). Löwy (2010, p. 144) warns:

> Screening programs generate an intermediate category of people: healthy carriers of a risk. People are no longer simply healthy or sick, but may now be at risk, pre-ill, or diagnosed with a precancerous condition. This notion of risk expands medical jurisdiction to individuals who may never develop a disease. [...] The boundaries between health and disease become blurred, and healthy individuals can be labeled and treated as if they were already patients. The medicalization of risk creates a population of concerned healthy individuals — individuals without symptoms who undergo repeated testing and live with the anxiety of possibly developing a condition that may never occur[26].

Therefore, practices such as periodic exams, routine check-ups and strict screening protocols are elevated to the status of health control mechanisms, without their benefits being sufficiently proven. As the PAHO report (2012) emphasizes, "[...] there are those who claim that they add few benefits to people's health and lead to unnecessary diagnostic and therapeutic interventions that have a high impact on health care costs" (p. 241). Furthermore, "[...] the concept of quaternary prevention was proposed [...], to protect users from excessive screening interventions, the medicalization of risk factors, and defensive medicine" (PAHO, 2012, p. 241).

> Due to the excesses committed in the field of medicine, the concept of quaternary prevention was proposed, adopted by the World Organization of Family Physicians (WONCA), which means the actions taken to identify people and populations at risk of excessive medicalization, to protect them from invasive medical interventions and to provide them with services that are scientifically and medically acceptable. Quaternary prevention is intended to protect users from excessive screening interventions, the medicalization of risk factors, the request for excessive complementary tests, excessive diagnoses, unnecessary medicalization of vital events and self-limited illnesses, requests for tests and treatments requested by users, and defensive medicine (Pan American Health Organization, 2012, p. 241).

Now, the analysis of the above quote reveals that the culture of risk within PHC requires recognizing that contemporary biomedical rationality has been structured on a shift: from the treatment of the disease to the anticipation of the possibility of illness. As Rose (2013) points out: "[...] our bodies and brains are becoming sites of risk management, both through biomedical techniques and through our own conduct as prudent citizens" (p. 20). This implies a new regime of subjectivation, in which "[...] citizens are governed through responsibility for the biological risk of their own bodies" (Rose, 2013, p. 21).

But, at the same time, this regime reinforces inequalities by projecting a disproportionate responsibility for health onto individuals, disregarding the social and contextual determinants of illness. Young (1997) already warned that "[...] Diagnostic

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[26] Our translation.

categories are often shaped less by patients' actual experience than by cultural conventions and institutional structures" (p. 110). And he adds: "[...] the very idea of trauma can be transformed into a technique of government, as a tool to classify and control populations" (Young, 1997, p. 145).

Therefore, PHC must resist the temptation to adopt simplified models of stratification and surveillance that reduce the clinic to technique. According to Kidd, Heath and Howe (2013), "[...] Family medicine is more than a compilation of evidence – it is an ethical commitment to the person in his or her social and emotional context" (p. 55). In addition, "[...] a patient's unmet needs are often not visible in clinical data, but emerge from prolonged dialogue and knowledge of the life trajectory" (Kidd et. al., 2013, p. 78).

> Family medicine was not born from laboratory discoveries, but from human needs. It emerged as a response to the limitations of a model centered on disease and specialization, unable to deal with the complexity of daily care. [...] Family medicine promotes the encounter between technical knowledge and the patient's lived world, respecting their experiences, fears and choices. [...] The family doctor must be, first and foremost, a caregiver of the life path and not just a solver of specific problems (Kidd, Heath & Howe, 2013, p. 97).

Although early detection is justified in some contexts, its generalization can empty care of meaning and convert the body into an object of permanent screening. Lowy (2010) demonstrates that "[...] prevention began to include invasive practices, such as preventive surgery to remove healthy organs based only on statistical risks" (p. 162). And he adds: "[...] the female body was one of the main targets of this new logic, where the risk of becoming ill legitimizes radical interventions even in the absence of symptoms" (Lowy, 2010, p. 164).

Therefore, the criticism of the culture of risk does not turn against science, but against the uncritical use of standardized evidence that obscures the singularities of the subjects. As Barbara Starfield points out, "[...] clinical variability is a reality, and trying to eliminate it with rigid protocols can reduce the effectiveness of care" (2002, p. 331). And he adds: "[...] comprehensiveness requires flexibility, active listening and shared decision-making, not the automatic application of guidelines" (2002, p. 332).

> The use of standardized clinical guidelines tends to transform medical practice into an automatic application of protocols, obscuring the patient's particularities. [...] Prevention is no longer a contextualized process and becomes a set of instructions for everyone, ignoring social and subjective variables. [...] In addition, excessive focus on statistical evidence can marginalize individual experiences and render factors that do not fit normative models invisible. [...] This approach tends to

> reinforce medical authority to the detriment of listening to the patient, converting care into technical execution (Lowy, 2010, p. 173).

In addition, the growth of preventive medicine has not, in many cases, accompanied a critical assessment of its consequences on people's daily lives. Szasz (1974) had already warned, for example, that "[...] institutionalized psychiatry transforms existential conflicts into mental illnesses, perpetuating dependence and erasing ethical responsibility" (p. 58). And he adds: "[...] mental illness is often a social label and not a diagnosis based on objective criteria" (Szasz, 1974, p. 60).

Consequently, the logic of mass screening compromises the equity of care by favoring investment in sophisticated tests for low-risk populations, while neglecting structural actions aimed at vulnerable populations. According to the Ministry of Health (2012), "[...] comprehensive care presupposes the confrontation of inequities, not just the standardization of clinical conducts" (p. 25). And according to the Primary Care Booklet[27], "[...] work in the territory requires knowing the living and health conditions in order to plan actions consistent with the local reality" (Brasil, 2000, p. 34).

> In general, socially less privileged groups have a higher risk of becoming ill and dying than socially more privileged groups. The health conditions of a population are strongly associated with the pattern of social inequalities existing in society. On the other hand, social inequalities in access to and use of health services are a direct expression of the characteristics of the health system. The availability of diagnostic and therapeutic services and equipment, the geographical distribution, the mechanisms for financing services and their organization represent characteristics of the system that can facilitate or hinder access to health services (Travassos & Castro, 2012, p. 184).

Therefore, rethinking PHC is also rethinking the very notion of health that sustains it: it is about affirming the centrality of the subject and their autonomy in the construction of care. As Ivan Illich (1975) reminds us, "[...] autonomy is a condition for health – a human being is not healthy when he depends exclusively on specialists to deal with the contingencies of life" (p. 89). And he concludes: "[...] medicine centered on compulsory

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[27] The Primary Care Notebooks are publications prepared by the Ministry of Health with the objective of guiding the practices of the teams that work in Primary Health Care (PHC), offering theoretical, methodological and operational subsidies to qualify care. These documents address strategic themes, such as health promotion, disease prevention, organization of the work process, health planning, welcoming, and humanization, and are fundamental to support the consolidation of the Family Health Strategy (FHS) throughout the national territory. According to the Ministry of Health, "[...] the Primary Care Notebooks aim to support Primary Care professionals in the organization of the work process, in the qualification of practices and in the expansion of the problem-solving capacity of the services offered" (Brasil, 2000, p. 9). See: Brazil. Ministry of Health. *Cadernos de Atenção Básica n.1 – Welcoming in health production practices*. Brasília: Ministry of Health, 2000.

prevention prevents the individual from learning from his or her experience of living" (1975, p. 90).

Thus, even though the discourses on prevention are clothed in an ethical and rational ideal, it is necessary to recognize that early detection carries with it a structural tension: it anticipates diagnoses without necessarily promoting care. Illich (1975) denounces that "[...] the medicalization of early diagnosis not only hinders and discourages true prevention, but also leads the potential patient to behave as an object for which the physician is responsible" (p. 152). And he concludes: "[...] he learns to give himself to the physician, whether or not he is in good health; he becomes a patient for the rest of his life" (1975, p. 152). Add Löwy (2010: 4):

> Diagnosing an 'embodied risk' of cancer can put people in a limbo between health and disease (becoming 'healthy patients'), change how they feel about the dangerous parts of their bodies ('living with a ticking time bomb'), and lead to a rift between the self and the treacherous part of the body. Prophylactic surgery for a precancerous lesion – be it histological, cellular or molecular – is a way to heal this split. [...] The history of surgical (and occasionally radiological) management of cancer risk is largely the history of diagnoses of precancerous conditions and the persistent uncertainties attached to such diagnoses.

If, on the one hand, screening can expand access to tests and diagnoses, on the other hand, it can generate a series of perverse effects, such as anxiety, early labeling, and unnecessary intervention. As highlighted by the Ministry of Health (2012): "[...] preventive interventions are indicated when the benefit in the future outweighs the possibilities of a loss in the present" (p. 241). And he warns: "[...] preventive interventions must be used based on scientific evidence that proves that they do more good than harm" (Ministry of Health, 2012, p. 241).

Therefore, it is necessary to make it clear that it is not a matter of denying the importance of prevention, but of questioning its capture by the logic of pathological anticipation, which transforms PHC into a diagnostic production machine. According to Illich (1975), "[...] the practice of routine early diagnosis procedures on important populations has ensured that the scientific physician has abundant raw material for his activity" (p. 196). And he adds: "[...] This practice reinforces people's conviction that they are machines whose durability depends on the frequency of visits to the maintenance workshop" (1975, p. 196).

> Tracking is a peculiar technology. Unlike other medical practices, it does not rely on the presence of symptoms or calls for help. It turns asymptomatic people into

> potential patients, who enter medical circuits based on an estimated risk. [...] This process can be reassuring, but it can also produce anxiety and lead to unnecessary procedures. [...] Rather than promoting health, screening can lead to the discovery of conditions that may never cause harm, creating new patients, diagnoses, and interventions (Lowy, 2010, p. 178).

As a result, the notion that being healthy means being permanently under technical surveillance[28] and subjected to preventive interventions is expanding. This creates a new figure: the asymptomatic patient, someone who, although he feels well, is treated as potentially ill. The book "Policies and Health System in Brazil" (2012) reinforces this logic by stating that "[...] secondary prevention comprises the early diagnosis of diseases, allowing immediate treatment [...]. In this case, the disease is already present, often asymptomatically" (p. 125). In this sense, "[...] selective tests and screening surveys are individual and collective measures for the discovery of cases" (Brasil, 2012, p. 126).

Therefore, the culture of risk shifts the axis of PHC, weakening the relational dimension of care and prioritizing the constant monitoring of biological parameters. As Illich (1975) reports: "[...] the environment is recomposed in such a way that most people lose [...] the power and the will to be self-sufficient" (p. 193). And he concludes: "[...] the result is a morbid society that demands universal medicalization and a medical institution that attests to universal morbidity" (1975, p. 193).

> The medicalization of prevention has created a new group of people: those who live with a constant awareness of a potential risk. [...] They are healthy, but they don't feel that way. Constant vigilance, repeated testing, and the expectation of a positive diagnosis profoundly affect their perception of themselves. [...] Screening, therefore, transforms care into permanent suspicion. The absence of symptoms is no longer an indication of health, but an interval between two tests. This logic reinforces the idea that the body should be constantly monitored, even in a state of normality (Lowy, 2010, p. 174).

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[28] In contemporary times, being healthy has come to mean, paradoxically, being permanently under technical surveillance, as if health depended on the constant inspection of invisible risks. This process is closely linked to the panopticon view described by Michel Foucault, in which bodies are watched not only by institutions, but also by themselves, internalizing norms of conduct and standards of normality. Health, in this context, becomes a moral requirement and a political obligation, managed by tracking technologies, protocols, and algorithms that transform the subject into a potential patient. Foucault states that "[...] The examination combines the techniques of the hierarchy that monitors and those of the sanction that normalizes. It is a normalizing look, a surveillance that allows qualifying, classifying and punishing" (Foucault, 2001, p. 185). This view is articulated with biopower, understood as the power to manage life, which "[...] it is exercised through a multiplicity of institutions and knowledge that affect the body and the population" (Foucault, 2014, p. 35), transforming health into an object of continuous regulation. See: Foucault, M. *The birth of the clinic: an archaeology of the medical gaze*. Rio de Janeiro: Forense Universitária, 2001; Foucault, M. *Watching and punishing: birth of prison* (40th ed.). Petrópolis: Vozes, 2014.

Although preventive medicine is important in certain contexts, its uncritical generalization can reinforce inequalities, medicalize life, and capture subjectivity in the form of risk. PAHO[29] (2012) notes that "[...] the classification of risks is fundamental to organize the care network [...], it defines, according to the risks, the right place for care and the response time of the system" (p. 54). And he emphasizes: "[...] the stratification of the population by risks is a fundamental element in the model of care for chronic conditions" (PAHO, 2012, p. 360).

Thus, it is worth stating that the contemporary challenge of PHC is to resist the colonization of the logic of risk and to reaffirm itself as a space of expanded care, singularized and committed to the autonomy of the subjects. As the PAHO report (2012) concludes: "[...] population-based health care moves the system from an individual who needs care to the planning and provision of services to a given population" (p. 361). And he reinforces that "[...] stratification methodologies [...] must consider not only clinical variables, but also the degree of support for self-care" (PAHO, 2012, p. 254).

As such, it is important to highlight that prevention, when captured by a technical and statistical logic, can produce invisible side effects, such as the imprisonment of the subject to the condition of "permanent patient". As Illich (1975) states: "[...] the medicalization of life is unhealthy for three reasons: [...] it takes away from the patient characteristics commonly designated by the word health" (p. 11). And he adds: "[...] the consumer of medical care becomes powerless to cure himself or his fellow men" (1975, p. 11).

> The medicalization of early diagnosis not only hinders and discourages true prevention, but also leads the potential patient to behave as an object for which the physician is responsible. He learns to give himself to the physician, whether or not he is in good health; He becomes a patient for the rest of his life. [...] Like every growing industrial sector, the health system puts its forces where the demand seems limitless: protection from death. [...] Much time and effort is devoted during treatment to preventing the patient from committing suicide for a year or perhaps two of life that he sometimes gains (Illich, 1975, p. 196).

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[29] The Pan American Health Organization (PAHO) is an international organization that acts as the regional office of the World Health Organization (WHO) for the Americas and has played a strategic role in strengthening public health systems in the countries of the region, including Brazil. In the context of Primary Health Care (PHC), PAHO has contributed to the formulation of guidelines and recommendations aimed at the reorganization of care models, emphasizing the approach to chronic conditions, care coordination, and equity. The organization has also warned of the risks of excessive medical interventions and unnecessary diagnoses, promoting the notion of quaternary prevention as an instrument of protection against excessive medicalization. As the entity states, "[...] The stratification of the population by risks is a fundamental element in the model of care for chronic conditions, and should consider not only clinical variables, but also the degree of support for self-care" (PAHO, 2012, p. 254). See: Pan American Health Organization. *Care of chronic conditions in primary health care: the imperative of consolidating the Family Health Strategy*. Brasília: PAHO, 2012.

Therefore, what begins as an action of care can slip into the imposition of norms of behavior, reinforcing an ideal of a technically controlled healthy body. Starfield (2002) already warned that "[...] population-based strategies may not always be the most efficient [...] and become less justifiable as the probability of risk decreases" (p. 320). In addition, she notes that "[...] not everyone wants to engage in prevention when it requires personal action or when it is enforced through a visible bureaucracy" (Starfield, 2002, p. 319).

However, large-scale screening not only transforms the individual into permanent risk, but also destabilizes the boundary between health and disease. According to Illich (1975): "[...] the iatrogenic labeling[30] of the different ages of human life [...] transforms life into a sequence of periods that require particular forms of therapeutic consumption" (p. 135). And he concludes: "[...] domesticated man enters into permanent stagnation to be managed in a sequence of specialized cells" (Illich, 1975, p. 135).

> This labeling ends up being an integral part of popular culture when the layperson accepts as something 'natural' and banal the fact that people need routine medical care simply because they are pregnant, are newborns, children, are climacteric, or because they are old. When one reaches this point, life is no longer a succession of different forms of health, but a sequence of periods, each requiring a particular form of therapeutic consumption. [...] Man is boxed in an environment made for the members of his category, as conceived by the bureaucratic specialist in charge of his management [...] the individual is instructed to follow the behavior that befits an administration of pedagogues, pediatricians, gynecologists, geriatricians and their various classes of servants (Illich, 1975, p. 135).

In addition, the obsession with risk creates an anxious society dependent on medical authority, which redefines life based on interventions. That said, we endorse what the Ministry of Health states: "[...] comprehensive care presupposes confronting inequities, not just the standardization of clinical conducts" (Brasil, 2012, p. 25). And according to the same document, "[...] secondary prevention actions are centered on early diagnosis and limitation of disability, often on asymptomatic diseases" (Brasil, 2012, p. 125).

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[30] Iatrogenic labeling refers to the process by which medicine, by classifying life stages as clinical categories, transforms ordinary human experiences into objects of therapeutic intervention. This medical labeling creates a normativity about bodies by defining, for example, childhood, menopause, or old age as stages that require constant vigilance and specific treatments, even if there is no disease present. It is a form of medicalization that fragments life into pathologized periods, promoting the continuous consumption of medical services and products. Ivan Illich criticizes this phenomenon when he states that "[...] the iatrogenic labeling of the different ages of human life [...] transforms life into a sequence of periods that require particular forms of therapeutic consumption. [...] Man is boxed in an environment made for the members of his category, as conceived by the bureaucratic specialist in charge of his management" (Illich, 1975, p. 135). See: Illich, I. *The expropriation of health: nemesis of medicine*. Rio de Janeiro: Nova Fronteira, 1975.

Therefore, the excess of tests and diagnoses can shift care from the field of listening and bonding to an infinite sequence of prescriptions. As the document "Care of Chronic Conditions in PHC" warns: "[...] overdiagnosis[31] can make people sicker and poorer" (Brasil, 2012, p. 239). And he adds: "[...] this contradiction is expressed in the very title of the book, in which it is shown that the US spends between 500 and 700 billion dollars per year on unnecessary medical interventions" (2012, p. 239).

> Overdiagnosis is discussed beyond the concept of overdiagnosis and refers to diagnoses of health conditions that are made, but that will never cause serious symptoms or deaths to people in the course of their lives. Overdiagnosis, although it has a value in itself, is also one of the determining factors of overtreatment which, as a result of unnecessary medical interventions, can make people sicker and poorer (Brasil, 2012, p. 239).

However, the imposition of rigid protocols ignores the complexity of daily life and the uniqueness of health trajectories. As stated by Löwy (2010); "[...] By focusing on future risks, preventive medicine loses sight of people's current suffering and concrete needs" (p. 168). And he continues: "[...] this approach transforms asymptomatic individuals into 'pre-patients' [...], ignoring social and subjective variables" (Lowy, 2010, p. 168).

In this way, risk becomes a category of subjectivation: the subject perceives himself as vulnerable even in a state of well-being. Rose (2013) observes that "[...] our bodies and brains are becoming sites of risk management [...] through our own conduct as prudent citizens" (p. 20). And he adds that "[...] vital existence becomes the focus of government, the target of new forms of authority and expertise" (2013, p. 17).

> As the millennium approaches, [...] nowhere have these changes been more eloquent than in the field of health, where patients are increasingly encouraged to become active and responsible consumers of medical services and products ranging from medicinal drugs to reproductive technologies and genetic testing. [...] Currently, it is at the molecular level that human life is understood [...], and it is at this level that life can now be manipulated. [...] Since human beings come to experience themselves in new ways as biological creatures, as biological selves (Rose, 2013, p. 17).

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[31] The concept of *overdiagnosis* refers to the detection of health conditions that, although identified by diagnostic tests, would never cause relevant symptoms or harm to the patient's life over time. This practice, often associated with large-scale population screening, can turn healthy people into patients, generate anxiety, unnecessary medicalizations, and increase the costs of the health system without proportional clinical benefit. In the context of Primary Health Care (PHC), *overdiagnosis* represents a distortion of the purpose of care, replacing listening and bonding with compulsory anticipation of risks. As the Ministry of Health warns, "[...] *overdiagnosis*, although it has a value in itself, is also one of the determining factors of *overtreatment* which, as a result of unnecessary medical interventions, can make people sicker and poorer" (Brasil, 2012, p. 239). See: Brazil. Ministry of Health. *Care of chronic conditions in primary health care: the imperative of consolidating the Family Health Strategy*. Brasília: Ministry of Health, 2012.

Not only that, but there is also an infantilization of the population, which is increasingly dependent on technical prescriptions to manage life. Illich (1975) already denounced that "[...] medicalization transforms the individual into a patient for the rest of his life" (p. 152). And he continues: "[...] the practice of routine early diagnosis procedures [...] reinforces people's conviction that they are machines whose durability depends on the frequency of visits to the maintenance workshop" (1975, p. 196).

Now, subjectivity also suffers from the excess of diagnostic labels that invade life from childhood to old age. As Illich (1975, p. 135) points out: "[...] the school, the street and the aseptic atmosphere of the clinic are enriched with professional prescriptions and impoverished in options". He states that,

> The general acceptance of the iatrogenic classification multiplies by all patients faster than doctors and medications. Within each category of patients, the hierarchical stratification established by school, salary and status is born and reinforced. [...] Life is no longer a succession of different forms of health, but a sequence of periods, each requiring a particular form of therapeutic consumption. Each age corresponds to a special environment to optimize this health-commodity: the cradle, the workplace, the retirement home and the resuscitation room in the hospital. Man is boxed in a medium made for the members of his category, as conceived by the bureaucratic specialist in charge of his management. [...] The school, the street and the aseptic atmosphere of the clinic are enriched with professional prescriptions and impoverished in options (1975, p. 135).

However, the criticism of medicalization does not deny the advances in medicine, but questions its authoritarian use and its tendency to hyperintervention. According to Werner (2009), "[...] Some modern medicines are very important and can save lives. But for most diseases it is not necessary to take medication" (p. 317). And he adds: "[...] The health worker may feel the temptation to prescribe just to please, but in reality it was the body that healed itself" (2009, p. 317).

In addition, the expansion of secondary prevention in PHC is increasingly being captured by the logic of consumption and the health industry. As the document "Care of Chronic Conditions in PHC" warns: "[...] there has been unequivocally manifesting a tendency towards its commodification" (Brasil, 2012, p. 239). And he highlights: "[...] the system of payment for procedures encourages doing more services with higher costs, but not the most necessary" (2012, p. 239). According to Foucault (2001: 45):

> Medicine appears as a technique at the service of the population. But this technique can only function fully as knowledge and as power at the price of a new constitution

> of the object of the disease and of the space in which it manifests itself. The clinic, by becoming a totalizing and disciplinary look, replaces the old relationship between doctors and patients with a new regime of visibility and control, in which the body is exposed to continuous examination, and medical knowledge is exercised as a power of normalization.

That said, the political and ethical meaning of care must be resumed, rescuing the autonomy of the subjects and attentive listening as the foundations of PHC. As Canguilhem (2005) recalls: "[...] health is not the absence of disease, but the ability to institute new norms in the face of aggression" (p. 75). And he adds: "[...] there is no biological norm without subjectivity: it is the subject who judges the normality of his condition" (2005, p. 76).

In this context, even though Primary Health Care (PHC) is conceived as the first level of care and promoter of comprehensiveness, it has been crossed by surveillance and control practices that reduce the subject to a body at risk. As Ivan Illich warns: "[...] medicine is transformed into a ritual for the maintenance of man used as a non-human product" (1975, p. 8), and this logic transforms health into a commodity and life into an object of management. Therefore, it is urgent to demedicalize prevention and restore to PHC its power as a space for the production of life. After all, "[...] the medicalization of life is unhealthy for three reasons: it alienates, paralyzes and takes away from the individual his power as a citizen" (Illich, 1975, p. 6).

Because prevention has been instrumentalized by a technocratic rationalism that operates under the logic of population risk, it is urgent to recover care as an encounter between subjects. According to Barbara Starfield, "[...] The essence of primary care is not simple; it requires the recognition of the complexity of health as a human phenomenon" (2002, p. 12). And, as Annemarie Mol reinforces that "[...] good care requires sensitivity to the situation and cannot be delegated to abstract formulas" (2008, p. 20). In this way, bonding, listening and the singular therapeutic project emerge as ethical alternatives to the technical capture of prevention.

> Listening means, at first, welcoming every complaint or report from the user, even when apparently not directly relevant to the diagnosis and treatment. More than that, it is necessary to help him reconstruct and respect the reasons that caused his illness and the correlations that the user establishes between what he feels and life – the relationships with his guests and disaffections. That is, ask why he believes he got sick and how he feels when he has this or that symptom. The more the disease is understood and correlated with life, the less chance there is of it becoming a problem only for the health service (Ministério da Saúde, 2007, p. 25).

Now, if the subject is more than his biological body, then care must recognize the historicity, the territory and the social networks that cross it. As Emerson Merhy points out when he says that "[...] the expanded clinic implies the acceptance of the senses and meanings of daily life in health acts" (2007, p. 45). And, according to David Armstrong, "[...] the patient's identity is a social and clinical construction, shaped by the forms of knowledge and power" (2002, p. 17). Therefore, demedicalizing prevention also means giving back to the subject the word about himself.

However, the fragmentation of services and the hegemony of the biomedical model hinder practices that value singularity. As Foucault states when he says that "[...] power produces knowledge, and knowledge reproduces power relations" (2014, p. 35). And, in this field, "[...] the body is invested by a political technology that makes it productive and submissive" (2014, p. 34). Therefore, breaking with this rationality requires creating gaps where care is constituted as an exercise of freedom, not of subjection.

> The body is also directly immersed in a political field; power relations operate an immediate effect on him; they invest him, mark him, control him, supplicate him, subject him to work, force him to ceremonies, demand signs from him. [...] The body only becomes a useful force if it is both a productive body and a submissive body. [...] This knowledge and this mastery constitute what could be called the political technology of the body (Foucault, 2014, pp. 33-34).

Despite this, there are powerful experiences that resist normalization and celebrate the power of encounter. Qualified listening, for example, allows you to build therapeutic bonds based on trust and recognition of the other's pain. As Iona Heath points out: "[...] the clinical consultation is a space of radical hospitality, where nameless suffering fits" (Kidd et. al., 2013, p. 89). Similarly, for Jane Macnaughton, "[...] symptoms are symbolic expressions of life lived, not just signs of illness" (Ahlzén et. al., 2017, p. 55).

Therefore, it is necessary to re-enchant clinical practice, betting on situated, ethical care that is sensitive to real life. Ilana Löwy reminds us that "[...] preventive medicine, when centered on risk, transforms a healthy woman into a potential patient" (2010, p. 42). And, according to Rose, "[...] the politics of life becomes the administration of the probability of future diseases" (2007, p. 15). These perspectives require us to rescue the ethics of care as resistance to the logic of anticipating the disease.

> You don't have to be sick to become a patient. The concept of morbidity has simply been extended and covers situations where there is no morbidity in the strict sense, but the probability that such morbidity will appear in due time. [...] This

> medicalization of prevention is a third symptom of social iatrogenesis (Illich, 1975, p. 147).

In addition, the territory is not only a geographical space, but a field for the production of subjectivities and care practices. As Merhy argues: "[...] the live work in action reorganizes the ways of doing health, activating listening, bonding and the shared construction of the therapeutic project" (2007, p. 87). And, according to Starfield, "[...] primary care should be oriented to the needs of communities, not only to biomedical demands" (2002, p. 20). Thus, PHC becomes a place of meeting and not of surveillance.

Although the discourse of prevention promises control and safety, it also establishes permanent anxiety. Byung-Chul Han warns that "[...] excess of positivity and performance generates syndromes such as burnout and depression" (2015, p. 12). And, as Peter Conrad points out, "[...] medicalization transforms social and existential problems into clinical disorders" (2007, p. 4). Therefore, to resist technocracy is also to protect the mental health of subjects and workers.

> The performance subject finds himself at war with himself. The depressive is the invalid of this internalized war. Depression is the illness of a society that suffers under an excess of positivity. It reflects that humanity that is at war with itself. [...] Overwork and overperformance are exacerbated in self-exploitation. This is more efficient than an exploitation of the other, because it goes hand in hand with the feeling of freedom. The exploiter is at the same time the exploited. Aggressor and victim can no longer be distinguished. [...] The psychic illnesses of the *performance society*[32] [emphasis added] are precisely the pathological manifestations of this paradoxical freedom (Han, 2015, p. 30).

However, it is not a matter of denying the importance of technical-scientific knowledge, but of integrating it with popular knowledge, building an ecology of knowledge[33]

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[32] The performance society, a concept developed by Byung-Chul Han, is characterized by a model of subjectivation in which individuals are constantly stimulated to personal improvement, uninterrupted productivity, and self-responsibility for their success or failure. In this context, the subject is no longer seen as exploited by external structures and starts to explore himself, internalizing the logic of efficiency and performance. This way of life, although it seems liberating, generates psychic suffering, exhaustion, and disorders such as depression and burnout. According to Han, "[...] the performance subject is at war with himself. The depressive is the invalid of this internalized war. [...] The psychic illnesses of the performance society are precisely the pathological manifestations of this paradoxical freedom" (Han, 2015, p. 30). See: Han, B.-C. *Society of tiredness* (5th ed.). Petrópolis: Vozes, 2015.

[33] The notion of ecology of knowledge in care proposes the recognition and appreciation of the multiple knowledges that coexist in the processes of health and illness, including popular, traditional, community and non-hegemonic knowledge, alongside biomedical knowledge. This perspective breaks with the hierarchy between science and other ways of knowing, advocating a horizontal articulation between different rationalities, capable of enriching the practice of care and promoting autonomy, integrality and respect for cultural diversity. In the context of Primary Health Care (PHC), the ecology of knowledge becomes fundamental to build interventions that are sensitive to the territory and to the real needs of people. As Boaventura de Sousa Santos states, "[...] an ecology of knowledges presupposes the recognition of the

in care. Débora Diniz states that "[...] disability should be understood as a way of life, and not as an absence or failure" (2007, p. 4). And Canguilhem reinforces that "[...] the norm is always constructed in relation to the concrete life of individuals" (2005, p. 89). Thus, care becomes more potent when it embraces the multiple ways of existing.

As a path of transformation, the training of health professionals needs to be rethought to include the ethics of care, the pedagogy of encounter[34] and respect for otherness. For Mol, "[...] care is a collective practice that requires negotiation and sensitivity" (2008, p. 56). And, according to Foucault, "[...] the birth of the clinic is linked to a new configuration of the gaze and language" (2001, p. 121). Therefore, learning to look and listen is more revolutionary than just learning to diagnose.

> Seeking this change in the formative years is the great challenge of medical schools today. For this, they must arm themselves with devices that operate the construction of a therapeutic project centered on the production of care. [...] The exercise of synthesis of competences, in particular the articulation between the generic competence of any health professional as a caregiver and his/her specific action as a medical professional, for example, with his/her specific competence in the face of a certain theory about the ways of becoming ill, allows the construction of restorative interventions (Merhy, 2007, p. 137).

Furthermore, large-scale tracking practices, when decontextualized, run the risk of transforming PHC into a surveillance apparatus. The article on breast cancer screening in Brazil shows that "[...] there are risks of overdiagnosis and excessive medicalization" (2021, p. 3). And Geoffrey Rose warns us that "[...] population measures can generate invisible benefits for many, but concrete harms for some" (2008, p. 56). Therefore, it is necessary to critically evaluate the effects of these strategies.

Thus, the demedicalization of prevention does not mean the denial of science, but the reaffirmation of an ethical and political health project. Thomas Szasz already

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plurality of knowledge and the refusal of the idea of a hierarchy among them, demanding reciprocal translation between diverse knowledges and the valorization of the concrete experiences of the subjects" (Santos, 2010, p. 32). See: Santos, B. S. *Beyond abyssal thinking: from global lines to an ecology of knowledge.* In: Santos, B. S. & Meneses, M. P. (Orgs.), *Epistemologias do Sul*. São Paulo: Cortez, 2010.

[34] The pedagogy of the encounter is an ethical and methodological proposal that places the relationship between subjects at the center of the educational process and health care. Based on Paulo Freire's thought, this approach values dialogue, listening, and the collective construction of knowledge, recognizing each subject as the bearer of legitimate experiences and knowledge. In the field of Primary Health Care (PHC), the pedagogy of the encounter implies abandoning authoritarian and technicist postures, betting on horizontal links and the co-authorship of therapeutic projects. As Freire states, "[...] it is in the encounter of knowledge that the true educational process takes place, the one in which the educator is also educating, and the student, the educator" (Freire, 1996, p. 27). In this sense, health care becomes a pedagogical act, guided by respect, listening and mutual transformation. See: Freire, P. *Pedagogy of autonomy: knowledge necessary for educational practice*. São Paulo: Paz e Terra, 1996.

denounced "[...] the myth of mental illness as a justification for social control" (1974, p. 10). And Agamben suggests that "[...] the contemporary is the one who knows how to see the darkness of his time" (2009, p. 13). Thus, rescuing PHC as a space for the production of life is also an act of lucidity and political courage.

CONCLUSION

The consolidation of population screening and risk management strategies within Primary Health Care (PHC) has produced significant effects on care practices, contributing to the intensification of the medicalization of daily life. By replacing the clinical encounter with the anticipation of statistical problems, these strategies tend to reduce the subject to a permanent bearer of risks, emptying listening, bonding and the construction of unique therapeutic projects. And, in this process, PHC, previously conceived as a space of welcome and integrality, starts to operate under a logic of surveillance and standardization, where care gives way to the technical administration of life.

However, this shift from the focus of listening and bonding to risk algorithms and protocols results not only in the loss of the relational dimension of care, but also in the expansion of iatrogenic practices, which weaken the autonomy of the subjects. As we have seen throughout the analysis, mass screening and risk management, although justified by efficiency criteria, can, in practice, convert PHC into an instrument of disciplinary regulation, emptying its ethical and political power.

In addition, if, on the one hand, prevention is a fundamental strategy for health promotion, on the other hand, it becomes problematic when dissociated from the social and singular context of the subject. Now, when medicine transforms health into a statistical anticipation of problems, it runs the risk of fabricating pathological identities even before the disease exists. And, as authors such as Illich (1975) and Rose (2013) have shown, this logic of risk compromises the construction of a sensitive, person-centered clinic.

However, there are paths of resistance: the expanded clinic, the ethics of care, and the recognition of the territory's knowledge emerge as counter-hegemonic strategies that reaffirm PHC as a space for listening, bonding, and shared responsibility. Therefore, demedicalizing prevention does not mean denying it, but rescuing it as a situated, plural practice committed to concrete life.

Therefore, for PHC to fulfill its function of comprehensive care, it is necessary to break with the imperative of standardization and bet on practices that value the uniqueness and autonomy of the subjects. This implies recognizing that care cannot be reduced to the application of guidelines, but requires sensitivity, dialogue and mutual trust.

Thus, if the rationality of risk produces a subject that is subject and permanently watched, ethical care produces subjects that are implicated and co-responsible. Thus, the answer to the starting question is to affirm that the centrality of screening and risk management strategies has indeed contributed to the intensification of medicalization and the emptying of the expanded clinic, but also calls us to reinvent practices that restore PHC to its original place: that of the production of life, bonds and freedom.

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