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National Humanization Policy as a commitment to collective production of changes in management and care methods

Política Nacional de Humanização como aposta na produção coletiva de mudanças nos modos de gerir e cuidar

Política Nacional de Humanización como apuesta en la producción colectiva de cambios en los métodos de gestión y cuidado

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ABSTRACT

Construction of the Brazilian National Health System (SUS) is inscribed as a process of striving to affirm healthcare as a substantive social value for Brazilian society. The SUS has produced reforms in the healthcare sector, while at the same time giving rise to ethical, cultural and political changes. Over two decades of experimentation, the SUS has achieved changes and conserved characteristics that have marked Brazil as one of the countries with the greatest inequality of access. The National Humanization Policy (NHP) was constructed with the dual recognition that the SUS works well in some respects, but in other respects, there are problems and contradictions that need to be addressed. To achieve this, the NHP organizes a set of concepts, methods and devices to confront the problems that remain limits on healthcare services and practices.

Keywords: Humanization. Public healthcare policies. Health System. Healthcare. National Humanization Policy.

RESUMO

A construção do Sistema Único de Saúde (SUS) se inscreve como processo de luta para a afirmação da saúde como um valor social substantivo da sociedade brasileira. O SUS tem produzido uma reforma na saúde ensejando, ao mesmo tempo, mudanças éticas, culturais e políticas. Em duas décadas de experimentação o SUS tem realizado mudanças e conservação de características que marcaram o Brasil como um dos países com maior iniquidade no acesso. A Política Nacional de Humanização (PNH) se constrói no duplo reconhecimento de que há um SUS que dá certo e que há problemas e contradições que necessitam ser enfrentados e, para tanto, organiza um conjunto de conceitos, métodos e dispositivos para o enfrentamento de problemas que ainda permanecem como marcas dos serviços e práticas de saúde.

Palavras-chave: Humanização. Políticas Públicas de Saúde. Sistema Único de Saúde. Cuidado em Saúde. Política Nacional de Humanização.

RESUMEN

La construcción del Sistema Único de Salud (SUS) en Brasil se inscribe como proceso de lucha para la afirmación de la salud como un valor social substantivo de la sociedad brasileña. El SUS ha producido una reforma en salud dando oportunidad, al mismo tiempo, a cambios éticos, culturales y políticos. Eh dos décadas de experimentación, el SUS ha realizado cambios y oonservación de características que habían convertido Brasil en uno de los paises con menor equidad en el acceso. La Política Nacional de Humanización (PNH) se construye en el doble reconocimiento de que hay un SUS eficiente y de que hay problemas y contradicciones que es necesario afrontar y, para tanto, organiza un conjunto de conceptos, métodos y dispositivos para afrontar problemas que permanecen aún como marcas de los servicios y prácticas de salud.

Palabras clave: Humanización. Políticas Públicas de Salud. Sistema Único de Salud. Cuidado en Salud. Política Nacional de Humanización.

INTRODUCTION

Debating the humanization of healthcare is an attitude that invites us to reflect, to generously criticize the construction of a Brazilian National Health System (*Sistema Único de Saúde*, SUS) that is ever more powerful at expressing the public interest and common good.

Placing the Humanization Policy of the SUS in question is movement towards opening. Opening to alterities, as also incurred by those who forge the way, giving passage and opening passage; influencing and being influenced. Synthesis is proposed, of displacements, of the construction of common perceptions, permitted by the encounter with difference; but also the ratification of differences, disagreements and nonagreements.

Courage, generosity, giving way, allowing oneself to be touched by the difference to dissent, solely for the purpose of improving the public health system. This is an ethical-political commitment that unites many individuals who, through their reflections and practical actions, are intent on qualifying services and health practices in the defense of life, improving our experience of living in society. Above all else, talking about the humanization of healthcare practices poses the need to make certain distinctions regarding the constitution of public health policy, seeking to understand the meaning of its commitments. Based on this understanding, it is thus possible to define the role and action of the National Humanization Policy (NHP) for the SUS, verifying the strategic reasons for its formulation and its importance in the construction of the SUS as inclusive and resolutive policy. These are the proposals of this text.

SUS: ethical, social and cultural reform in the healthcare system, its services and practices

The Brazilian Federal Constitution of 1988 established a new judicial-legal basis for healthcare policy, defining health as a right of every citizen and thus, an obligation of the State. Moreover, in Brazil, an understanding was established that health represents a broader enunciation than the absence of disease and more concrete than the idea of well-being. Health began to be understood as social production, thus resulting in complex causal networks that involve social, economic and cultural elements that are processed and synthesized by the concrete experience of each individual subject, of each particular group and of society in general.

In order for the State to fulfill its constitutional obligation with regard to health, the need to implement fair social and economic policies that distribute income and dignify life was established, because health results

from the modes of life that define the quality of life, which is better when the capacity of society to produce rules that prevail in the interest of the common good is greater.

Health as social production means recognizing that the more unequal the distribution of wealth, the more precarious the access of social groups to consumer goods and public redistributive policies, the more heterogeneous and inequitable the patterns of illness and mortality.

However, the production of a "good life" through fairer social rules does not eliminate the presence of injuries, illnesses and health risks, rather it alters their nature. The organization of health systems is essential for societies to produce health; hence they should structure and organize this sector, which plays an important role in the quality of people's lives.

Thus, health production results from two macrocomponents that influence each other: (1) the organization of public policies that distribute income and (2) ensure access to services and comprehensive health actions. Among other aspects, comprehensive actions correspond to the combination and articulation of health promotion and prevention measures with those of healing-rehabilitation, the synergy of which should result in the provision of quality, resolutive healthcare practices for society and its citizens.

Guaranteeing access to healthcare services in Brazil is provided by the organization of a decentralized healthcare system. Decentralization corresponds to the creation of healthcare strategies for shared accountability in healthcare between the three spheres of government, such that, preferably, the municipalities organize comprehensive healthcare networks, sustainably and in cooperation with other managers. The basis of these networks, according to the principle of integrality, is primary care, which is organized nationwide and has the task of achieving the simple, but very significant guideline of achieving the effectiveness of the practices: every citizen has the right to a team to take care of them, with whom they establish strong therapeutic ties, the fulcrum of processes of coresponsibility within the care network.

Another directive of healthcare policy in Brazil is citizen participation. In other words, the system and healthcare services should be co-managed, which requires, among other things, the inclusion of new subjects in decision-making processes in healthcare, particularly segments of users, who through councils and conferences - co-management arrangements of the State - encounter spaces for voicing interests and needs, which, once the negotiation processes have been surmounted, begin to organically compose the healthcare policies.

Citizen participation in healthcare is a space of opening for the construction of processes of coresponsibility in the management of healthcare policy, with society as a whole, without freeing the State from responsibility for its key functions. The construction of collective spaces and arenas for decision-making processes and management interests in the formulation of public policies is an important strategy in the democratization of the State and of access to healthcare services.

Inscription of the new legal basis of the SUS resulted in an accumulation of forces within Brazilian society at a particular historical time, driven by the desire for the democratization of social and economic relations, contending with inequities regarding access to healthcare services and combating the privatization of healthcare policies. The creation of the SUS was only possible through the construction a movement for health reform, pluralist and outside party lines, which brought together very broad segments of society in defense of profound changes in the system and healthcare services, reaffirming the right of the people to universal quality healthcare.

The judicial-legal framework of Brazilian health policy, substantiated by the ethical-political definition that health is a universal right, has emerged as an important opening and opportunity to reform the country's healthcare system. However, inscription into law is not in and of itself a guarantee of the transmutation of values and practices in the healthcare system and the judicial-legal basis of the SUS is presented, principally, as ethical, political and organizational guidelines to construct a new healthcare system, based on social justice, equity and solidarity; a commitment and an ethical and utopian horizon.

The construction of a new legal reality does not guarantee the production of changes at the desired velocity, since the organization of healthcare services is constantly permeated by multiple interests of social groups, instituting forces that cause tension and provoke changes in the rules and practices of healthcare. Not even the direction of change is assured and the dispute between antagonistic interests - privatization and the common good, universalist theses or of restrictive access, the provision of comprehensive practices or basic menus, among others - are amended and defined through the game of politics.

In these twenty years of the SUS, in the twenty years of struggle, many advances have been made and, indeed, Brazil is included among the nations that consider health as a substantive social value; a view has taken shape in the construction of a robust public health system, the largest healthcare organization in Latin America. In these twenty years of the SUS, the care

network has been reorganized, solidifying the same based on strengthening strategies for primary care; people's access to services has expanded, the entire country has been integrated through care networks at municipal and regional levels, the quantity, diversity and quality of health workers has expanded, advancing the organization of teamwork; investment in research and scientific and technological development has occurred both in equipment and strategic resources, including vaccines and medicines; information and management systems have been developed, which has permitted the monitoring of results and improvement in decision-making processes. In addition, the SUS can now count on several programs and policies recognized as excellent, such as the immunization and STD/AIDS prevention programs, among others.

However, these advances are only equal to the challenges that SUS has yet to face: overcoming the biomedical health culture, which associates healthcare with medical action and access to medications and hospital attendance, a concept that permits the medicalization of life; insufficient contribution of resources to finance health actions (underfunding of the SUS); inequities in access; lack of assistance in many areas; operational deficiencies in the care network, which hinders the continuity of treatment; inefficiency of primary care, which is still understood as action directed toward the poor; the strong presence of a hospital-centric culture and private, corporate and party political interests in the definition of health policies and the organization of healthcare services (privatization); an underdeveloped federal culture that leads to competition for resources and low accountability between municipal and state health secretaries; low planning capacity for workers' training procedures in relation to the needs of the healthcare system, especially in graduate programs and health career residencies; the absence of a "career in the SUS" for health workers, among others.

Thus, after twenty years, the Brazilian health system still shows, in its structure and organization, strong signs of concepts that have hegemonized, especially since the mid-1960s (Oliveira and Teixeira, 1986), which instituted a private, assistentialist system primarily focused on disease intervention, and thus devoid of the ability to bestow life, to place health production first, to place humans at the center of health policy actions.

National Humanization Policy: the experience of *a SUS that works* as a strategy for coping with the problems and challenges that still mark Brazilian public health policy

It is important to understand that the advances achieved and the prominent presence of challenges in the SUS should be the dynamics of public policies, which are permeated by political and economic interests that systematically (re)update. Public health policies should be reviewed and evaluated in the light of their historical, political and institutional elements, which allows us to understand the patterns of capillary action and selectivity of the State machine regarding the actions of interest groups. In addition, the effectiveness of health policies stems from the ability of the health sector itself to deal with organizational issues and their management, including the cumulative forces to change the modes of attendance, furthering the interests of the common good, of the collective.

Analysis of the social, political and institutional construction of the SUS prompts the understanding that it is an ambiguous movement, simultaneously presented as progress towards the universalization and qualification of access and as the conservation of contradictions that have marked the Brazilian healthcare system as one of the most unjust on the planet. The SUS is at one and the same time, change and conservation (Pasche et al., 2006).

The NHP (Brasil, 2007) is presented and is constructed precisely on this fold, this dual recognition: there is a SUS that works and there are problems and contradictions that need to be addressed.

The NHP considers that constructs and experimentations developed in public health policy exist in many planes, spheres and places that permit the affirmation that much progress has been made in constructing new modes of management, such as the constitution of new modes of care in accordance with the discursive basis of the SUS.

It was due to the investigation of, listening to, analysis and synthesis of this SUS that works that the principles, methods, directives and instruments of action and the devices of the NHP were produced (Brasil, 2007). Thus, the NHP has no means if not its own accumulation of experiences from a large quantity of collective subjects scattered in many places in the country, which work and produce innovations in a wide range of services, in "care spaces" and in "management spaces".

This methodological option has the effect of positivization on the SUS, since although it considers the problems and challenges of the SUS, it does not come from them, rather from the location of substantive elements of the experiences that allow the challenges to be surmounted, to propose ways of doing and direction for the processes of change in healthcare. This positivization movement potentializes the action of subjects and social groups, since it is not derived from the negative, it elicits effects of the amplification of and contagion to change. Thus, the problems are not taken on except to face them, constructing with discursive and concrete tools of action based on the positivity of experience.

This is a significant and radical difference, an important dislocation for confronting the contradictions of the SUS, since wherever the problem is announced (modes of management and caring), wherever the more radical problems are located (autonomous action of the subjects) and the impossibility of constructing plans for common action (relation between subjects with noncoinciding needs and interests) is where the strength and the possibility of producing change are sought. An action of contagion for the SUS that works, which "works" as a way of doing and as an ethical-political direction.

It is from concrete experiences in the services and practices of the SUS, from the analysis of its construction, that the NHP extracts its discursive and practical constructs. Its organizational framework organically articulates principles, methods, directives and devices.

From the experiences of the SUS that works, the NHP derived a set of articulated and inseparable principals:

- inseparability of modes of management and care, understanding that they are mutually influenced and determined;

- transversality of knowledge, power and affects in the everyday action of services and health practices, encouraging subjective dislocations and the production of plans for common action, but not to the point of denying specifics, rather arranging them in relationships, in a network, to dissent;

- commitment to the autonomy and leadership of the subjects, who in relationship and oriented by ethical guidelines - and historical constructs - are capable of effecting the will and desire for change, constructing networks of coresponsibility.

These principles - the starting point - evoke reflection concerning what to do so that they are effectively inscribed in healthcare practices; i.e., they demand that the modes of doing are defined. Thus, the question is raised

regarding the method, the path required for the construction of new realities. The experiences of the SUS that works clarify what should be included; i.e., they indicate the creation of strategies for the inclusion of the subjects in the production processes of these changes. The NHP takes this principle, amplifying and qualifying it as a method of triple inclusion:

- the inclusion of all subjects in the arrangements, processes and management devices, in clinical and public health. Inclusion implies the construction of collective spaces to put subjects in contact, in relationship, such that, when meeting, they produce understandings and common actions. In other words, to promote the comparison of differences between subjects for the construction of processes of coresponsibility in management and care and the responsibilities arising from these;

- the inclusion of social groups, networks and social movements. The SUS, as a commitment to change the modes of management and care in healthcare, solidifies and tends to be more stable if embodied as a collective experience, as a synthesis of the plurality of heterogeneous interests and needs. The promotion and production of social networks in both the conduct and management of public affairs and in effecting clinical care and public health, expand support for changes in public policy (always a synthesis of plural and heterogeneous interests) and the construction of new subjects in production processes of care (coresponsibility) and public health (collective action regarding territories, from the perspective of increased production of health and citizenship);

- the inclusion of social analyzers, of the perturbation arising from the inclusion of individuals and social groups in the arrangements and devices of management and care (individual and collective). This inclusion is perhaps most radical in the NHP, since the meeting of alterities cannot be understood only as opening toward the participation of users and workers for greater adherence to heteronomous requirements, or simple improvements in the processes of conventional management of the organizations. Including the other implies a generous attitude that gives rise to changes in power relations between subjects. Changing power relations requires dislocations and resignification of the places and positions they occupy in relation to the other from the perspective of the production of coresponsibility; which, in turn, requires relativizing constructs prior to meeting, so common action can be produced. This does not mean giving up tradition, science, social mandates, rather using them as resources for the coproduction of healthcare. Including the other and including the perturbation of this inclusion imposes the need to deal with difference with less paranoia; and dealing with/and managing conflicts, understood as

spaces of opening, of passages to the other, is a necessary condition for producing change.

The triple inclusion method is thus presented as a strategy for the construction of collective processes, since it enables confrontation, in public spaces, of positions that are not necessarily coincident - hence the expression of the collective, always plural - for the production of the common within difference.

The principles of humanization and its triple inclusion method, however, cannot be devoid of ethical, clinical and political guidelines, which generally indicate the direction of action, of the coproduction of subjects and healthcare.

The NHP indicates a set of directives, which signal direction for the collective constructs. These are:

- reception, understood as an attitude of openness to receiving healthcare needs that are expressed in the form of demands for services and health professionals. Reception requires the construction of satisfactory answers to such needs, regardless of the organizational logic of the services, which must involve reception as a guiding directive concerning their manner of functioning. Reception is an ethical directive, therefore, non-negotiable and thus, a fundamental direction for the construction of attendance networks, care networks;

- participatory-management and co-management, which are expressions of the democratization of healthcare institutions and the relationships between subjects. Democracy presupposes openness, the creation of collective spaces and their substantiation, permitting the confrontation of differences in the shared production of coresponsibility in management and care;

- the expansion of clinical attendance, whose principal meanings tend toward the expansion of dialogue and the interference of the subjects regarding the definition of contracts (management and clinical); inclusion of alterity implies accommodating difference in the contractualization of tasks (extending management offers of care, practice etc); personalization of care and management methods, considering that all clinical relationships and management is always determined by the interests, desires and needs of subjects that update and individualize in this relationship;

- the provision of networks of valorization of the work and the worker. Valorizing the worker (and their doing, their constructs) implies at least three major movements: (1) inclusion of the worker in definitions concerning the functioning of the healthcare organization; i.e., the

decentralization of decision-making power over the daily life of the institutions; (2) the construction and achievement of improvements to the concrete conditions of employment, such as pay, environment, access to appropriate technological supplies for the production of healthcare, etc.; and (3) the regulation and intervention of elements and factors that interfere in the production of healthcare by the workers, e.g., including workers in the mapping and control of risks;

- defending the rights of users: the SUS recognizes that users are the holders of rights in healthcare, which pervade the management system (collegiate system of management of the SUS and its services), the clinical relationship and that of public health. Recognizing these rights requires the perception of the constitution of the subjects of alterities (individual and collective), whose references and thresholds are consensual and agreed upon as social relations. User rights – an ethical-political constitution – must (1) regulate and determine the organization of work processes and guide clinical and public health practices. Moreover, they presuppose (2) the construction of contracts of coresponsibility, a synthesis between "the social mandate of healthcare workers" and the "rights of users", antinomian extremes. Thus, the tension between the rights and duties of users takes the place of shared construction of care, which means recognizing rights and social mandates, which are updated in the construction of individualized attendance/care.

- the environment: work and healthcare occur within areas of healthcare organizations, among others. These workspaces do not always respond to the immediate interests of users and workers, obeying other interests and multi-interest institutional logic. The production of subjects and health also results from the organization of workspaces, which should reflect the principles and directives of the SUS, the humanization of healthcare. Humanization means putting the subjects, people, first in the construction of care and management and, from this perspective, the reconstruction of the workspaces should be a collective exercise to (1) adequate the work environment to the directives of the reorganization of work processes (as a team and co-managed) and (2) respond to the concerns of healthcare workers and users (warm, pleasant environment as a device for producing well-being and health);

- the construction of memory of the processes of change: the politics of narrativity; new modes of doing require new ways of narrating, making these the producers of meaning for change. The construction of meaning in changes in the production of healthcare, the task of subjects and collectives, is essential for the maintenance of the ethical-political principles in the reorganization of the services and practices of healthcare. Perceiving the self

as constructor of the story, as a constructor of works (Campos, 1997), is to appropriate the condition of the subject who creates the world and who reinvents him/herself within it. This means recognizing, as Freire says (1996, p.19), that "we are conditioned beings, but not determined. Recognizing that history is a time of possibility and not determinisms, the future [...] is problematic and not inexorable". Assisting the subjects to recognize themselves as constructors of the story through the narrative of their own trajectories is a strategy of dealienation, of the production of new subjects and the construction of possibilities of surmounting the new challenges that arise from the very construction of public policies.

It should be emphasized that the exercise of these directives should always question the ways of doing, which, from the perspective of the NHP, implies the inclusion of subjects, of collectives, of social analyzers in the multi-interest production of new realities.

The NHP incorporates a set of methodological principles that affirms it as a way of doing, a mode of addressing problems in healthcare services and practices. Thus, the way of doing considers principles and directives, general guidelines for the process of change, which are experienced through working arrangements devices). By devices, the understanding is not one of requirement, rather of forms of organization of work processes that are updated and take on meaning in each of the unique experiences, or are amenable to the experimentation of the subjects and their political-institutional contexts.

The National Humanization Policy as an offer to deal with the problems and contradictions that persist in the SUS

Another element that comes from the NHP - besides the positive productions of the SUS - is the existence of, as a important point of public health policy, a set of problems and contradictions, whose presence indicates that there are visible signs of crisis in healthcare in Brazil (Campos, 2007). This crisis is highlighted, on the one hand, by society as a whole, and particularly by users, who complain of: neglect in attendance, discontinuity of treatment, long waits in queues and “off-book” payments, among other problems, which often earn the description of *the dehumanization of attendance*.

On the other hand, health workers have also highlighted a series of limitations in the SUS, whether in relation to the concrete conditions of work - such as low pay, lack of career plans and salaries - that lead to precarization, exploitation and devaluation of work, or in relation to ways of

organizing the work process, in general, towards the expropriation of workers in decision-making processes.

These problems mentioned by users and workers (while exercising activities and by those who occupy posts in management) compose the constitution of complexity, because they coincide with the genesis of a set of elements of different plans, which are mutually engendered, constructing complex causal networks. To confront these hypercomplex realities, the NHP indicates the need for the exercise of method, the exploration of which places the subjects in contact and in relation so that, collectively and with reference to the ethical-political principles and accumulations of the SUS that works, they construct unique solutions.

Thus, the NHP presents as an expression of the SUS that works, whose synthesis organizes a set of concepts and tools for overcoming the problems and contradictions that still remain as marks on the healthcare services and practices.

Thus, the NHP cannot have a single value, something to which the practices aspire to and are sustained by, rather it must inform the production of concrete changes (Barros & Passos, 2005) that reaffirm humanization as a value; i.e., humanization depends on a dual value - social practice.

Experimentation and consolidation of more equitable, inclusive and supportive public policies is a civilizing task because it trusts in the capacity to confront and outline social contradictions, which when surmounted, assist in the emergence of new consciousness, new ethical and political thresholds, fulcra for the qualification of life and experience in society.

The task of the SUS for the next twenty years is to keep alive, strengthen and sustain the vibrancy of the social and political forces that create and drive Brazilian healthcare reform. Radicalizing collective interest in the actions of the State, affirming the nature of public social policies, inviting civil society to "play the game of politics", to dispute the guidelines in the conduct of public affairs, is an action undertaken in all the unique spaces of micropolitics, and on other planes, within and encompassing the limits of the State machine.

This is the role and strategic function of the National Humanization Policy: maintaining vibrant within the SUS, in each of its policies, the spirit of solidarity and action, the construction of the common good and the uncompromising struggle against the sense of cooptation by the State machine in general, or by any particular institution or individual group.

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