

INSERTION OF PHYSICAL EDUCATION PROFESSIONALS IN THE UNIFIED HEALTH SYSTEM: HISTORY, ADVANCES AND CHALLENGES

INSERÇÃO DE PROFISSIONAIS DE EDUCAÇÃO FÍSICA NO SISTEMA ÚNICO DE SAÚDE: HISTÓRIA, AVANÇOS E DESAFIOS 

INSERCIÓN DE PROFESIONALES DE EDUCACIÓN FÍSICA EN EL SISTEMA ÚNICO DE SALUD: HISTORIA, AVANCES Y DESAFÍOS 

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Abstract: This essay explores the historical configuration of Physical Education (PE), highlighting its approaches and distances with public health, and discusses the critical aspects of the incorporation of PE professionals in the context of the Unified Health System (UHS). Initially configured as a school component, the PE expanded its field of action to Sports/Leisure and, later, to Health, when body practices/physical activities (BP/PA) were incorporated by public health policies. Numerically insufficient in the UHS, PE professionals are trained based on a model that is anchored in preventive and behaviorist discourses, which disregard the social determination of health-disease processes. The core of PE needs to transcend the practice based on BP/PA prescription under the sole pretext of increasing energy expenditure for the prevention and control of chronic non-communicable diseases, and the training processes need to be directed towards the understanding of health as a right.

Keywords: Physical Education and Training. Unified Health System. Work. Professional Training.

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1 INTRODUCTORY NOTES

Since the establishment of the Unified Health System (UHS), the country began to have several local interventions to promote bodily practices/physical activities (BP/PA). These have gained greater contours since 2005, when the government included them as a focus of policies to promote health and address chronic non-communicable diseases (NCDs), and more recently, recognized them as a determinant and conditioning factor of health (HALLAL, 2014; LOCH *et al.*, 2018). This scenario placed the BP/PA as a relevant element in the know-how of the public health field, and established the link of Physical Education professionals (PEP) to UHS, which began to be inserted as members of multiprofessional teams in different devices of Primary Health Care (PHC) (HALLAL, 2014; LOCH *et al.*, 2018; KNUTH; ANTUNES, 2021).

In this context, the PEP is allowed to perform BP/PA and integrative and complementary practices, conduct programs and groups of health education, community therapy, consultation and individual and group care in the unit and at home, and rehabilitation and continuing education actions (SILVA, 2020). In addition to these, a comprehensive set of interdisciplinary and multiprofessional activities to support the Family Health Care teams are provided for by health policies, which have the integrality of care as a guiding principle (BRASIL, 2008; 2013).

Despite this, evidence shows that the work of the PEP in PHC is concentrated, and sometimes restricted, to issues involving weight loss and control of NCDs. From this perspective, the work of PEP focuses on comorbidities already installed, to the detriment of a multidimensional, interprofessional, collective and intersectoral approach directed to the promotion and maintenance of health (NEVES *et al.*, 2015; CARVALHO; ABDALLA; BUENO JÚNIOR, 2017; KNUTH; ANTUNES, 2021).

Without disregarding the importance of interventions focused on the control of NCDs, the leading cause of death in Brazil and worldwide (PAHO, 2019), the role of the PEP in PHC should be more comprehensive, in order to collaborate with other professionals to consolidate the UHS care model and to address the multiple and complex health demands. In addition to NCDs, the socio-epidemiological context points to the progressive increase in the prevalence of degenerative, psychosocial conditions and injuries from external causes, while human interventions in the ecosystem have potentiated the risks for infectious diseases – the Covid-19 pandemic is an example – and deficiency diseases (BARRETT; CHARLES; TEMTE, 2015).

Multiple factors seem to explain this scenario, but one element recurrently described in the literature is that this reductionist performance is supported by the training of PEP, still centered on biologicism and guided by the standards of the leisure, consumption, beauty and aesthetics industry, not properly contemplating the theoretical and practical knowledge about the UHS, public health and those focused on teamwork (NEVES *et al.*, 2015; LOCH; RECH; COSTA, 2020; BAGRICHEVSKY; ESTEVÃO; PALMA, 2008; NOGUEIRA; BOSI, 2017; PASQUIM, 2010; GUARDA *et al.*, 2014; FALCI; BELISARIO, 2013).

With this in mind, and considering the comprehensive scope of the PEP in the UHS, not restricted, therefore, to the biological and individual dimension, this

essay seeks to explore the critical aspects of the incorporation of this professional in the UHS from a historical perspective. Although there has been an increase in the number of studies on this topic, formulated under truly diverse theoretical pretexts and objectives (NOGUEIRA; BOSI, 2017), we did not find publications that address what is intended here. This production, however, worked, for us, as an object of concern and as a source of data to be explored in this essay.

Resulting from the appreciation of available evidence and the authors' mental elaboration, substantiated by readings, secondary data, and experiences with research on the theme of work and education in health, this production does not seek to contest the epidemiological knowledge that invades the speeches and practices of PEPs (KNUTH; ANTUNES, 2021), but rather to bring to light elements that contribute to the success or failure of the incorporation of this professional in the UHS, especially in PHC.

2 THE HISTORICAL CONFIGURATION OF PHYSICAL EDUCATION IN BRAZIL: APPROACHES TO AND DISTANCING FROM PUBLIC HEALTH

In Brazil, Physical Education started to be structured in the 19th century, when the first military groups started to promote and organize recreational bodily activities and athletic competitions, from which a body of knowledge essential to the constitution of a profession was established (SOUZA NETO *et al.*, 2004). Besides the military institutions – which greatly contributed to relating Physical Education to healthy and strong bodies – doctors, educators, and jurists were also involved with the process of valorization of Physical Education, especially from the 20th century on, which started to be incorporated as a strategy for the development of health, moral, and intellectual capacity, and as a necessary part for the establishment of a culture of national modernization (FONSECA; HONORATO; SOUZA NETO, 2021).

These groups, responsible for the institutionalization of Physical Education in elementary schools from the 1930s on, configured different interests and disputes for the control of this profession, taken at that moment as an instrument of social intervention in health. While the educators involved with BP/PA aspired to the recognition of their know-how, the doctors wanted to keep their position of authority in the planning and control of health policies and in the regulation of educators' practices in schools. The military, already organized and politically articulated, wanted to train Physical Education teachers according to their method, in order to exercise authority over the education and health conditions of young people, who would be prepared for military exercise (FONSECA, 2017).

In 1931, when Physical Education became mandatory in high school, the use of the French method – based on eugenic, hygienic, and militaristic principles – was mandatory, and the Army started training civilians to act as teachers in public schools (FONSECA, 2017). In that period, the educational reforms leveraged by Getúlio Vargas' government assumed the eugenic training as a model to be pursued for the development of morality, discipline and physical conditioning, this being an indispensable factor for the conformation of a "physically strong race, with aesthetic

standards that would define, according to eugenicist parameters, the nobility of a race” (ROCHA, 2014, p. 9).

Years later, the practice of exercises became mandatory in all educational institutions, requiring the training of a larger contingent of teachers, leading to the creation of the National School of Physical Education and Sports and the establishment of guidelines for professional training, in 1939 (FONSECA, 2017). Five types of technical professional training were implemented in this School: (1) training of Physical Education teachers to act in secondary and higher education; (2) training of gymnastics instructors to act in primary education; (3) training of sports technicians and (4) of massage technicians, both directed to act in sports institutions; and (5) specialization of physicians in Physical Education to assist all the above mentioned (FONSECA; HONORATO; SOUZA NETO, 2021).

In 1945 a curricular reform was undertaken, but without major changes. In 1961, Physical Education gained the status of a higher level and training was restricted to only one modality, lasting three years, granting its graduates the diploma of full license, or of sports technician, if they chose the complementation of two more sports subjects. The dismissal of the other courses occurred under the justification that they were not meeting the labor market, because it was the former athletes who continued to occupy the place of professionals trained by a higher education school (FONSECA, 2017; FONSECA; HONORATO; SOUZA NETO, 2021).

If, on the one hand, the training of Physical Education teachers was strengthened in order to keep up with the expansion of the national education system, notably with the purpose of physically and civically conditioning the students in favor of the dominant project of nation; on the other hand, the increase of social demands for BP/PA outside the school context was disregarded and the duality between pedagogical and technical knowledge was deepened, which reflected on the identity of professionals for society and for the class itself (FONSECA; HONORATO; SOUZA NETO, 2021).

In this sense, a movement of discussion about the formation of the PEF gains strength, with diverging positions on the conceptual framework that should underlie it. While a group of experts defended a generalist education from the degree, arguing that the graduate exercised an essentially pedagogical intervention whatever the field of action (school or non-school); another group advocated in favor of another degree, whose training was more specialized to work in the out-of-school context (KUNZ *et al.*, 1998).

From this debate, the second proposal prevailed and, in 1987, the degree of Bachelor of Physical Education was created from a licentiate-bachelor division, which would end up further straining the discussion around a specific core of knowledge for Physical Education. Moreover, the new degree was offered by few educational institutions. Some of them doubly titled their graduates (bachelors and licentiates) from a process of concomitant training, depriving the perspectives of differentiated training (KUNZ *et al.*, 1998).

Meanwhile, the first postgraduate programs in Physical Education were created that, in this identity crisis and seeking to raise its scientific status, started to produce knowledge that would meet the needs of the basic sciences based on biologicism (such as Anatomy and Physiology) in a way detached from the reality of everyday work and the global movement around health (and not disease), not contributing, therefore, to instrumentalize the professional practice, especially in the field of public health (VERENGUER, 2004). Concomitantly, Physical Education becomes devalued as a curricular subject by the educational policies, while the BP/PA performed outside the school context are seen positively, under a liberal and biomedical perspective that encourages the proliferation of private spaces for the practice of physical exercise (NOZAKI, 2004).

On the other hand, the Brazilian Sanitary Reform, conceived in the 1970s, was a social force against authoritarian and privatizing health policies, leading to the 8th National Health Conference in 1986, which expanded the concept of health adopted as a reference until then. This concept – of health as a result of the forms of social organization of production – ended up being assimilated by the legal framework in Brazil (PAIM, 2008). From this broad movement, and in a context of a struggle for the re-democratization of the country, the UHS is created under the aegis that health is a fundamental human right and a duty of the State.

While the UHS begins to be implemented nationally, Physical Education, alienated from this process, goes through an epistemological crisis and a lack of consensus as to its concept and its work object (NOZAKI, 2004). The inexistence of an identity element linked to the trades of BP/PA is even taken as one of the biggest obstacles to the regulation of Physical Education in Brazil, which only happened in 1998, and was crossed by many disputes and controversies, not happening in a consensual manner (VERENGUER, 2004).

For Nozaki (2004, p. 201), the regulation came to meet more specifically the corporatist sector, especially formed by owners of gyms and clubs in great expansion, which sought to disqualify the action of the so-called laypeople (usually former athletes or professionals trained in other areas) and ensure market reserve. The author associates this process to the crisis of capitalism and the precarization that the teaching work assumed in the 1990s, which forced the “appearance of a physical education worker as a service provider, liberal professional, entrepreneur”, which from then on is called *Physical Education professional*.

The fact is that, despite the regulation, the unity and the sense of professional identity expected among workers in the area were not achieved, nor was defined what is exclusive in the intervention of the PEP, whether in the field of education, sport or health (FONSECA, 2017). On the contrary, the regulation accentuated the duality and fragmentation of the work between licentiate and bachelor's degree, which was ratified in the National Curriculum Guidelines (NCG) of the Physical Education Undergraduate Course, promulgated in 2002.

3 TRAINING IN PHYSICAL EDUCATION IN DISHARMONY WITH THE UHS

Looking from the prism of professional regulation, formalized education is an important pillar for professional socialization, besides being the propeller of a regulation system that protects the field of action of its professionals. From this point of view, the increase in the number of undergraduate courses in Physical Education denotes an advance in the professional structure to ensure that the BP/PA were exercised only by holders of specialized knowledge proper to graduates (FONSECA, 2017). It does not mean to say, however, that this number translates into quality.

In the year 2000, undergraduate courses in Physical Education totaled 267; in 2014 there were more than a thousand (PIERANTONI; MAGNAGO, 2017). Currently, there are 1,511 courses, which together offer more than 443,000 places and train about 58,000 professionals. Of the total number of courses, only 17.6% are public, and 51% are aimed at training bachelors (BRASIL, 2020). These data show that the appeals to the demands of the neoliberal labor market were met by private institutions, generally with little tradition in research and with a strong vocation for technical and mechanistic professional preparation (FONSECA, 2017) – different from what was desired by the UHS.

The increased offer of courses, with the consequent exponential increase in the number of PEP in the country, was motivated by the favorable perspectives of an expanding labor market, both in the public and private sectors. In the first case, because of the reconduction of Physical Education as a mandatory curricular component in elementary school, the focus of licentiates; in the second case, because of the expansion of clubs, gyms and other sports venues, the main focus of bachelors (PRONI, 2010).

This expansion of courses and vacancies, especially in the private sector, was experienced by all health courses. However, unlike other professions, whose NCG sanctioned a training focused on the expanded concept of health, the UHS and teamwork, Physical Education assumed health only as a field of professional practice and not as a guiding concept of its training (JESUS; COSTA, 2016). The UHS is not even mentioned in its NCG, although PEPs were already recognized as higher-level health professionals since 1997, when the National Health Council (NHC) considered them essential to the advancement of comprehensive care (BRASIL, 1997). This finding brings us to the current deficit of knowledge in the area of Physical Education about public health and collective health, a fact that seems to confirm a historical epistemological disharmony that still today limits the training and work of PEP in the UHS.

For Castellani Filho (2016), the training of Physical Education graduates is centered on an anachronistic view of health, which has nothing to do with the conception of health that guides Brazilian public policies. This traditional technicism-centered training, with little focus on the needs of the territories and UHS users, does not prepare the professional to act collaboratively and focus on solving the health problems of the communities. Studies denounce that there are still few curricula that offer subjects from the field of public health and that include professional interventions

in health – understood here as socially determined –; or, when incorporated, they are marginalized and do not provide opportunities for students to have contact with other health professionals, nor with the complex problems that mark the reality of working in the UHS (CARVALHO; ABDALLA; BUENO JÚNIOR, 2017; LOCH *et al.*, 2020; PASQUIM, 2010; FALCI; BELISARIO, 2013; COSTA *et al.*, 2012; SAPORETTI; MIRANDA; BELISARIO, 2016).

More recently, an expectation was created around the review process of the NCG of Physical Education, in the belief that its reformulation would incorporate conceptions that guide the field of public health and overcome the limits of prescriptivist professional intervention centered on the biomedical paradigm. After a wide debate that once again constituted two divergent sides around the division/unification of bachelor-licentiate (CASTELLANI FILHO, 2016), in 2018 the new NCG are instituted, which divides the graduation into two formative stages: the common one, to be completed in the initial two years by all students; and the specific one in licentiate or bachelor degree (BRASIL, 2018a).

It is in the specific bachelor's degree that health is announced as one of the axes of training, in which there is the only mention of UHS and themes directly related to the performance of the PEP in this scenario are foreseen. This is an advance! However, this axis seems disconnected from the set of provisions enunciated in the text, which denounces “a character of sanitary syncretism”, mobilizing different perspectives of health, and does not move towards interprofessionalism (ABIB; KNUTH, 2021, p. 14). In a final analysis, we conjecture that the new guidelines propose to register the polyvalence of the PEP (to the delight of the capitalist market), without, however, deepening the intended articulation between the different “niches” of professional performance.

Costa (2019) warns that this movement of change in the PEP training should involve the entire curriculum, aiming at ways to break with a structure based on the disarticulation of content and knowledge. And because it is a health profession, it is necessary to move towards a curricular structure based on interprofessional education (IPE), without which the training will be subject to complete anachronism. The IPE supports the proposal of a training model that provides opportunities for joint and interactive learning moments between students from different health professions, so that they learn among themselves, with and about others, and develop attitudes, knowledge and skills for collaborative interprofessional practice (CIP) (REEVES *et al.*, 2013).

Understood as a synergistic process of communication and decision-making, CIP allows the individual and shared skills and knowledge of different professionals to influence patient care. Its main objective is to supplant competition among professionals in favor of cooperation, softening power imbalances and reaffirming the collective responsibility for care (KHALILI; HALL; DeLUCA, 2014). In the Brazilian context, this proposal gains strength for its potential to reverse the logic of biomedical education, verticalized and traditionally established, and for providing opportunities for advances in the consolidation of work processes based on interprofessional teams (MATUDA; AGUIAR; FRAZÃO, 2013).

In this sense, the NCG, through Resolution No. 569/2017, establishes IPE as one of the general principles to be incorporated into the NCG of all courses in the area (BRASIL, 2018b). Although this guideline is prior to the publication of the normative that established the new NCG of Physical Education, the latter did not consider it as a source of inspiration. This fact shows that the category remains largely removed from the intellectual, political and social movement that seeks the consolidation of the UHS and the right to health.

The academic community of Physical Education can and should commit and join the other collectives of the health field and society, seeking to expand access and quality of health care, and repudiating any initiative that results in loss of rights or precariousness of assistance (COSTA, 2019, p. 3).

4 THE WORK CONTEXT: IMPULSES AND LIMITATIONS FOR THE INSERTION AND PERFORMANCE OF THE PHYSICAL EDUCATION PROFESSIONAL IN THE UNIFIED HEALTH SYSTEM

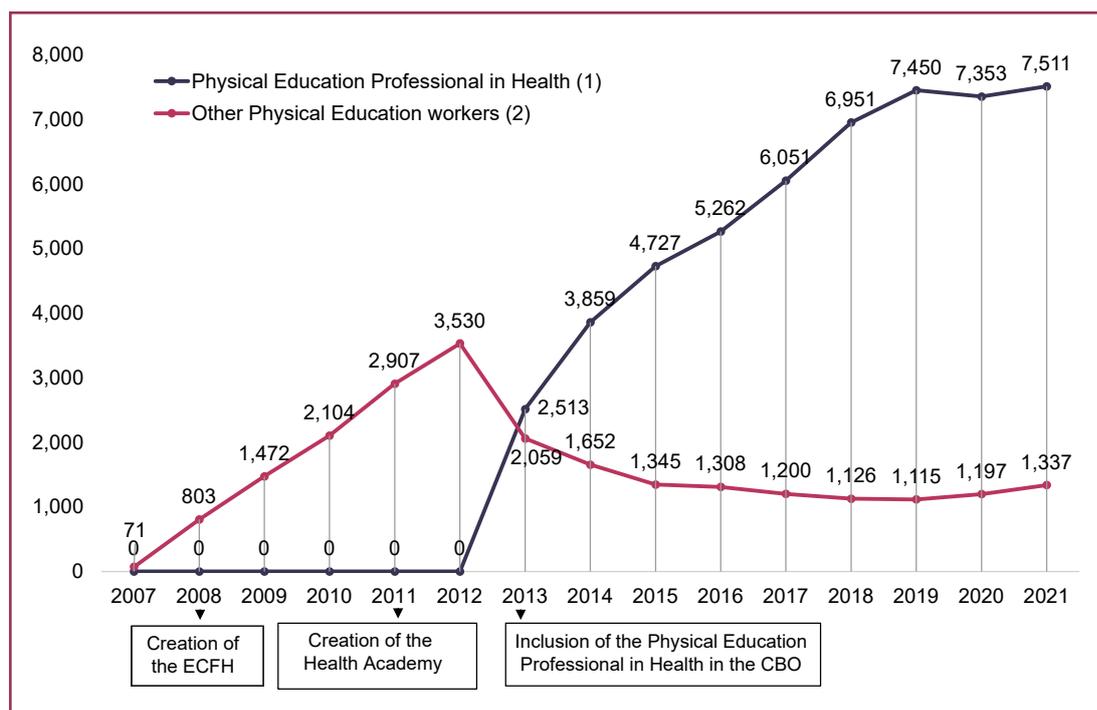
Considering that the professionalization of Physical Education took place separately from the Sanitary Reform movement and the creation of the UHS, the role of the PEP in this scenario has only been highlighted since 2008, when the Expanded Centers for Family Health and Basic Care (ECFH-BC, initially called Family Health Support Centers) were created. These were created with the aim of expanding the offer, scope and resoluteness of PHC services and health actions, through teams composed of different health professionals, including the PEP, which favored the strengthening of BP/PA as a care offer in the UHS (CARVALHO; NOGUEIRA, 2016).

Another milestone that boosted the insertion of the PEP in the UHS was the creation of the Health Academy Program (HAP) in 2011. This is a health promotion strategy that works with the implementation of public spaces where BP/PA are offered to the population, in association with other practices and care that seek to develop autonomy and social participation (MALTA; SILVA JÚNIOR, 2013).

Moreover, the provisional inclusion of the *Physical Education Professional in Health* in the Brazilian Classification of Occupations (CBO 2241-E1), in 2013, favored the recognition of the functions and the inclusion of a series of new procedures in the list of activities of this professional (BUENO; BOSSLE; FRAGA, 2018). Until then, PEPs working in healthcare were registered under other codes of the CBO family 2241, 2321, and 2344.

These milestones are shown in Figure 1, which breaks down the evolution of the number of PEPs registered in health facilities, and through which we see an exponential growth of PEPs over the years in the health area, from 71 in 2007 to 8,848 in 2021. Of these, more than 90% work for the UHS.

Figure 1 – Number of Physical Education Professionals registered in health facilities. Brazil, 2007-2021



Source: National Registry of Health Care Facilities, Jan. 2022.

(1) Registered under CBO code 2241-E1; (2) Registered under the other CBO codes in the 2241 family (physical evaluator, ludomotor trainer, athlete trainer, physical trainer, sports technician, sports laboratory and inspection technician, and soccer coach) and under codes 2321-20 (High School Physical Education Teacher) and 2344-10 (Higher Education Physical Education Teacher).

This does not mean to say that most PEP are inserted in the UHS, since there are more than 555 thousand registrations in the Federal Council of Physical Education, including bachelors, licenciates, and provisioned (Physical Education workers without higher education who obtained the functional registration after proving exercise in the area for at least three years before the regulation of the profession). On the contrary, data indicate that 55.3% of active formal PEP jobs in December 2020 were concentrated in the Sports sector, where clubs, gyms, and other sports facilities are located; while only 5.2% were registered in the Health sector (BRASIL, 2022a).

Another aspect to be highlighted is that the growth observed in Figure 1 refers to the absolute number of professionals, regardless of the workday practiced. Unlike the above, standardized analyses for a 40-hour work week in PHC point to a reduction in the number and density of workers by population (SILVA *et al.*, 2022).

When we consider only the PEPs registered by CBO 2241-E1 and who work in the UHS, we see that they are mostly linked to PHC services, especially in basic units and health academies (Table 1).

Table 1 – Distribution of Physical Education Professionals in Health who attend the Unified Health System by type of establishment. Brazil, Nov. 2021.

Health Care Facilities	N	%
Health Center/Basic Health Unit	2,698	39.7%
Health academies	2,298	33.8%
Psychosocial Care Center	560	8.2%
Family Health Support Center	342	5.0%
Specialized Clinic/Specialized Outpatient Clinic	342	5.0%
General Hospital	173	2.5%
Secretariat of Health	92	1.4%
Specialized Hospital	90	1.3%
Health Center	75	1.1%
Polyclinic	61	0.9%
Diagnostic and Therapeutic Support Service Unit	28	0.4%
Health Surveillance Unit	12	0.2%
Clinic	11	0.2%
Mixed Unit	8	0.1%
Center for Disease Prevention and Health Promotion	7	0.1%
Emergency Care Unit	2	0.0%
Regulation Center	1	0.0%
Cooperative	1	0.0%
Pharmacy	1	0.0%
Residential Care Unit	1	0.0%
Land Mobile Unit	1	0.0%
Total	6,804	100%

Source: National Registry of Health Care Facilities, Jan. 2022.

However, if we consider that there are more than 3,100 health academy centers and approximately 5,500 ECFH-BC teams (out of a total of 100,500 PHC teams), PEPs would be present in only 85% of the academies and 55% of the ECFH-BC. This is a limited insertion. Moreover, PEPs represent only 0.7% of all higher-level professionals working in the UHS, a proportion lower than almost all other professions, including physical therapists (7.1%), nutritionists (2.8%), biomedical doctors (1.2%), and occupational therapists (0.9%) (BRASIL, 2022b).

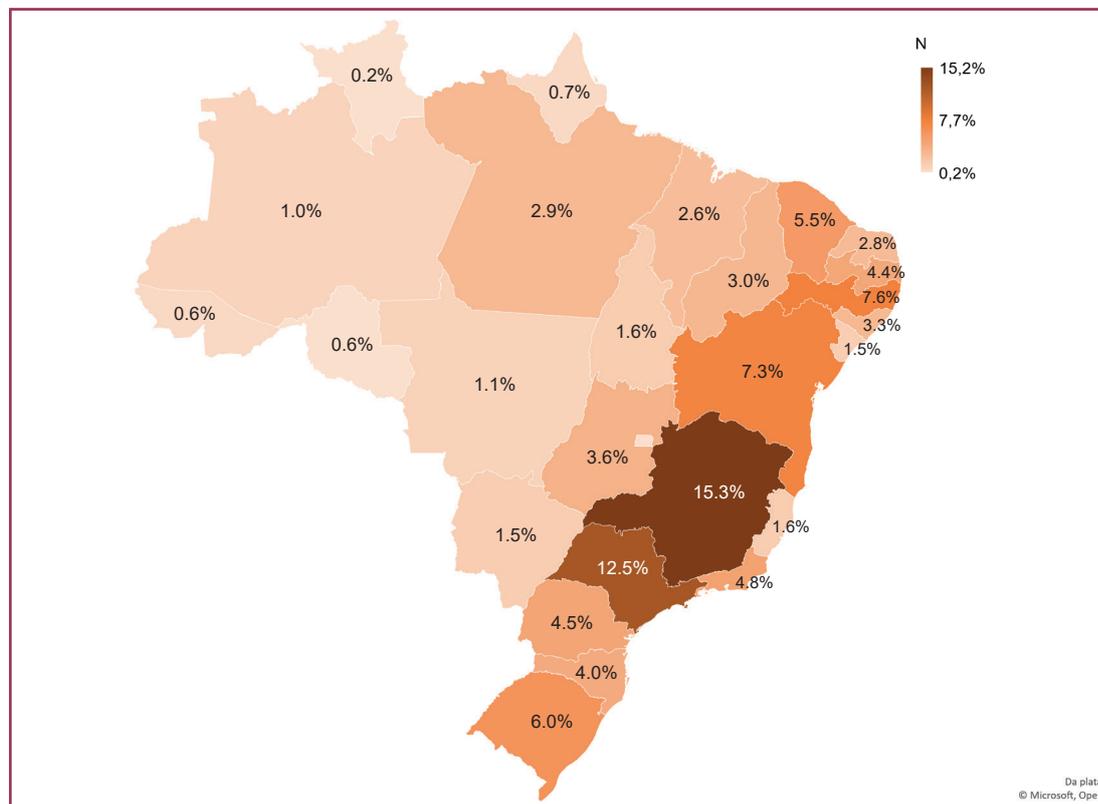
Besides being minimal, this proportion can be reduced in the coming years, since the programs and actions linked to the National Primary Care Policy, especially those that operate on the matrix support logic, are currently being discontinued by the federal government. For example: with the implementation of a new form of financing the PHC in the UHS, the existence of ECFH-BC became a decision of the local government, since it is no longer a requirement for the transfer of federal funds to municipalities.

In addition to the change in the ECFH designation, it is conjectured that the current government is signaling a new direction of the actions of the matrix teams, giving priority to the isolated and uniprofessional performance of each profession, instead of an expanded and interprofessional look. It is even feared that the priority of

the PHC model supported by Family Health will be discarded in favor of other models of care that operate on the logic of capital (LOCH *et al.*, 2017).

The distribution of current professionals throughout Brazil is also quite unequal, being concentrated mostly in the Northeast (37.6%) and Southeast (34.1%). Among the states, the highlights are Minas Gerais (15.2%) and São Paulo (12.5%) (Figure 2).

Figure 2 – Distribution of Physical Education Professionals in Health who attend the Unified Health System by state. Brazil, 2021



Source: National Registry of Health Care Facilities, Jan. 2022.

In addition to being numerically insufficient, which generates work overload and impairs professional performance, PEPs are mostly hired temporarily, making it difficult to establish a link with the teams and the population and, consequently, the continuity of therapeutic plans (KNUTH; ANTUNES, 2021; CARVALHO; ABDALLA; BUENO JÚNIOR, 2017; NEVES *et al.*, 2015; SÁ *et al.*, 2016; RODRIGUES *et al.*, 2013). Moreover, evidence points out that most of the population is unaware of the existence of BP/PA public programs, being these more used by the elderly and poor (FERREIRA *et al.*, 2019). In general, physical exercise is practiced by people of higher income, in gyms and clubs (KNUTH; ANTUNES, 2021; OLIZ; DUMITH; KNUTH, 2020; GONZÁLEZ, 2015). It can be said, then, that access to PEP in Brazil is not democratic and is configured as elitist.

Not surprisingly, physical inactivity is more prevalent among women, the elderly, blacks, people with lower incomes, and residents of areas where there are no public places for leisure and exercise (BRASIL, 2019). These data reaffirm that health-disease processes and access to health actions and services are determined by social and material conditions of existence.

Another point is that access to the PEP is not always associated with better health outcomes, considering that the nature of its performance did not completely break with the ideals of hygienic moralization and militarization of the bodies. With the advent of health promotion, the BP/PA started to be conceived as a resource to overcome sedentarism (conceived as a lifestyle to be fought) and, consequently, contemporary diseases (BAGRICHEVSKY; ESTEVÃO; PALMA, 2006; CECCIM; BILIBIO, 2007). This direction of praxis engenders new binarisms (such as active body versus a sedentary lifestyle/obesity) that allude to those historical ones that founded and still inscribe the search for integrality of the human being and care (health versus disease, body versus mind).

In this view, the performance of the PEP in UHS is centered on the biological dimension, which denies health (and not the sick body) as an object of know-how. The work seems to be directed to the maintenance of medicalizing and moralizing professional practices, anchored in hegemonic discourses that attribute to the subject complete and unrestricted responsibility over their own health, disregarding the social determination of health-disease processes (KNUTH; ANTUNES, 2021; CARVALHO; ABDALLA; BUENO JÚNIOR, 2017; NEVES *et al.*, 2015; CARVALHO; FREITAS; AKERMAN, 2021).

This anachronistic practice emerges largely due to the meanings that Physical Education attributes to health promotion, which are based on prevention and focus on lifestyle and individual behaviors. In this case, health promotion actions tend to concentrate on educational components, related to behavioral risks that can be changed and are under the control of the individuals themselves, as is the case of physical inactivity (BUSS, 2000).

The health promotion envisioned by the UHS, on the contrary, seeks to ensure better living conditions, which include education, work, and basic sanitation, among others. In this case, the actions are intersectoral and comprehensive, being more focused on the collective, the realization of citizenship rights and the production of autonomy, which would allow individuals and collectives to make more conscious decisions about their life and health (FERREIRA *et al.*, 2019; BUSS, 2000). In this last perspective, the PEP's actions would not be limited to prescribing BP/PA or even conducting activities with the sole purpose of increasing energy expenditure. But it would include listening and welcoming; the establishment of intersectoral partnerships in the territory; the involvement in actions to build/maintain collective public spaces that ensure access to BP/PA; the empowerment of the struggle for access to basic rights, as is the case of physical activity, and the strengthening of public policies.

In addition, the limited performance of PEPs is also ensured by the disarticulation between the services of the health network; the models of care that predominate in the professional context in which the PEP is inserted (SÁ *et al.*, 2016); the working conditions (CARVALHO; NOGUEIRA, 2016); and by the very meaning given to BP/PA in global and national health policies – compulsory, required or demanded, to fulfill tasks oriented to a productive result, namely: energy expenditure (GONZÁLEZ, 2015).

Another aspect that obscures the potential of PEPs in the UHS, especially in PHC, is the low articulation between them and other health professionals – an

aspect very little reported in the literature on Physical Education. The few studies that address the theme report that PEP suffer prejudice and resistance from other professionals (FERREIRA *et al.*, 2016; SOUZA; LOCH, 2011; MENDONÇA, 2012), who see the work of PEPs limited to the fight against NCDs (PEDROSA; LEAL, 2012). Indeed, these workers may be focusing on offering BP/PA for groups.

An analysis of the production of PEPs in PHC points out that the largest number of procedures performed by them, in November 2021, were the BP/PA in groups (50.9%), while professional consultations, home visits and individual home care or multidisciplinary team, which would indicate an integrated action, totaled only 17.1% (BRASIL, 2022c). Studies also report that the actions are more directed at people with NCDs and are characterized by repetition of movements (SOUZA; LOCH, 2011; MENDONÇA, 2012).

5 FINAL THOUGHTS

The historical process of institutionalization of Physical Education was marked by an identity crisis, disputes, and conflicts of interest that distanced it from the field of public health and the movements for the construction and implementation of the UHS and its policies. Its late, dissensual and controversial professional regulation, driven by the commodification of sports practices, accentuated the division between licenciates (teachers) and bachelors (sports professionals), drove the unbridled creation of undergraduate courses, and increased the segmentation of the PEP labor market, until then with little presence in public health settings.

The differences established between the licentiate's degree and the bachelor's degree marked not only the academic disputes and the conformation of a professional identity, but also the process of incorporation of the PEP into the UHS. Although recognized as a health professional, and even after the implementation of policies and programs that encouraged and established its linkage in the health area, especially in PHC, its training and performance remain in disagreement with the principles of the UHS and the advances achieved by the field of public health.

From another perspective – that of the work context in the UHS – PEPs are in a vulnerable situation. First, because they are usually hired under precarious contracts and face adversities related to salary, organizational and infrastructure conditions. Second, because they constitute a small portion of the professionals working in PHC and are, therefore, numerically insufficient to cover the entire user population. Third, because the current sociopolitical conjuncture and its short-, medium- and long-term effects may limit even more the participation of PEPs in the UHS, since a series of programs and initiatives have been rearranged or discontinued. An example of this was the elimination of exclusive federal funding mechanisms for the implementation and funding of ECFH-BC, one of the main locus of PEP activities in the UHS. In the same direction, reckless waves put at risk the Brazilian PHC model, whose current configuration, which favors interprofessional and collaborative work, can retreat towards exclusively biomedical, specialized, and uniprofessional practices.

Therefore, the core of Physical Education needs to transcend the practice based on the prescription of BP/PA under the sole pretext of increasing energy

expenditure for the prevention and control of chronic noncommunicable diseases; and the training processes need to be directed to the understanding of health as a right. From the macro-political perspective, the UHS, PHC and public health policies, notably those that operate on the matrix support logic, need to be strengthened by interprofessional education and practice.

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Resumo: Este ensaio explora a configuração histórica da Educação Física (EF), destacando as suas aproximações e distanciamentos com a saúde pública, e discute os aspectos críticos da incorporação do profissional de EF no contexto do Sistema Único de Saúde (SUS). Inicialmente configurada como componente escolar, a EF expandiu seu campo de atuação para o Esporte/Lazer e, mais tardiamente, para a Saúde, quando as práticas corporais/atividades físicas (PC/AF) foram incorporadas por políticas públicas de saúde. Numericamente insuficientes no SUS, os profissionais de EF são formados a partir de um modelo ancorado em discursos preventistas e comportamentalistas, que desconsideram a determinação social dos processos saúde-doença. O núcleo da EF precisa transcender a prática baseada na prescrição de PC/AF sob o pretexto único de aumento do gasto energético para a prevenção e controle de doenças crônicas não transmissíveis, e os processos de formação precisam ser direcionados para a compreensão da saúde enquanto direito.

Palavras-chave: Educação Física e Treinamento. Sistema Único de Saúde. Trabalho. Formação Profissional.

Resumen: Este ensayo explora la configuración histórica de la Educación Física (EF), destacando sus proximidades y distancias con la salud pública y discute los aspectos críticos de la incorporación del profesional de EF en el contexto del Sistema Único de Salud (SUS). Configurada inicialmente como componente escolar, la EF amplió su campo de acción al Deporte/Ocio y, posteriormente, a la Salud, cuando las prácticas corporales/actividades físicas (PC/AF) fueron incorporadas a las políticas públicas de salud. Numéricamente insuficientes en el SUS, los profesionales son formados a partir de un modelo anclado en discursos preventivos y conductistas, que no consideran la determinación social de los procesos salud-enfermedad. La EF necesita transcender la práctica basada en la prescripción de PC/AF bajo el pretexto único de aumentar el gasto energético para la prevención y control de enfermedades crónicas no transmisibles, y los procesos de formación deben orientarse hacia la comprensión de la salud como derecho.

Palabras clave: Educación Física y Entrenamiento. Sistema Único de Salud. Trabajo. Formación Profesional.

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CONFLICT OF INTERESTS

The authors declare that this work involves no conflict of interest.

AUTHOR CONTRIBUTIONS

Rodrigo Ossoda Moura Bandeira: conceptualization, methodology, research, formal analysis, writing of the first draft.

José Rodrigues Freire Filho: conceptualization, resources, methodology, research, formal analysis, supervision, writing of the first draft.

Carinne Magnago: conceptualization, methodology, research, formal analysis, proofreading and editing, validation, preview.

Aldaísa Cassanho Forster: conceptualization, research, formal analysis, validation, preview.

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