THE "HUMANIZA SUS" POLICY: ANALYSIS AND REFLECTIONS FOR ITS EFFECTIVENESS

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ABSTRACT

This article presents the results of a research carried out in 2018 that analyzed the implementation of the National Policy for the Humanization of Health Care and Management (PNH) in a University Hospital (HU) in Rio Grande do Sul (RS) after its adhesion to the Brazilian Company of Hospital Services (EBSERH). Having used a qualitative approach, it was possible to conclude that the National Policy for the Humanization of Health Care and Management has a hybrid form, allowing an appropriation of its concepts by different societal projects and, in this case, the Neoliberal project represents one of the greatest challenges for its implementation.

Keywords: Unified Health System, Brazilian Company of Hospital Services, National Policy for Humanization of Health Care and Management, University Hospital.

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INTRODUCTION

This article presents the results of a research that analyzed the implementation of the National Policy for the Humanization of Health Care and Management (NHP) in a University Hospital (HU) in Rio Grande do Sul (RS) after its adhesion to the Brazilian Company of Hospital Services (EBSERH). It was carried out in 2018, linked to the research line "State, social rights and social policy" of the Graduate Program in Social Policy and Human Rights – Master's course, of the Center for Social and Technological Sciences of the Catholic University of Pelotas (UCPEL).

The study followed the dialectical-critical materialist method of qualitative approach of the subjects (workers, managers and users) involved with the PNH.

Thus, considering the need to cover the subjects involved in the implementation of the PNH, the quantitative and qualitative indicators referenced in the Ministry of Health document and in the indicators pointed out by the EBSERH guidelines, the total number of participants was 28 (twenty-eight) subjects, of these, 3 (three) are managers, 6 (six) are workers, 4 (four) are users and 15 (fifteen) are members of the GTH.

The instruments used were: questionnaire, semi-structured interview script and focus group. The first was applied to the 28 participants of the research. The second was applied with managers, workers and users. The latter was applied exclusively to the members of the GTH. These instruments were developed based on the guidelines of the PNH: Expanded and shared clinic, participatory management and co-management, welcoming, ambience, valuing the worker and defending rights (BRASIL, 2015).

It should be noted that the project was approved by the Research Ethics Committee of UCPEL and also by the Ethics Committee of the HU where the research was carried out, thus respecting the guidelines and standards that regulate Research on Human Beings – Resolution 466/2012 of the National Health Council. The study involved

For this analysis, we sought to identify health projects (sanitary or privatist reform) that are hidden in the subjects' discourses, as well as in the actions of the PNH of this hospital; to identify whether the different forms of employment contracts (Single Federal Legal Regime and Consolidation of Labor Laws) interfere in the implemented Humanization actions; identify whether humanization actions are responding to the demands of the user population or the Capital.

The theoretical framework used discussed the process of democratization and health policy in Brazil, providing a reflection on the disputes from the evaluative field of Health Reform and the Neoliberal tendency, followed by introductory elements about the PNH and bringing some categories of analysis such as work, humanization and praxis.

It is important to point out that the PNH is perceived as a hybrid outfit, which allows any strand or evaluative field - of whatever the civilizing project in dispute - to appropriate its concepts, with the neoliberal State being one of the greatest challenges for the PNH.

The results of the research indicate that the health care model present in the work processes and in the discourses of the subjects is close to the model that defends the idea of the "possible SUS" or "SUS that works" in the sense that it groups the principles of the health reform of the social democratic line, and evidences the supremacy of individual rights to the detriment of collective rights.

THE DEMOCRATIZATION PROCESS AND HEALTH POLICY IN BRAZIL

The process of redemocratization in Brazil, contrary to the political orientations of the world, built the foundations of the Federal Constitution of 1988 (FC), permeated by disputes between social classes, materialized in distinct and antagonistic societal projects.

In this scenario of dispute, during the transition from the dictatorial period to the process of Brazilian democratization, the health reform project in Brazil prevailed based on the legal framework in the 1988 Federal Constitution, where Health is recognized in the title of the Social Order and article 196 as a citizen's right and a duty of the State.

The Unified Health System (SUS), initially established by laws 8,080 of 1990 and 8,142 of 1990, is the model of health actions and services in Brazil. However, it is from the 1990s onwards that we have the emergence of the neoliberal orientation policy and the intensification of the tension between two distinct projects: the Brazilian Health Reform (RSB) model and the one linked to the market, or privatist.

It should be noted that the process of the Brazilian Health Reform (RSB) was consolidated as a social reform and not a health sector. Jairnilson Silva Paim (2012, p; 07) states that, "many times, associated with the SUS proposal, the RSB project, in reality, was broader than the SUS".

Paim (2007, p. 158) also mentions that by "irony of history, the parties and groups that opposed the Health Reform became responsible for the implementation of the SUS", and the scenario in which the Organic Health Law project was discussed was one of deep economic instability with hyperinflation and the State's fiscal crisis.

The process of redemocratization in Brazil, permeated by tensions generated by the antagonistic disputes present to this day, has suffered since the 1990s, a process of dismantling the rights provided for in the 1988 Federal Constitution, which, recently enacted, encountered political obstacles to its implementation, with health being one of the rights greatly affected by this dismantling. According to Sonia Fleury and Assis Mafort

Ouverney (2012), health policy, as a social policy, is subject to multiple, often contradictory, determinants. Thus, the analysis of a given health policy is based on the social relations that are found in the dialectical movement of the interface between the State, society, the market, and the disputes of societal projects. It is understood, therefore, that the PNH emerges within the dispute over the evaluative field of health policy. He presents himself in defense of the SUS and in accordance with the precepts of the Health Reform.

NATIONAL POLICY FOR THE HUMANIZATION OF HEALTH CARE AND MANAGEMENT: DISPUTES IN THE EVALUATIVE FIELD OF HEALTH REFORM AND THE NEO-LIOBERAL TREND

On the issue of humanization in Health, Marina de Castro Castro (2018), when discussing humanization in its "restrictive" aspect, and Talita Neulls (2016), who discusses the incompatibility of humanization in the face of the non-linking of dehumanization with the capitalist system, state that what exists is a crisis in the material and not evaluative spheres, that is, in the capitalist mode of production system and not in the values defended or employed in our society.

Considering that the Brazilian Health Reform is characterized as a civilizing project, and the PNH seeks to put into practice the principles of the SUS, which was constituted as an "incomplete health reform", it is necessary to reflect on the evaluative issue, since it is in this aspect that the societal projects in dispute are inserted.

Castro's (2018) criticism is that the PNH is not problematized within its limits, considering, for example, the issue of precarious working conditions and relationships and their fragmentation among health teams, as well as the difficulty of access to health services. At the same time, restricting this problematization to the capitalist mode of production - in the question: subject-nature, as Neulls (2016) does, also restricts the strategic character of the PNH in its scope of contribution to the RSB as a civilizing project.

This means that a civilizing project, or another societal project that is not capitalist, must be associated, concomitantly, with the development of a sanitary awareness, which can be developed within the evaluative field. Also according to Sonia Fleury Teixeira (2011),

> the concept of Health Reform refers to a process of transformation of the legal norm and the institutional apparatus that regulates and is responsible for the protection of the health of citizens and corresponds to an effective displacement of political power towards the popular strata, whose material expression is materialized in the search for the universal right to health and in the creation of a single system of services under the aegis of the State. The elements of this process are: The expansion of health awareness; The construction of an analytical paradigm from the disciplinary field called Social Medicine or collective health, organized from the notions of social determination of the health-disease process and the organization of practices; The development of a new professional ethic; The construction of an arc of political

> alliances in the struggle for the right to health; The creation of instruments of democratic management and social control over the health system (TEIXEIRA, 2011, p. 39-40).

In the capitalist system, investing in a field of value of another form of sociability also implies restrictions, limits and difficulties to overcome. Therefore, as much as it is recognized that, in the 1988 constitutional text, health is not linked to the market, we are clear that policies, programs and actions are intrinsically linked to the market system. In this sense, considering Nogueira (2002), when thinking about the expanded conception of health, it is necessary to recognize the intrinsic relationship between social and economic rights, that is, state intervention cannot be seen as independent of economic interests.

Therefore, in order to understand a little more about the disputes in question, now, in addition to the heterogeneity and contradictions of the sanitary movement, it is necessary to materialize the evaluative contradictions designed by the PNH from a civilizing project of the Sanitary Reform, from the tendency to the privatist project underway after 1990, with the advent of the productive restructuring of flexible accumulation or Toyotism. Thus, the contribution of Giovanni Alves (2007) follows.

> What we call Toyotism implies the constitution of a capitalist enterprise based on fluid production, flexible production, and diffuse production. Fluid production implies the adoption of organizational devices such as, for example, just-in-time/kanban or kaizen, which presuppose, on the other hand, as an essential nexus, the subjective fluidity of the workforce, that is, the proactive involvement of the worker or employee (ALVES, 2007, p. 158).

This author also adds that public administration service organizations tend to incorporate the values of "Toyotist neo-productivism", considering as its essence the search for "stimulated engagement" of work, especially of the "stable" worker, and states: "It is through the 'capture' of subjectivity that the worker or employee is able to operate, with relative efficiency, the series of technical-organizational devices that sustain fluid and diffuse production" (ALVES, 2007, p. 159).

We highlight the main evaluative dimensions, pointed out by Pereira (2016), represented by the binomials needs/preferences; rights/meritocracy. In relation to the first:

> The partisans of bourgeois ideologies, on the other hand, prefer to deny the existence of human needs in order not to admit the possibility of them being met by public policies. Thus, as already insinuated, they identify these needs, which are social, with individual preferences, if not with vices, desires and dreams of consumption, whose satisfaction would escape the commitment of the State. In this way, human needs have a subjective and relative character, since they cannot be shared by the social collective (PEREIRA, 2016, p. 59).

This is a crucial point in the conflict of the societal projects in dispute and one of the criticisms of Neulls (2016) and Castro (2018) and which places the PNH in approximation with the privatist health project, as it focuses a lot on the issue of the subjectivity of the subjects, or as Alves (2007) states, on their "capture". However, it is observed, when reading the other base documents for managers and workers, and other HumanizaSUS booklets and notebooks, that it is not only the issue of subjectivity that is discussed, because within the PNH there is an emphasis on the discussion of the participation of the subjects based on the inclusion of social movements and other collectives, hence its strategic character. As for the second evaluative binomial (rights/meritocracy),

> this type of rights, therefore, must be referenced in the values and principles inherent to public social protection, such as equity and social justice, and guaranteed or regulated by the State. [...] However, with the supremacy of neoliberal ideology – which despises the aforementioned values – social rights have been harshly dismantled and replaced by meritocratic logic (PEREIRA, 2016, p. 64).

Inês de Souza Bravo, Elaine Junger Pelaez and Wladimir Pinheiro (2018), point to the expansion of the projects in dispute. If before it was "health reform" and the "privatist model", today there is already the defense of the "possible SUS". Thus, with the study on the PNH, it is identified that it is close to the defense of the possible SUS or the SUS that works and, here, it is associated with the social democratic strand, which does not seek to overcome the capitalist system, thus imprinting the main difficulties of effectiveness of the PNH. However, this "new" project is also threatened by the project of the private market, because,

> the solidary, collective and universal values proposed by the health movement are being replaced by individualistic, corporative and focalist values, strengthening the market-oriented project and consolidating the SUS only for the poorest (BRAVO apud BRAVO; MARQUES, 2013, p. 211).

Based on the contributions of Maria Inês de Souza Bravo and Morena Marques (2011), it is possible to affirm the complexity we find ourselves in, considering that it is from the SUS that a policy of universal access is materialized. However, underfunding linked to the restriction of public funding for health reduces the capacity to promote this access.

To better understand the reflections on the field of value, whether it is a tendency towards BSR or neoliberalism, it is essential to understand a little about the PNH and its categories of analysis.

THE NHP AND ITS ANALYSIS CATEGORIES

The National Policy for Health Care and Management - PNH or HumanizaSUS as it is better known - emerges, according to the base document for managers and workers, as a movement to change the SUS care and management model and is structured based on principles, methods, guidelines and devices.

> By humanization we mean the valorization of the different subjects involved in the health production process: users, workers and managers. The values that guide this policy are the autonomy and protagonism of the subjects, the co-responsibility among them, the establishment of solidarity bonds, the construction of cooperation networks and collective participation in the management process. (BRASIL, 2010, p. 4)

It is observed that the category "work" is highlighted in this policy, both in terms of the training of those who provide care to users, as well as in the working conditions (or rather, their precariousness) and management of work processes (resources/capital).

It is a policy that is defined as transversal to the entire SUS network and that intends to qualify it, because the PNH does not aim to change the structure of the capitalist system, but is characterized as strategic in the sense of changing the ways of thinking, managing and caring for health.

> If, on the one hand, we can point to advances in the decentralization and regionalization of health care and management, with an increase in the levels of universality, equity, comprehensiveness and social control, on the other hand, the fragmentation and verticalization of work processes fray the relations between the different health professionals and between them and the users; Teamwork, as well as preparation to deal with the social and subjective dimensions present in care practices, is weakened. (BRASIL, 2004, p.5)

The qualification refers to the understanding that the SUS, despite the difficulties, managed to incorporate the concepts of decentralization and regionalization of health care and management based on the principles of universality, equity, integrality, as well as social control measures – health councils. However, the PNH (BRASIL, 2004) points out that the model of training health professionals remains distant from the debate and formulation of public health policies, a limit that the SUS encounters by not guaranteeing horizontality in the health work processes, perspectives that the PNH proposes to achieve.

It is observed that the basis for the need to create this policy is the fragmentation and verticalization of work processes, as well as the point that there is no investment in the qualification of professionals in the following areas: participatory management, teamwork and formulation of public health policies.

By recognizing the expanded concept of health proposed by the World Health Organization on the one hand and the weaknesses of care practices on the other, it is

understood that the process of horizontality is complex, considering that health actions, in order to occur fully and in an interdisciplinary way, must permeate the different professionals in the health area, which are coated with a plurality of ideas and concepts that direct the production of health of the subjects.

Based on this, the PNH highlights as necessary and urgent an approximation between management and health care combined with the training of health professionals.

Considering the article by Rogério Miranda Gomes (2012) that dialogues with the Marxian tradition and the reading of Neulls' (2016) dissertation, some concepts/understanding and/or interpretations of the category "humanization" were identified, expressed in four ways, as shown in chart (1) below.

Chart 1 – Concepts/interpretations of what Humanization is

Humanization from the relationship complaint/conduct (prior to policy)	Humanization from language and communication (PNH)	Humanization from the overcoming of the capitalist mode of production	Humanization from the humanization-alienation dialectic
Assistentialist, paternalistic view, in which focused and verticalized actions prevail, without interaction between the subjects.	A view of the PNH itself, where it directs exclusively to the subjects the transformations of the forms of care and health management.	It starts from the idea of the ontology of the social being, of the process of humanization of man in a human race and of the capitalist mode of production as a producer and reproducer of objectified social relations.	It starts from the idea that "Never humanization or alienation, but always "humanization-alienation"" - united by social relations. Constitution of subjects permeated by "self-consciousness", "self-determination" and "omnilaterality".

Table elaborated from the discussion about the concepts of humanization discussed in the dissertation of Talita Fernandes Neulls and critical reading of the article by Rogério Miranda Gomes.

It is important to highlight here that both authors, Neulls (2016) and Gomes (2012) start from the Marxist contribution of the constitution of the social being, however, it was observed that while Neulls, (2016) and Castro (2018) dedicate themselves and limit themselves to problematizing man as a subject and nature as an object, Gomes (2012) advances in the dialectical relationship of humanization-alienation and includes in the debate the issue of praxis, of subject-subject relations.

However, the approach of Castro (2018) and Neulls (2016, p.11) is pertinent, where they criticize the way in which the PNH excluded the "questioning of the social structure, or the unequal way in which social relations are configured in the capitalist mode of production".

Thus, analyzing the implementation of the PNH confronts us with the controversial and recurrent category of "humanization" in the debate in the health area, as it immediately evidences the recognition of (un)human relations that occurs in institutional health spaces.

Considering that "Work" and "humanization" are categories that are dialectically related, these will be reflected in his movement. Karl Marx (2017) warns us that:

> Work, as a creator of use values, as useful work, is indispensable to the existence of man – whatever the forms of society – it is a natural and eternal necessity to effect the material exchange between man and nature and, therefore, to maintain human life. (MARX, 2017, p.64-65).

Thus, it is understood that it was from work that the human species was constituted, as a new type of being, the social being. The history of how the social being develops can be described as the process of humanization of men. Thus, José Paulo Netto and Marcelo Braz (2012) reveal that:

> The process of constitution of the social being has its starting point in the peculiarities and demands posed by work; From these requirements [...]: theologically oriented activity, the tendency towards universalization and articulated language), the subjects of work experience a multimillennial process that ends up distinguishing them from nature: the process of humanization. (NETTO; BRAZ, 2012, p.51)

These authors point out that man, when transforming nature, began to transform himself, and the question of knowledge about nature is pertinent in this process, stating that communication and articulated language are forms in which "the subject of the work expresses his representations about the world that surrounds him". The language articulated from its communication externalizes and enables the choice between alternatives thought and reflected, that is, humanization.

> The advancement of the humanization process can be understood, therefore, as the differentiation and complexification of the objectifications of[3] the social being. Work appears as the primary and ineliminable objectification of the social being, from which the needs and possibilities of new objectifications arise, through increasingly complex mediations. (NETTO; BRAZ, 2012, p. 52-53)

In this sense, it is understood that although work is constitutive of the social being, it is not reduced to work. For Netto (2012, p. 55) "the development of the social being implies the emergence of a rationality, a sensibility and an activity that, on the necessary basis of work, create their own objectifications". For Netto, it is through praxis that the social being reveals his creativity, projects and realizes the material and ideal objectifications of a world of products, works and values.

However, in the social relations of capitalist society in which the exploitation of labor prevails, exploitation of man by man, in its various presentations (liberalism, social

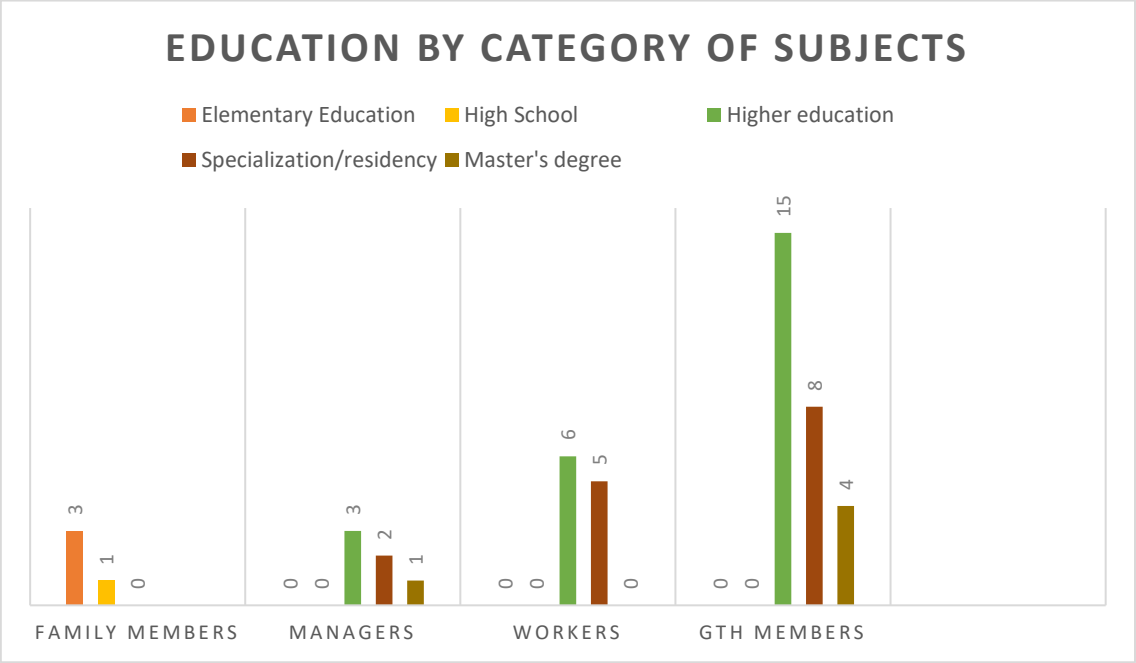
[3] For Netto (2012) about objectification: material transformation of nature, from idealization (mentally in his brain), before carrying out the activity of work.

democracy, developmentalist, neoliberalism) what happens is that the objectifications produced are not presented as creativity produced by man himself, but as something external, in which he creates life and his own value, in view of the limits arising from the priority given to the market. In this way, profitability, economic opportunities prevail, making living conditions more precarious, being more important than working conditions and forms.

RESULT AND FINAL CONSIDERATIONS

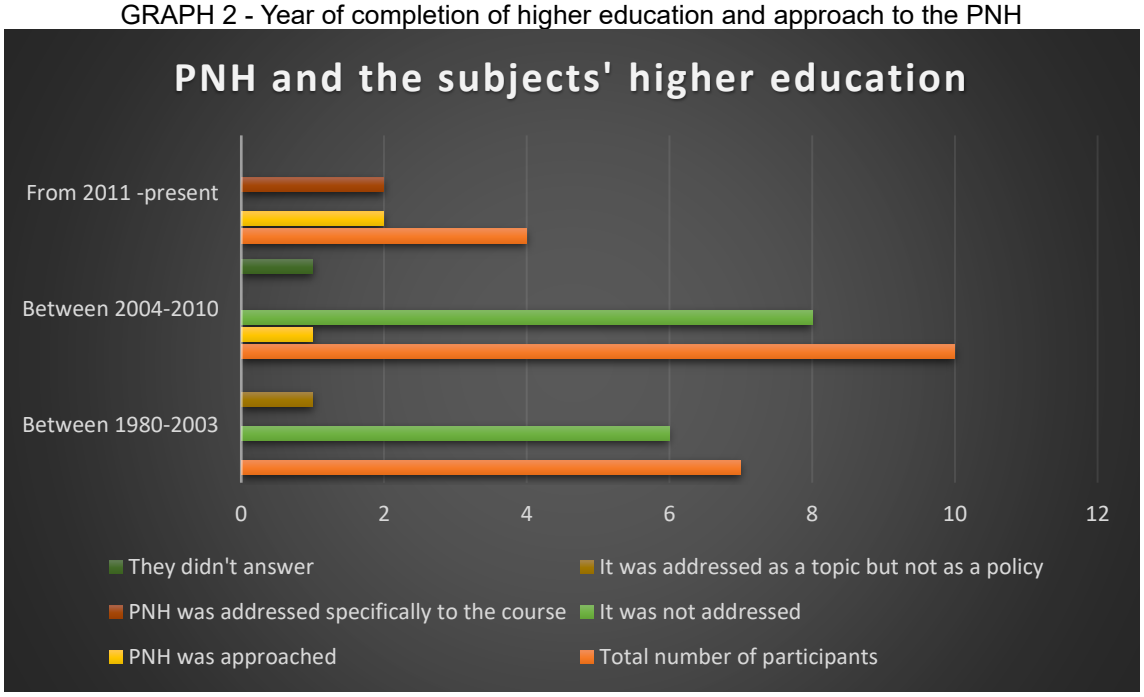
In relation to the results, we highlight, in graph 1, the heterogeneity of the level of education, pointing out the inequality, responsible for the asymmetries existing in the power relations between the research subjects and which infers in the values that guide the PNH, such as the autonomy and protagonism of the subjects.

GRAPH 1 – Education by category of subjects



Another aspect to be highlighted, in view of the need for approximation between management and health care, combined with the training of health professionals, the results of the research show that participants graduated between 2004 and 2010 did not have the PNH addressed in their courses, and the 2011 undergraduates saw aspects relating Humanization to their professional practice. It is thus revealed that professionals start to hear about the PNH when they start working in the health field. In the following graph (2) we can see the year of completion of higher education and the approach to the PNH.

GRAPH 2 - Year of completion of higher education and approach to the PNH



In Graph 2, it is imperative to highlight that humanization, as a policy, only began to be recognized in 2003, which is why the participants who completed their course in the period from 1980 to 2003 reported not having been addressed. It is noteworthy that only one interviewee who graduated in the period said he had been discussed about the issue of humanization as a theme. It is interesting to think that the participants graduated in this period may also have heard about humanization, but not have revealed this information, given that the question referred to humanization as a policy. The importance of bringing this information is that humanization as a policy, as we know it today, brings in its precedents humanization initially as a program (2001), based on the claim of social movements and users of health policies, still in the 1970s.

Considering the results from the participants who manage the PNH, humanization is seen as a program associated with EBSERH and with the objective of qualifying the process from a vertical bias for its implementation and does not necessarily have the intention of changing a culture (of health care and management).

Only the Public Governance Meeting was identified by the management participants as a space for "Co-Management and Participation", but this does not necessarily have the participation of workers and does not constitute a deliberative space, unlike the GTH, which is expected to play this role, but is not recognized by the research participants in general, as a space for this purpose.

The users brought up the issue of humanization, within the complaint-conduct conception, as individual behaviors. Although these participants pointed out structural issues that need change, they were tolerant and understanding of the ideology of the

"health crisis". The difficulty of communication between users and workers and access to health as an individual and not a collective right was identified. They also highlighted negative reactions from professionals to the detriment of users who sought protagonism and co-responsibility in care.

In relation to the worker participants, some statements gave visibility to the fragmentation of workers by different work regimes, workload, among other aspects. The lack of salary equality defended by the Health Reform was also identified, as well as the emotional fragility that these differences can potentiate at times in the work environment, reiterating the fragility of the environmental guideline evidenced by the managers, adding issues alluding to the privacy of users, which does not exist.

Only one of the interviewees was aware of the expanded and shared clinical guideline and the singular therapeutic project device provided for in the PNH booklet. The unfolding of the answers suggests that the users are not perceived as integral subjects, the professionals are organized by disciplines and conduct the care in a still fragmented way.

In this study, we identified that the health care model present in the work processes and in the discourses of the subjects is close to the model that defends the idea of the "possible SUS" or "SUS that works", in the sense that it groups the principles of the health reform conditioned to the privatist perspective, and is aligned with the health reform of the social-democratic line, within the discussion carried out in the theoretical framework, evidencing the supremacy of individual rights to the detriment of collective rights.

Although several provisions of the PNH have been implemented, such as open-door management, ombudsman, risk classification, we can say that it has not been implemented as a policy. We observed that the devices linked to the guideline of participation and co-management, as well as the environment, and the expanded and shared clinic, are not very effective.

The PNH is defended here with a strategic potential for the implementation of the SUS, however, it was revealed that the EBSERH has the capacity to interfere in the implementation of the PNH, given that it materializes structural changes in the management of the SUS through the privatist bias.

Considering that the PNH has existed for 21 years, it can be said that it has not been able to prevent the transition from the rule of law to the neoliberal state and, for this reason, does not infer a change in the capitalist mode of production. We realize that the PNH has a hybrid outfit, which allows any strand or evaluative field, of whatever the civilizing project in dispute, to appropriate its concepts.

We conclude that the right to information, privacy, communication between users and professionals, as well as between professionals and management, and the implementation of the provisions of the expanded and shared clinical guideline continue to be the greatest challenges for the implementation of the PNH.

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