Continuing Education Policy in Health: A study proposition based on the principles of interfederative and interinstitutional conformation

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Bruno Costa de Macêdo[1], Katia Rejane de Medeiros[2].

ABSTRACT

This article aims to present the analytical structure developed for the study of the evaluability of the institutionalization of the National Policy for Permanent Education in Health from its interinstitutional and interfederative character. It consists of an exploratory analytical work, of a qualitative nature, which resorted to documentary research and narrative literature review. Data collection included ministerial ordinances, State Health Plans (PES), State Plans for Permanent Health Education (PEEPS) and Annual Management Reports (RAG) in the public domain. 40 documents were selected based on specific criteria. Results and Discussion: The data analysis was carried out through the description and classification of educational actions and strategies in four modalities that guided the investigation and enabled the constitution of eight categories of analysis based on the development of institutionality with a view to deepening network interdependence. The conclusion highlights that the proposed analytical structure addresses the regional interfederative and interinstitutional character of the PNEPS, aiming to subsidize analytical and evaluation studies that involve not only traditional actors in the management of the SUS, but also health councils and public and private educational institutions. These training and network structuring actions encompass workers from different origins, bonds, categories, and levels of care and management, adapting to the multiple realities of the territories and health services.

Keywords: Health Policy, Permanent Health Education, Health Regionalization, SUS, Evaluation of Health programs and projects.

[1] Aggeu Magalhães Institute - IAM/Fiocruz-PE
ORCID: https://orcid.org/0000-0002-4775-2627
LATTES: http://lattes.cnpq.br/5122714173822920
E-mail: brunomacedo85@yahoo.com.br
[2] Aggeu Magalhães Institute - IAM/Fiocruz-PE
ORCID: https://orcid.org/0000-0002-7518-4137
LATTES: http://lattes.cnpq.br/4754111804677434
E-mail: katia.rejane@fiocruz.br

INTRODUCTION

Human resources for the health sector have been one of the central issues for the Unified Health System (SUS) since its inception, whose complexity is amplified in the face of a federative system with three entities, whose organizational principles imply regionalized and hierarchical decentralization (Paim, 2008; Cohn, 2012; Brazil, 1990a, 1990b).

In the context of decentralization, the 1990s were marked by a strong process based on the municipal federative unit – municipalization – at the same time that, for the issue of human resources, essential guidelines for work in the SUS were abandoned, especially with regard to the rights and guarantees of workers, and a period that Machado (2005) described as the "lost decade for human resources in health" (Lavras, 2011; Santos, 2014; Axe; Ximenes, 2018).

From the 2000s onwards, an institutional movement gained strength to overcome municipalization and the conformation of a hierarchical model, organized in service networks based on the regionalization of health care in the country, reorienting the conformation of care units and networks of services articulated and referenced to the health regions (Brasil, 2001, 2002; Andrade, 2011; Viana, 2011; Santos, 2014; Santos, 2014; Axe; Ximenes, 2018).

In this context, the National Policy for Permanent Education in Health (2004) was instituted, implemented through the Centers of Permanent Education in Health, local and regional instances, inter-institutional, of collegiate management, which had the purpose of identifying the needs of the SUS regionally and proposing articulated strategies between Management, Education, Teaching Control, Sectoral Management, Care Practices, Social Control (Campos et al., 2006b; Sarreta, 2009; Cardoso et al., 2017; França et al., 2017; Santos, 2014; Axe; Ximenes, 2018; Souza; Costa, 2019).

For Ceccin (2005), this is a policy with a strategic role to consolidate changes in the SUS, without being limited to the management of the workforce. It consists of a complex proposal that begins with the need to develop new technologies to operate work, aligned with the notion of working in teams, the construction of daily routines and new care practices, with the worker himself as an object of individual, collective and institutional learning. It thus corroborates the understanding that Permanent Education in Health is the *"laeducacióneneltrabajo, por eltrabajo y para eltrabajoenlos diferentes servicios, cuyafinalidad es mejorarlasalud de lapoblación"* (Haddad; Roschke; Davini, 1994. p. 8).

With the establishment of the Pact for Health, in 2006, new guidelines were elaborated for the PNEPS, aimed at strengthening the process of overcoming regional inequalities based on the resignification of work in the SUS based on inter-institutional governance and regionalization, adapting the hierarchy of services based on Regionalized Care Networks that resize the relations between federated entities and require the establishment and articulation of a set of services to be based on the specific needs of the population, including workers appropriate to the needs of the

System (Brasil, 2007; Davini, 2009; Viana, 2010; Santos, 2014; Axe; Ximenes, 2018; Souza; Costa, 2019).

For Ouverney (2005), the integration between the subjects that make up such eclectic arrangements is more efficient when they manage to establish a pattern of interdependence in a network. An organizational phenomenon with fundamental aspects, such as composition by autonomous actors, interdependence and stable patterns of relationship, but also develops an institutionality specifically aimed at deepening the existing interdependence. Such institutionality is constituted from the intentional planning for the division of labor and for the strategic articulation aimed at delimiting the operation of the network, that is, it is defined by the planned collective work (Ouverney, 2005; Matos; Saints; Vieira, 2021).

Institutional theory investigates the establishment of arrangements, processes, strategies, perspectives and competencies, as they are structured based on patterns of interaction and organizational adaptation. Its analysis should proceed from everyday processes to the detriment of occasional events, and it should be common to all members of the organization. Therefore, institutionalized actions involve the definition of a certain number of roles within an organization, which concern the development of the role itself and the institutional need for conducts reserved for a certain actor. Thus, all institutionalized conduct involves a certain number of roles within the conduct or control of institutionalization. As the role is played, a socially defined body of knowledge is built (Berger; Luckmann, 1996; Tolbert; Zucker, 2007; Stanise, 2008).

With the resumption of the health regionalization process based on the sharing of decision-making power and the diversification of funding sources, a variety of multistructural arrangements of public policies emerge, whose greatest challenge is the establishment of mechanisms and strategies of integration and articulation that confer rationality and efficiency to such arrangements. The greater the sharing of structures in an organization, the greater the institutionalization, while the more fragmented and restricted, the lower the institutionalization. Its speed varies according to the type of organization, and there may be a supervisory authority in its structure that leads to the faster institutionalization of certain practices (Fleury, 2010; Stanise, 2008).

Therefore, to the extent that a basis of institutionality emerges, the pattern of interdependence is modified and no longer involves only the construction of interorganizational relations between the actors and starts to assume a pattern of interdependence in a network, guided, among other things, by the establishment of interorganizational coordination relations. Thus, to the extent that cooperation between federated entities goes beyond the ratification of agreements and consortia between parties and starts to assume a character of regional coordination, as in collegiate managers, health policies are established based on networks, with high degrees of interdependence and measurable associative patterns (Fleury, 2010; Ouverney, 2005).

Thus, in order to define the institutionalization of the Permanent Education Policy in Health, its implementation should be considered as a necessarily regional strategy, developed from deliberate planning for the division of labor and articulation between the three levels of government, educational institutions, workers' representative entities, education sectors and social control (Macêdo, 2016; Brazil, 2007).

In the EPS, the attributions common to the three spheres are: Formulating, promoting and supporting the management of the EPS; Mobilize and articulate with educational institutions and Education, in their respective scope, with the objective of inducing changes in undergraduate and graduate courses for the health professions; and Carry out the EPS process in cooperation between the entities, integrating all the processes of training and development of human resources to the policy of permanent education in their respective scope (Brasil, 2006; 2007).

Of these, perhaps the easiest to verify is the financial decentralization through ministerial ordinances, made possible through the elaboration of the Regional Plans for Permanent Education in Health (PAREPS) by the then Regional Managing Collegiate (CGR)* and the institution of the Permanent Commissions for Teaching-Service Integration (CIES), agreed upon in CIB and in accordance with the state's PDR (Cardoso et al., 2017; França et al., 2017; Souza; Costa, 2019; Brazil, 2007).

Considering these notes, it is concluded that the institutionalization of the PNEPS derives from the establishment of a pattern of interdependence, with parameters defined internally and externally, where the actors involved develop collectively planned actions, strategically elaborated with a view to achieving common objectives. This structure aims to integrate political forces so that the network develops, enabling the enhancement of actions and optimization of available resources.

In this study, an analytical structure is proposed that allows the understanding of the institutionalization of the PNEPS from its interinstitutional character, based on the sharing of responsibility and power to carry out strategies and actions of education at work essential to the consolidation of the SUS.

MATERIAL AND METHODS

The design consists of an exploratory analytical study, of a qualitative nature, which, according to Vieira-da-Silva (2014), are essential and precedents to a systematic evaluation of a program or policy. Its purpose is a systematic and preliminary examination of a program or policy, in its theory and in its practice. In this way, it can justify an extensive evaluation or subsidize the prioritization of critical areas in the evaluation.

For data collection, documentary research and narrative literature review were used.

The review was carried out in the Scientific *Electronic Library Online* (Scielo), Scientific and Technical Information in Health of Latin America and the Caribbean (Lilacs) and Virtual Health Library (VHL) databases, with the objective of gathering information about the formulation of this policy within the state sphere of SUS management, as well as the expansion of knowledge and composition of a diverse theoretical repertoire that supported the constitution of the analytical categories applied to documentary research.

Unlike a systematic review, it comprises a more open thematic approach, being characterized by the absence of a rigidly defined specific question, which makes it difficult to establish a rigid protocol for its elaboration. In this approach, the research of sources does not follow a predetermined and specific plan, often covering a smaller theoretical territory, while favoring the deepening of a certain position, since the selection of articles is influenced by the subjective perception plays a significant role (Cordeiro; Oliveira, 2007).

Despite this, it is a great mistake to assume unrestrictedly that "this category (...) allow the reader to acquire and update knowledge on a specific theme in a short period of time" (Rother, 2007, p. 1). On the contrary, in a scientific investigation, the narrative review enables the transgression of the "sampling period" and significantly expands the scientific framework that subsidizes the investigation. It repositions the researcher prior to the norms and convections that he proposes to delimit scientific thinking and doing.

Documentary research is very close to bibliographic research. The differentiating element is in the nature of the sources: the bibliographic research refers to the contributions of different authors on the subject, paying attention to the secondary sources, while the documentary research resorts to materials that have not yet received analytical treatment, that is, the primary sources. This is the main difference between documentary research and bibliographic research. However, in documentary research, the researcher's work requires a more careful analysis, since the documents have not undergone any scientific treatment before (Oliveira, 2007).

In the documentary stage, the Ministerial Ordinances that establish guidelines and allocate financial resources to PNEPS were analyzed; State Health Panels (PES), State Plans for Permanent Education in Health (PEEPS) and Annual Management Reports (RAG) in the public domain, made available by the State Secretariats of Health (SES) in an institutional virtual environment and in the Management Report Support System (SARGSUS) between 2007 and 2014.

In all, 40 documents were selected - 5 ministerial ordinances; 11 ESP; 12 PEEPS; and 22 RAG, whose criteria used were:

a) The redefinition of national guidelines and specific funding for the PNEPS in 2007, through Ministerial Ordinance No. 1,996;

b) The conditioning of the transfer of resources to the construction of the State Plans for Permanent Education in Health (PEEPS);
c) Interruption of funding by the Ministry of Health in 2011, establishing a three-year margin for the completion of actions initiated and/or reprogrammed by the States in the respective PEEPS.

Notwithstanding the conceptual and methodological discussions that involve the proposition of a permanent education policy for the health sector, in addition to objectively educational or educational actions, strategies for the qualification and structuring of and for work in the SUS were identified and analyzed, such as conversation circles, workshops or thematic meetings, implementation of participatory management spaces, seminars, among others.

To interpret the data, the analysis of the content of the constituted collection was used, describing and classifying the actions or strategies according to: number; realization or not; target audience; and as they are identified in the documents - Permanent Education, Health Education, Distance Learning, Course(s), Training(s), Qualification, Education, Conversation Circles, Workshops, Seminars, Congresses, Training and Permanent Education in Health.

As this is a qualitative study, there was an analysis based on nominal variables, without any intention of establishing ratios or hierarchy between them, based on the national guidelines of the PNEPS, established by Ordinance No. 1,996/2007, in addition to extensive reading on the subject, establishing parameters to assess the proposed dimensions of analysis (TOBAR; YALOUR, 2004).

RESULTS AND DISCUSSION

With the support of the literature review, from the analysis of the content of the ministerial ordinances, the PES, the PEEPS and the RAG's, the following categories were constituted:

a) **Short Duration:** inter-institutional training activities linked to educational institutions with a pre-established duration and theme; Training: training activities of an intra-institutional nature, with pre-established duration and theme;
b) **Research:** Intra- or inter-institutional activities aimed at responding to a pre-established problem;
c) **Events:** exceptional short-term activities aimed at institutional integration or scientific purposes;
d) **Structuring Actions:** strategies aimed at changing the routines of services or institutions, for the integration-teaching-service (school network, for example), implementation of strategies or services and structuring or reorganization of the health network; implementation and/or coordination of the PNEPS; advice to collegiate bodies (CIR and CIB).

Subsequently, the proposition of an analytical structure for the characterization and evaluability of the PNEPS was constructed, having as a reference the development of an institutionality specifically aimed at deepening the interdependence in the network of the actors involved in its implementation.

MANAGERIAL FOCUS

Definition: Set of priority activities in interorganizational coordination.

Correlation with the Object: Through the managerial focus, the priorities of the PNEPS in the state were identified based on its form of organization. Based on national guidelines, the PNEPS can assume different levels of articulation and organicity, organizing itself both for the fulfillment of conditionalities to federal transfers and the execution of courses, as well as for the presentation of new arrangements for teaching-service-community integration, implementation of strategies for the reorganization of management and services.

Verifiable Component: Types of actions carried out; responsibility of the continuing education sector in health of the SES; and their priorities.

Based on the concept implemented by the Program for Technical Cooperation in Human Resources Development of the Pan American Health Organization (PAHO), the international relevance of this entity, created in 1902 as an organ for the promotion of technical cooperation in health in the Americas, was considered. Its mission is to organize strategic collaborative efforts among countries to promote equity in health, combat diseases, improve quality of life, and increase life expectancy for the populations of the Americas (Castro, 2009).

The program abandons the proposal of continuing education for health teams and for the region, following a traditional academic school model. The new conception considers that health work is developed from the practical application of specialized knowledge acquired at the university, without the intention of being continuous or following a constant logical sequence, remaining centered on professional categories and not on health work (Souza et al., 1990).

Although training plays an important role in the quality of services and in the change of individuals, "trainingism" alone does not solve all the problems arising from a lack of knowledge, skill and expertise. In addition, isolated training of health problems, relationships and the organization of the work of health teams are not the best strategies to solve such problems (Davini, 2005).

EMPHASIZED OBJECTIVES

Definition: Focus of objectives of the actors involved in interorganizational training.

Correlation with the Object: Even organized in a single document, the actions and strategies foreseen in a plan can be more or less individualized. Analyzing this element allowed us to verify how articulated the proposals are and whether they consider regional needs or follow the determinations of one of the actors.

Verifiable Component: Target audience of actions and strategies; type of actions (courses, training, events, research or structuring actions); relationship with other health policies.

The return of the PNEPS to the government agenda boosted a national movement to defend and reaffirm its relevance and importance for the qualification of work in the SUS. The analysis of the policy implementation process in the different regions of Brazil revealed the heterogeneity of the states and the varying levels of implementation of PEH, as indicated by the reports of the regional workshops held in 2017 (Pinto; Teixeira, 2022).

Among the challenges identified for the implementation of the policy, the need to institutionalize the planning of PHE actions and implement a system for monitoring and evaluating the PNEPS stands out, unanimously among the states. This system must include clear definitions of the responsibilities of each level of government, guarantee the autonomy of decentralized spaces, promote dialogue between different levels, count on the participation of various actors and articulate with the management bodies of the SUS (Pinto; Teixeira, 2022).

The process of elaborating the PHE plans, therefore, represents a great opportunity to advance in the implementation of the policy, imprinting a strategic rationality of management and evaluation. At the same time, it qualifies and technically supports the teams responsible for monitoring and managing the EPS in the states. In addition, the institutionalization of a process of monitoring and evaluation of the planning and execution of state PHE plans can contribute significantly to the institutional development of this area within the SES and, consequently, to the improvement of SUS management (Pinto; Teixeira, 2022).

INTERNAL SPACES OF AGREEMENT

Definition: Form of action of political support units aimed at composing decision-sharing strategies, promoting consensus and hegemonic projects, in addition to preventing blockages and impasses.

Correlation with the Object: In addition to the formal existence of collegiate bodies, the identification of the internal spaces for agreement of these bodies allowed us to analyze the articulation of regional proposals for the composition of a state proposal. Once the challenge of individual action has been overcome, it is essential for the state to articulate based on its various regions and realities.

Verifiable Component: Existence of state CIES; participation of regional CIES in the state CIES.

In view of the process of decentralization of policy and the deconcentration of resources, it is possible to understand that it is a process of transfer of operational power and necessary resources from a higher level to another level of decision and execution. However, Stanise (2008) observes that the simple decentralization of responsibilities accompanied by the deconcentration of resources can only characterize the physical dispersion of activities and financing by the Ministry of Health.

Viana (2010) analyzed the PNEPS from the institution of the Pact for Health (2006) and concluded that the success of the policy was directly related to the structuring of the CIES and the CGR, and that it should be organized around the decentralization of health with strategies to strengthen the SUS based on the qualification of workers. It also reestablishes the articulating role of the states in the conformation of the CGR, which could be considered "the great novelty introduced by the Pact" and an instance for the construction of regional consensus between municipalities and states capable of carrying out the regionalization of health.

The research analyzed the Regionalization Stage and the Levels of Institutionality of Permanent Education, assuming as parameters the guidelines established by the Pact for Health and by the GM/MS ordinance No. 1,996/2007. It was found that, at that time, approximately 15% of the Brazilian states were in a stage of incipient regionalization and low institutionality of PEH, while about 22% had an advanced stage of regionalization and high institutionality of PEH. The other states were in intermediate stages (Viana, 2010, p.12).

Finally, Viana (2010) concludes that there is a high and positive correlation between the levels of regionalization and the institutionalization of the PNEPS, to the extent that the advanced regionalization stage corresponds to the high institutionality of continuing education. Therefore, the integration of regionalization through the CGR and the PNEPS through the CIES should be encouraged.

Such strategies require the articulation of state and national policy guidelines, through bottom-up mechanisms, for the construction of strategies for the transfer of intergovernmental financial resources, for collegiate decision-making of policies and systemic functions, for the institutionalization of mediation instances and the construction of intergovernmental agreements at the three levels of government, in addition to other elements essential to the organicity of the SUS (Fleury, 2002).

Thus, it is verified that the interorganizational composition constitutes a constant challenge in the implementation of health policies, which consists of the integration between the various actors of the system through the articulation of resources and organizational bases of decisions that confer rationality to the guidelines and policies (Fleury, 2009).

STRATEGIC INSTANCES OF INTERORGANIZATIONAL COORDINATION

Definition: Form of action of organizational units (instances) aimed at articulating and integrating resources in an efficient and flexible way, in addition to conducting decision-making support mechanisms (analysis of studies, information, reports, etc.).

Correlation with the Object: For its implementation, the national guidelines of the PNEPS determine the participation of several segments, in addition to state and municipal managers. Their participation contributes both to the strengthening of collegiate bodies and to the effectiveness of planned actions, which tend to be more comprehensive.

Verifiable Component: Participation of the State Health Council; participation of workers in the elaboration of actions/strategies.

The need to respond to training demands in a massive way leads the program to consider the development of various types of strategies based on the articulation between educational institutions, services and technological innovations, in the expectation of developing new reflections and proposals to strengthen continuing education in health. It is necessary, however, to pay attention to the origin of the institutions involved and to highlight the genesis of the mechanisms that can transform them into forces that oppose what is desired. An example of this is the role of educational institutions and the way they are organized, as well as their involvement with the issue of human resources for health.

How and through whom these initiatives are hired or promoted has a significant degree of importance, since these people or organizational instances represent different interests. This leads us to questions about the agents external to the educational process, since most of the time the emergence of these processes does not come from internal initiatives, or may not be sustained as such in practice. It is important to consider the existence of a transformation project with promoting agents who, even with the ideology of more "horizontal" cooperation, are still actors of a subjective and particular nature, gathered in a group or institution. In some cases, continuing education may not be so "permanent", especially if it disregards the antecedent conjuncture, the history and culture of the groups, and the role of accompanying a part of the process is more pertinent, while the process itself must be self-sustaining (Baquera, 1990; Haddad; Roschke; Davini, 1994; Merhy et al., 2006).

Finally, we can consider continuing education a modality of institutional intervention. It is a technical and simultaneously political activity that seeks to intervene directly on the health work process and, teleologically, on the health situation of a population, based on determinants and characteristics of the organizational model and the forms of relationship between services and society (Haddad; Roschke; Davini, 1994). It is configured as a strategy for changing the work process from the context of work itself, through educational processes whose central axis is problematization

ACTORS INVOLVED AND BREADTH OF INSERTION

Definition: Level of power of the actors involved in the organizations that make up the interorganizational formation and the extent of insertion of these organizations in the composition of the arrangement.

Correlation with the Object: Since the PNEPS is a policy that must be operated from collegiate instances, of which CIES deserves to be highlighted for its interinstitutional character, the plurality and involvement of the actors are essential. Thus, this element of analysis made it possible to measure the number of segments involved in conducting the PNEPS. From a poorer composition, with tendencies towards centralization of decisions, to a broad composition, with tendencies towards operational slowness.

Verifiable Component: Composition of the CIES.

According to Lavras (2011), the Management Pact required greater understanding of the System and the potential of regional planning and articulation, as it made the agreement between the managers of the three spheres of government more flexible through inter-federative agreements aimed at strengthening the regional capacity to respond to the health needs of its population. Seeking, therefore, to ensure social equity, based on the agreement between municipal and state managers, of flows of local and regional intermunicipal references aimed at structuring regionalized health care networks.

Thus, Permanent Education is reiterated as a central strategy to face the issue of human resources for the SUS. However, it is resized and new actors are directly responsible for facing the issue, both from the perspective of structuring work and in the qualification of SUS workers.

FOCUS OF POWER

Definition: Configuration of decision-making arrangements and distribution of power.

Correlation with the Object: As provided for in the PNEPS guidelines, PNEPS resources can be transferred to the FU and/or health regions, as long as such agreements are approved in the CIB. However, the decentralization of financing can indicate both the strategic organization of the actors and the complete disarticulation of actions.

Verifiable Component: Form of elaboration of the PEEPS (CIR + SES; SES; CIR); existence of PAREPS not foreseen/articulated with the PEEPS.

Based on the framework of institutionalization and network interdependence, the criteria and norms assumed in this work are related to the regional character, which, for Fleury and Malfort (2007), consists of a dynamic process, preceded by the joint action of several actors (municipalities and states) that converge in favor of a process of rearticulation of the resources available to a health region/micro-region. Thus, regionalization consists of a process of recognition and deepening of

relations of interdependence between organized actors, with the potential for collective work proportional to the legitimacy of the interorganizational dynamics (Ouverney, 2005).

Institutional theory investigates the establishment of arrangements, processes, strategies, perspectives and competencies, as they are structured based on patterns of interaction and organizational adaptation. Its analysis should proceed from everyday processes to the detriment of occasional events, and should be common to all members of the organization (Stanise, 2008).

Thus, institutionalized actions involve the definition of a certain number of roles within an organization, which concern the development of the role itself and the institutional need for conducts reserved for a certain actor. All institutionalized conduct involves a certain number of roles within the conduct or control of institutionalization. As the role is played, a socially defined body of knowledge is built (Berger; Luckmann, 1996).

The greater the sharing of structures in an organization, the greater the institutionalization. On the other hand, the more fragmented and restricted, the lower the institutionalization. The speed of institutionalization varies according to the type of organization, and there may be a supervisory authority in its structure that leads to the faster institutionalization of certain practices (Stanise, 2008).

With the resumption of the health regionalization process based on the sharing of decision-making power and the diversification of funding sources, a variety of multistructural arrangements of public policies emerged, whose greatest challenge is the establishment of mechanisms and strategies of integration and articulation that confer rationality and efficiency to such arrangements (Fleury, 2002).

For Ouverney (2005), the establishment of strategically planned actions with a common purpose, based on the establishment of formal commitments related to collectively agreed goals and the constant and long-term exchange for the optimization of available resources, characterizes the existence of a network structure. This organizational phenomenon develops an institutionality composed "around the deliberate planning of the division of labor and the strategic articulation aimed at manipulating the environment in which the network operates, that is, the network develops through specifically planned collective work" (Ouverney, 2005, p.97).

In the same direction, Stanise (2008) states that institutionalization is the process of incorporating evaluation into the routine, constituting a process by which an organization is widely established, recognized and universally accepted. The actors that compose it operate based on expectations that it will prevail in the foreseeable future, with institutionalization being the mechanism that confers value and stability to the procedures and to the organization itself.

In other words, to the extent that a basis of institutionality emerges, the pattern of interdependence is modified and no longer involves only the construction of interorganizational

relations between the actors and starts to assume a pattern of interdependence in a network, guided, among other things, by the establishment of interorganizational coordination relations. Thus, to the extent that cooperation between federated entities goes beyond the ratification of agreements and consortia between parties and starts to assume a character of regional coordination based on collegiate managers, health policies are established based on networks, with high degrees of interdependence and measurable associative patterns (Brasil, 2006; Fleury, 2002; Ouverney, 2005).

RESOURCES INVOLVED

Definition: Amount of resources directed to collective activities and their form of management.

Correlation with the Object: The PNEPS is a policy instituted essentially by federal guidelines and transfers. Thus, it is important to identify both the characteristics of its financing and the political-institutional resources for the execution of its actions, as well as who dominates them.

Verifiable Component: Functional link of the Executive Secretary or equivalent; percentage of federal resources executed; legal-administrative mechanisms available for financial execution (bids, agreements, contracts, foundations and/or others).

To define the institutionalization of the Permanent Education Policy in Health, its implementation can be considered as a strategy that should be developed regionally based on deliberate planning for the division of labor and articulation between the three levels of government, educational institutions, workers' representative entities, education sectors and social control.

In general, the attributions common to the three spheres are: to formulate, promote and support the management of PEH; mobilize and articulate with educational institutions and education, in their respective scope, with the objective of inducing changes in undergraduate and graduate courses for the health professions; and carry out the EPS process in cooperation between the entities, integrating all the processes of training and development of human resources into the policy of permanent education in their respective scope (Brasil, 2006).

However, four issues are not entirely common among the entities in the Pact for Health, namely: a) The approximation of popular health education movements to the training of professionals is attributed only to the municipalities; b) The strengthening and articulation between the municipalities, establishing references for the training processes and linking the municipalities to them, are attributions of the states; c) The execution of actions aimed at technical training in a decentralized manner is attributed only to states and municipalities; and d) The funding, which is allocated to the Federal Government, with the participation of the municipalities, does not constitute an attribution of the states.

Among these, perhaps the most easily observable is the financial decentralization of the PNEPS in line with the principles of the SUS. Especially with regard to the federal sphere, which transferred approximately one hundred and forty million reais to the Northeast Region of the country through ministerial ordinances between 2007 and 2011, as can be seen in ANNEX B.

To this end, the allocation of such resources is conditioned to the elaboration of the Regional Plans for Permanent Education in Health (PAREPS) by the Regional Collegiate Managers (CGR) and to the institution of the Permanent Commissions for Teaching-Service Integration (CIES), agreed upon in CIB and in accordance with the state's PDR (Brasil, 2007).

CONTROL FOCUS

Definition: A form of monitoring collective work and promoting accountability of the resources employed.

Correlation with the Object: The focus of control makes it possible to identify the instruments for monitoring the planned actions. More than that, it makes it possible to identify whether this is a secondary and disjointed activity for the collegiate bodies or if it is an exclusive attribution to one of the entities.

Verifiable Component: Records of the execution of actions provided for in the EPS plans; mechanisms and periodicity for monitoring and accountability of the goals and actions provided for in the EPS plans (CIR, SES and/or CIB).

According to Gonçalves et al. (2019), the analysis of the PNEPS implementation process revealed great heterogeneity in terms of progress in Permanent Health Education (PEH) among the states. While some states were in the early stages of implementation, others have made significant progress, even in the face of challenges. Most, however, still in 2018, were at an intermediate level, developing PHE actions in a fragmented manner, without an integrated planning that would guide a continuous action aimed at improving work processes at the various levels of the system.

Among the problems identified in the process of implementing the PNEPS, despite the heterogeneity found, "problem areas" common to all states stand out, regardless of the degree of development of management, planning, programming and execution of PHE actions. In particular, the monitoring and evaluation of PHE activities is identified as a widespread difficulty. The absence of indicators that go beyond the mere quantification of courses and other activities carried out was a recurring issue. Additionally, the lack of a National PNEPS Management System, which would feed an information bank on the actions developed in the states and municipalities, was also mentioned as a significant limitation (Gonçalves et al., 2019).

These weaknesses in the monitoring and evaluation process fostered the elaboration of a project by the Institute of Collective Health (ISC) of the Federal University of Bahia (UFBA), sent to

DEGES, aiming at the development of a theoretical-methodological proposal for the monitoring and evaluation of the PNEPS. It was assumed that the agreed construction of indicators for the monitoring of the PNEPS is crucial for the strengthening of the policy and definition of strategies for the development of permanent education in the states (Pinto; Esperidião, 2022).

Monitoring and evaluation are complex issues that involve the definition of criteria and indicators, both quantifiable and non-quantifiable, to evaluate reality in a reliable and undistorted way. The discussion process with the states took into account the challenges inherent in the policy implementation process (Gonçalves et al., 2019; Dick; Espiridião, 2022).

In addition, management processes and training/educational processes are intertwined in the development of policies, strategies and procedures to face, reorient, adjust, innovate and/or transform the daily work in the health sector. These processes can stimulate and support new forms of relationships and partnerships between professionals, institutions, and users of health services, strengthening their bonds and commitments to the necessary changes in the construction of the SUS (Gonçalves et al., 2019; Dick; Esperidião, 2022).

CONCLUSION

The proposition presented here focuses on the interfederative regional character and the interinstitutional PNEPS and seeks to subsidize analytical and evaluation studies that are more appropriate to its structure, which, in an extremely particular way, does not only mobilize traditional actors in the management of the SUS, but also the health councils, in addition to evoking the participation of public and private educational institutions to carry out training actions and structure networks within the territory of health of the states – health regions – involving workers from different origins, bonds, categories, levels of care and management, for the construction and resignification of health work based on the multiple realities of the territories and services.

Far from exhausting the discussions about the policy in question and much less the construction of regionalized policies, the results presented are potential to deepen the analysis of the institutionalization of a genuinely regional policy, as it presents important elements that contribute to analytical and evaluative processes, in addition to providing a set of elements and provocations to scholars in the area.

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