Essay

Health workforce regulation in complex and unstable times

A regulação do trabalho em saúde em tempos complexos e instáveis

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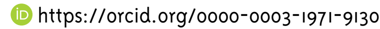
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Abstract

In Brazil, health is considered a right of all and a duty of the State, and health workforce regulation is essential to ensure the safety, quality and effectiveness of the health services provided, which require professionals with skills, abilities and attitudes consistent with the service in question, as well as to guarantee dignified working conditions for health professionals and patients. This essay is a critical and up-to-date analysis of the main characteristics of Brazil's health workforce regulation model. We first describe how the health workforce regulation is structured, addressing topics such as the regulatory autonomy of Professional Councils, the regulation of new healthcare professions and the judicialization of conflicts in the field. We then analyze the regulation of health higher education and the leading role of the Ministry of Education in this regulatory field. The present reflections point out possible ways to improve Brazil's health workforce regulation model, having the consolidation of the Brazilian National Health System (SUS) and the full implementation of the right to health as guides.

Keywords: Health Workforce; Health Regulation; Health Professions Regulation; Health Law; Health Judicialization.

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Resumo

No Brasil, a saúde é considerada direito de todos e dever do Estado. A regulação do trabalho em saúde é atividade essencial para garantir a segurança, qualidade e eficácia dos serviços de saúde prestados, que exigem profissionais com competências, habilidades e atitudes condizentes. O trabalho em saúde deve ainda ser exercido com condições de trabalho dignas aos profissionais de saúde e aos pacientes. Este ensaio apresenta uma análise crítica e atual das principais características do modelo de regulação do trabalho em saúde no Brasil. O texto descreve, inicialmente, de que forma está estruturada a regulação do exercício profissional na área da saúde, abordando temas como a autonomia regulatória dos Conselhos Profissionais, a regulação de novas profissões de saúde e a judicialização dos conflitos regulatórios. Finalmente, são analisadas as características da regulação da formação de nível superior na área da saúde e o papel protagonista do Ministério da Educação nesse campo regulatório. As reflexões aqui apresentadas objetivam apontar possíveis caminhos para o aperfeiçoamento do modelo de regulação do trabalho em saúde no Brasil, tendo como norte a consolidação do Sistema Único de Saúde (SUS) e a plena efetivação do direito à saúde no Brasil.
Palavras-chave: Força do Trabalho em Saúde; Regulação em Saúde; Direito à Saúde; Regulação de Profissões de Saúde; Judicialização da Saúde.

Introduction context

Article 196 of the 1988 Brazilian Constitution (CF) considers health as a right of all and a duty of the State, guaranteed by social and economic policies to reduce the risk of diseases and other health problems and ensure universal and equal access to actions and services for its promotion, protection, and recovery (Brasil, 1988).

State duties to fully achieve the right to health include regulating health work, an essential activity to ensure the safety, good quality, and effectiveness of the health services provided by professionals with competences, skills, and attitudes that are consistent with their nature. Moreover, healthcare must ensure providers and patients with adequate circumstances.

Healh work regulation in Brazil should be formulated as a priority that aims to render its Brazilian National Health System (SUS), created by the CF to organize public health actions and services in the country, effective. Article 198 of the CF defines SUS (the main guarantee of the right to health in the country), conducts the comprehensive care of about 215 million people (IBGE, 2023), and includes health promotion, prevention, recovery, and rehabilitation services. In addition to aiming to consolidate SUS, health work regulation must also guarantee the good quality and safety of private health services, authorized by art. 199 of the CF and which represent a market of about 50 million Brazilians in the supplementary health sector alone (ANS, 2023).

Thus, public health actions and services by SUS and the activities of private services presuppose the existence and work of healthcare providers within the scope of various public and private institutions in the area. Health work regulation in Brazil has very clear constitutional objectives, which can be summarized by the State duty to guarantee its population's right to health by directly providing public health services by SUS or adequately regulating the services of private agents.

A better understanding of healthcare regulation and its complexity within modern democratic

states of law includes three major regulatory fields emerging from the normative and institutional set in Brazil: regulating (1) the training of professionals for work in health (technical education, undergraduate and graduate programs, specialization, residencies, and master's and doctoral degrees); (2) professional practice (registration, ethics, scope of practice, legal competences); and (3) health labor relations (working hours and conditions, wages, and careers).

Each field has its own logic and regulatory modeling, configuring a complex, fragmented, and institutionally dispersed regulation model with serious functionality problems that compromise the effectiveness of state regulatory activities (Aith et al., 2018). Based on this scenario, this study offers a critical and up-to-date analysis of the main characteristics of the model that regulates health work in Brazil, especially of healthcare providers' practice and training. These reflections aim to point out possible paths for improving the regulatory model of health work in Brazil, having as a guide the full achievement of the right to health in Brazil.

Reflections on the characteristics of the model of regulation of health work in Brazil in the light of the state duty to guarantee the right to health

A more in-depth analysis of the multiple contexts and influences of the Brazilian health work regulation model requires knowing its characteristics.

Its first striking feature refers to the multiple state regulatory institutions with constitutional and legal competences to regulate one or more aspects of health work. At the federal level alone, we find more than a dozen legal institutions with regulatory powers over health work, and it is relevant to highlight some of them.

Regarding health work regulation aimed at adapting it to SUS principles and guidelines, the Union predominantly elaborates its general norms and defines national health policies, playing a strategic role in health work regulation in Brazil (CF, art. 24, item XII, § 1) (Brasil, 1988). The regulatory competences of the Ministry of Health stand out within the scope of the Federal Executive Branch for defining and conducting national public health policies and monitoring and supervising national capacities regarding health work.

Thus, the Brazilian Ministry of Health must establish a relevant regulatory set regarding SUS health service types; clinical and therapeutic protocols and guidelines for healthcare providers; national health policies on the scope of practices of professionals; the quality and safety standards of public and private health services in Brazil; the necessary regulatory harmonization or convergence between national regulatory institutions at the federal and inter-federative levels; the creation of national health careers; among other strategic competencies (Brasil, 2023).

The following federal competencies are also highlighted: the Ministry of Education regulates health higher education, graduate studies, and professional residencies; the Ministry of Labor supervises labor relations and conditions and edits the Brazilian Occupational Classification; and the Ministry of Planning organizes the work regime of federal civil servants and the creation and development of federal careers in health (e.g., the much-debated idea of a federal career for SUS doctors) (Brasil, 2023).

Another necessary emphasis should be given to the regulatory competences of the current 13 Professional Councils in the area that regulate the 14 health professions recognized by National Health Council Resolution no. 287/1998 (Brasil, 1998). Professional Health Councils enjoy broad discretionary power to regulate their respective professions (especially regarding ethics and professional practice) and are responsible for defining the scope of practice of each health profession, often against the understanding of the Ministry of Health or other regulatory institutions.

To complete the picture of regulatory institutional fragmentation, it is worth mentioning

the SUS federalist model and its consequences for the regulation of labor relations within the national health system. According to Art. 22, item II, of the CF, the Union, States, federal district, and municipalities are responsible for their respective systems and share an equal competence to carry out public health actions and services (Brasil, 1988). Thus, healthcare providers' labor relations will follow specific rules in each federative entity, generating an enormous diversity of work regimes and bonds.

The second striking feature of the current Brazilian health work regulation model refers to its complex set of juxtaposed legal norms. These laws, decrees, resolutions, ordinances, normative instructions, among other types of norms, regulate health work at the national, state, and municipal levels. Each federative entity has the competence to regulate health work regarding various topics, such as the type of work to be performed to conduct the respective health policies, the work regime to be observed, health work remuneration, clinical protocols and specific therapeutic guidelines (if any), among others, generating a normative framework that is difficult to understand.

Its third characteristic refers to the absence of a national regulatory institution to harmonize regulation between the institutions in this field, causing dissonances, contradictions, and even relevant regulatory conflicts in the normative system guiding all State regulatory activities. Such a reality generates inefficiency, errors, and corporate political disputes, causing the absence of a federal administrative institution that can harmonize the national regulation of health work and settle regulatory conflicts between institutions.

Thus, normative conflicts between regulatory institutions (for example, two Professional Councils or a Professional Council and the Ministry of Health) have been systematically taken to the Judiciary, unnecessarily judicializing regulatory conflicts that would be better solved by the administrative mediation from the Union. A study conducted in 2018 shows that Brazil is one of the only countries whose Ministries of Health have little or almost no competence for regulatory harmonization and conflict mediation between regulatory health institutions (Aith, 2019).

Regulation of the practice of higher education health professions in Brazil: corporate autonomy and public interest in 21st-century democratic States

The regulation of practices by higher education health professions stem from a historical construction dating back to corporations, and it is relevant to highlight, albeit briefly, some of this historical evolution and the way Brazil appropriated this model. This historical retrieval can better explain the current model in force in Brazil and the clashes involving corporate interests, on the one hand, and the public and social interest, on the other.

Corporations, whose most remote origins lie in ancient Rome were extinct at the time of the barbarian invasions, reappearing in the Middle Ages (12th century) to regulate craft production processes in cities with over 10 thousand inhabitants. These associations of producers (guilds) or merchants (hansas) showed a hierarchical (pyramidal structure: masters, officers, and apprentices) and centralized control of production techniques. The logic, which remains to this day, is that people could only work in a certain trade (e.g., masons, tailors, carpenters, bakers, stone carvers) in a certain region if they belonged to a corporation, under penalty of being expelled from the region.

An axis of the resurgence of corporations involved the idea of social protection in a period (12th to 14th centuries) still marked by private wars and the incipient acceleration of trade (Le Goff, 1990) and, therefore, by the need for guarantees of security and predictability for the exercise of certain socially relevant functions. These corporate associations protected the labor market by holding and controlling techniques to certain groups, whose members received work, apprenticeship, food, housing, and support in case of disability due to

age or illness. Corporations also established the rules for entry into the profession (Feliciano, 2013).

In 14th-century Portugal, the support of craft masters was decisive for the government of King John I (then in serious crisis), strengthening the power of corporations and creating a municipal deliberative corporate assembly – competing, therefore, with municipal councils or inserted in them. Other Portuguese cities and colonies also adopted this system. In Brazil, these assemblies never existed officially but the literature records similar institutions since at least 1641, "with the election of twelve masters in the city council of Salvador," in addition to the Ombudsman of Rio de Janeiro requesting the Court in Lisbon to authorize the election of two masters to the city council (Martins, 2007).

The worldwide rise of corporatism as a political system (especially in Spain, Italy, and Portugal) retrieved the political strength of professions. Corporatist organisms were treated as structuring elements of political power as much as the representatives elected by the people. For example, the 1933 Portuguese Constitution (during Salazar's government) created an advisory Corporate Chamber for the Republic. The 1934 Brazilian Constitution provided for professional federal deputies (40 of the 254 deputies were appointed by professional organizations).

This corporate idea was transplanted to Brazil with nuances, especially in view of the adoption of slave labor and the excessive restriction of the domestic market up to the early 19th century – together with the peculiarity of the prevailing patrimonialism in its national economic system (Faoro, 2008). It began to decline with the arrival of the royal family in Brazil and the subsequent economic and political rise of mercantile liberalism.

Corporatism was embraced by Brazil from 1930 onward, decisively influencing the structure of labor legislation (for example, the constitution of unions depended on authorization from the State following tax financing and a table of professions instituted by the Executive Branch). The Consolidation of Labor Laws followed themes (registration, vacations, wages, working hours, etc.) and professionals of specific economic categories: bank employees, telephone workers, railroad workers, port foremen, underground miners, journalists, stevedores, teachers, etc. Several of these provisions remain in force, but laws specific to each profession proliferated in Brazil from the mid-20th century onward – culminating in professional councils, parastatal entities to regulate such activities with certain autonomy.

However, the laws regulating specific professions evidently distinguish themselves from the CLT professional regulation by the latter having workers' protection as its principle based on the assumption of the conflicting relation between capital and labor (with a historical source in the industrial revolutions); whereas the former focus on professions as a whole (with an older historical source firmly influenced by medieval corporations).

Regulatory autonomy of higher education health professions councils to regulate professional practice in Brazil

Brazil currently recognizes 14 health professions that require higher education according to National Health Council Resolution No. 287/98 (Brasil, 1998): social workers; biologists; biomedical scientists; physical education professionals; nurses; pharmacists; physical therapists; speech therapists; physicians; veterinarians; nutritionists; dentists; psychologists; and occupational therapists.

From the 1950s onward, these 14 professions now have their own federal regulatory legislation (Table 1).

Table 1 — Legislation for the creation of higher education health professions in Brazil

Profession	Regulatory standard(s)
Social worker	Law no. 8,662/1993

continues...

Table 1 — Continuation

Profession	Regulatory standard(s)
Biologist	Law no. 6,684/1979
Biomedical scientist	Law no. 6,684/1979
Physical Education Professional	Law no. 9,696/1998
Nurse	Law no. 2,604/1955
Law no. 7,498/1986	Lei n. 13.021/2014
Pharmacist	Law no. 13,021/2014
Physical Therapist/Occupational Therapist	Decree-Law no. 938/1969
Speech therapist	Law no. 6,965/1981
Veterinarian	Law no. 5,517/1968
Physician	Law no. 3,268/1957
Nutritionist	Law no. 8,234/1991
Dentist	Law no. 5,081/1966
Psychologist	Law no. 4,119/1962
Radiology technician	Law no. 7,394/1985

Source: Centro de Pesquisas em Direito Sanitário da USP, Pesquisa Regulação de Profissões de Saúde, 2018.

With relative independence and competences attributed by respective laws, each profession, via its respective Federal and Regional Councils, issues resolutions on various topics related to the exercise of the profession, such as professional registration, codes of ethics, definition of the scope of practice and specialties, granting of the title of specialist, among others.

The laws that created these Professional Councils recognize their regulatory power, and the latter received the support of important decisions by Brazilian higher courts. The Superior Court of Justice (STJ), on an individual litigation in which the plaintiff claimed the right to be recognized as an expert despite the rules established by the Professional Council, established quite clearly the role of these Councils in modern society:

> [...] the Judiciary must be cautious when interfering in the requirements elected by professional bodies and the like to select and authorize the exercise of professional specialties, especially in the area of Public Health.
>
> In fact, the professional councils and the professional bodies of a technical-scientific nature, such as the defendant, are authentic heirs of the old guilds and craft corporations, which exercised a protective function to the interests of their members, either internally through the realization of a kind of market reserve, or externally, by curbing the actions of suppliers or employers. The external function has been exclusively taken over by the unions, which manifest it through strikes and other mechanisms of self-protection.
>
> Historically, however, the internal function has been transformed from a means of defending the profession against the entry of new agents into an instrument of defense of Society itself.

> The limitation of professional practice to qualified people can no longer be confused with a petty reserve or market restraint, provided, of course, that it is carried out within the legal frameworks. It is, at present, a public delegation to the councils so they can select their members and demand probity and expertise in the performance of their office, in accordance with the principle of reasonableness. From being a salient means of class protection, the disciplinary power of the councils has become necessary for sociodeontological execution [...] (Brasil, 2006b).

The Supreme Federal Court (STF) has also addressed the issue several times, such as in Writ of Mandamus No. 22.643, which decided that Professional Supervisory Councils have the legal nature of autarchies and stated that (1) these entities were created by law, having legal personality under public law with administrative and financial autonomy; (2) that they supervise professional practice, which, as follows from the provisions of arts. 5, item XIII, and 21, item XXIV, is a typically public activity; and (3) they have the duty to report to the Federal Court of Accounts (Brasil, 1998).

Regarding the nature of the public interest of Professional Councils, it is also worth highlighting the following excerpt from an STF decision reported by Minister Luiz Fux:

> Considering the legal autarchic nature of professional supervisory councils, which are created by law and have legal personality under public law, exercising a typically public activity, that is, supervision of professional practice [...]., it must be concluded that the rule provided for in article 37, II, of the CF/88 must be applied to them when hiring civil servants (Brasil, 2012).

Another decision from the STJ that is worth mentioning refers to its confirmation of the legality of the Chamber of Regulation of Health Work (CRTS). In the lawsuit, the Federal Pharmacy Council (CFF) sought a judicial declaration of the illegality of MS Ordinance no. 2,429/03, which created the CRTS to assist the Ministry in matters related to the regulation of health professions. The council thesis was based on the hypothesis that the Ministry of Health had exceeded its powers and that such regulatory activity is exclusive to the councils.

The court denied the measure, recognizing the competence of the Ministry to create the CRTS and stating that such regulation aimed to organize SUS, a typical function of the ministry that is not to be confused with the eminently supervisory function of professional councils. The importance of such action lies in it involving a dispute of competences between a professional council and the Ministry of Health, two central agents in the scope of health work regulation. This action also made explicit the conflicting relation between the corporate interests of professional councils and the public interest that may be present in public policies or in the regulation of other institutions with equal regulatory competence. Sometimes, conflicts occur between two professional councils that regulate different professions and deny that the other defines this or that scope of practice as their area of expertise, e.g., doctors × nurses; pharmacists × doctors, etc.

Complexities and uncertainties in regulating new higher education health professions in Brazil

Another source of broad current debates on health work regulation refers to the creation of new health professions regulated by law. From 1988 onward, the legal regulation of a new profession can occur by its inclusion in the Brazilian Occupational Classification or, even, in a more normatively solid and rights-protecting way, by the approval of an ordinary law in the National Congress.

Within this logic, the Committee on Labor, Administration, and Public Service of the Chamber of Deputies issued important recommendations for the elaboration of bills to regulate the exercise of new professions by applying a list of related requirements (Brasil, 2001).

The first recommendation warns that, due to the freedom to exercise trades or professions

established by the Federal Constitution in its art. 5, item XIII, the preparation of bills to regulate professional practice must cumulatively meet the following requirements: (1) the indispensability of regulating the professional activity– if carried out by a person without adequate training and qualifications –, as it would otherwise threaten the population's health, well-being, safety, or property interests; (2) the real need for technical and scientific knowledge for the development of professional activity, which makes its regulation indispensable; and (3) the requirement that the activity be performed exclusively by professionals with higher education, trained in a course recognized by the Ministry of Education. In addition to these recommendations, it also highlighted the need for the regulation project for a new profession of higher education to avoid proposing the creation of a market reserve for a segment of a certain profession to the detriment of others with identical or equivalent training to safeguard the public interest.[1]

Considering the laws in force and the STF decisions on the matter, the following normative parameters for the creation of a new higher education profession stand out: need for a high technical or scientific degree to work in the profession; existence of potential risk or actual damage to society, such as those that may result from professional practice; guarantee of professional practice supervision; and regulation following the Constitution and the public interest.

The current possible itinerary to regulate a new higher education profession in Brazil is complex and uncertain. Complex as it involves the collaborative and articulated participation of multiple actors and government institutions, including the National Congress and the Presidency of the Republic. Uncertain as it remains an environment with an intense legislative disharmony, especially regarding the role of the Ministry of Health and the National Health Council in the processing of these projects. Moreover, there remains a great controversy over the initiative of these bills, especially when they create associated oversight structures (e.g., Professional Councils). In these cases, the Executive Branch deems it a private initiative of the Presidency of the Republic, limiting proposals that may arise in parliament or civil society.

The regulation of new health professions in Brazil has been a contentious topic for decades that configures a minefield of conflicts for the future. In the last two decades, the National Congress processed or still processes bills to create several new health higher education professions, among which it is worth highlighting the following (either due to their importance for the Brazilian health system or to their degree of conflicts and judicialization): acupuncturists; art therapists; biotechnologists; gerontologists; health services managers; massage therapists; natural health technicians; osteopaths; podiatrists; psychomotor therapists; chiropractors; sanitarians; health technologists; and naturist/naturalist therapists.

This dynamic scenario of multiple interests, diversified state institutions, and interposed layers of power and competences has often faced the phenomenon of judicialization to resolve regulatory conflicts in health, whether between established professions or regarding the struggles for recognition of new health professions.

Judicialization of health work regulation in Brazil

Conflicts are to be expected in a regulatory environment with multiple decision-making centers and a wide range of activities to be regulated. Each of the 14 regulated higher education professions has a law that regulates it in general terms and provides powers for its respective professional council to proceed with infra-legal regulation. Moreover, direct public administration still can regulate such professions, specifically within the scope of the Ministries of Health and Education.

Thus, jurisdiction conflicts arise that are only judicially resolved, even reaching the STJ

1 Available from: <http://www.confef.org.br/extra/conteudo/default.asp?id=16>. Access on: Nov. 02, 2015.

and the STF. Thus, it is important to understand court positions, especially those that standardize jurisprudence and issue decisions that influence the legal thinking of the entire country.

An extensive research on the judicialization of regulatory conflicts in health work in Brazil found 52 lawsuits at Superior Courts, 23 of which at STJ and 29 at STF (Bastos et al., 2020). The authors' initial analysis of the decisions and rulings in their research found that the judicialization of health profession regulation mainly results from two factors: (1) the broad regulatory autonomy conferred on each Class Council, which has transposed competences and (2) a normative fragmentation into a massive set of laws, decrees, ordinances, and resolutions.

Among the lawsuits in that research, the Federal Council of Medicine emerges as the largest applicant, having proposed almost half (47%) of all lawsuits filed by federal professional councils against other councils or institutions to settle regulatory conflicts with the Judiciary. The Federal Pharmacy Council also constitutes the largest defendant, featured in 23% of all lawsuits filed against federal professional councils to resolve regulatory conflicts. It is no coincidence that 17.39% of the demands the CFM proposed require the Federal Pharmacy Council, and its Resolution no. 585/2013 appears as one of the main causes of conflict between these two Councils.

It is also worth noting that judicialization, despite its great presence in health work regulation in Brazil, fails to configure an adequate path to solve this type of conflict. Bastos et al. (2020) illustrate the inadequacy of this route for solving regulatory conflicts in health work, showing that 89% of cases showed requests for injunction anticipation and that most contained a rejection of injunction requests (with great legal uncertainty for everyone); 63.33% of cases were dismissed or extinguished; 17.81% of cases were yet to be sentenced after more than five years of their filing; 80% of sentenced cases were appealed to the Regional Courts; 12.33% of cases contained a special appeal to the STJ; and 5.48% of cases were subject to an extraordinary appeal to the STF.

The Ministry of Health took an important step to try to change this scenario of judicialization of regulatory conflicts between Professional Councils by creating the CRTS in 2004, a collegiate and consultative entity (Brasil, 2006a). The CRTS was created within the scope of the Secretariat of Work Management and Health Education of the Ministry of Health with three main attributions: (1) discuss professional regulation actions for health professions and occupations; (2) suggest mechanisms for health professional regulation; and (3) offer legislative initiatives to regulate the exercise of new health professions and occupations.

Its composition gathers representatives from the Ministry of Health, the Ministry of Labor and Employment, the National Council of Health Secretaries; the National Council of Municipal Health Secretaries; the National Health Surveillance Agency; the 13 Health Professional Councils; scientific entities of health professions; and national health workers' associations.

It is important to remember that the STJ judicialized the Ordinance that created the CRTS in a Writ of Mandamus filed by the Federal Council of Pharmacy against the State Health Minister (Brasil, 2006a). Although the court dismissed the lawsuit, it seems paradoxical that a body created to resolve regulatory conflicts out of court caused a judicialized conflict. However, this lawsuit shows that judicialization has become a common and inefficient practice in the Brazilian regulatory model to solve any regulatory conflicts in health work regulation.

Thus, the rule that created the CRTS remains in force, having not been subject to specific revocation and having its legality recognized by the STJ. However, the Chamber has failed to act in recent years due to the political turmoil Brazil experienced, especially after 2016 and an explicit choice by the Federal Government from 2018 to 2022 to dismiss participatory collegiates within federal public administration. Rescuing this important space for inter-institutional dialogue

is a necessary path to improve the regulation of health work in Brazil.

The regulation of higher education training in health

Regarding the regulation of higher education training for health professions requiring this level of education, it is worth noting that the Brazilian regulatory model points to the preponderance of the Union in defining Curricular Guidelines and supervising and evaluating these institutions by the Ministry of Education (Brasil, 2023).

As with the regulation of the professional practice of health professions, the regulation of health education is also fragmented at the federal level. The difference lies in that, in this regulatory field, the Union amasses greater powers and competencies in a single institution, its Ministry of Education. Both competencies mostly fall under the competence of the education sector, weakening the capacity of the Brazilian State to adequately plan the training of professionals for the Brazilian health system.

Surprisingly, the Ministry of Health has only an ancillary and lateral participation in strategic decision-making processes on at least three of the main aspects emerging from this regulatory field: it authorizes the operation of new higher education institutions; opens new courses (either for consolidated or new health professions); and defines the National Curriculum Guidelines for undergraduate health courses. Regulatory definitions occur within the scope of the National Council of Education (Brasil, 1995) and the National Commission of Medical Residencies (Brasil, 2011). Both cases evince the fragile (if not null) decision-making power of the Ministry of Health as the exercise of its powers lack a strong agenda toward the most relevant points of interest to Brazilian public health.

Regarding the federative fragmentation of health education regulation in Brazil, its legal system divides its national education system into three spheres: Federal, State and Federal District, and Municipal. Its legislation provides for specific treatments for each education system, depending on its sphere of activity. Thus, the regulation, supervision and evaluation of higher education institutions and higher education courses will follow this federative division.

The Brazilian Union, States, Federal District, and Municipalities will collaboratively organize their respective education systems. The Union will coordinate the national education policy, articulating its different levels and systems and exercising its role. Each federative education system has a specific regulation that the applicable legislation articulates by some stipulated mechanisms.

The Secretariat of Higher Education supervises higher education institutions and undergraduate courses (art. 21 of Decree No. 11.342/2023). Within the structure of the Ministry of Education, the Secretariat of Higher Education, the Secretariat for Regulation and Supervision of Higher Education (art. 25 of Decree no. 11,342/2023), and the Regulatory Policy Board (art. 28 of Decree No. 11,342/2023) deserve attention.

In this regulatory scenario, the Ministry of Education and its structures must define the regulation on strategic topics, such as the National Curriculum Guidelines; the evaluation system for higher education institutions and health professions courses; the rules regarding opening, monitoring, and evaluating graduate courses (including medical residencies); and the specialties recognized for the exercise of each profession (including specialized training), which the Ministry of Education strongly delegates to Professional Councils nowadays.

In view of the health needs of the Brazilian population and the Ministry of Health configuring the technically competent federal agency for defining the contents of the regulation of strategic themes of health education in Brazil, an institutional redesign is essential so the Ministry has greater power of participation and deliberation in the process of this regulation. It is necessary to train healthcare providers who can meet the demands of the public and private health systems in Brazil. Moreover, the state regulation of healthcare providers' training

should prioritize work at SUS to efficiently and adequately respond to the main health demands of the Brazilian population.

Final considerations

State regulation of health professions is essential to render professional practice adequate to the population's health needs. Adequately regulating healthcare providers' training, practice, and work relations is imperative to induce society as a whole – health, education, and liberal health – to provide adequate care in the Brazilian health system. Good regulation is also essential to curb inappropriate conduct or that which opposes societal public interest.

Its effectiveness requires integrating health profession regulation with health policies. Adjusting health training and professional practice to the principles and objectives of the SUS and the Brazilian Democratic Rule of Law configures the only possible path to actualize the right to health expressly protected by the CF.

Professional Council autonomy trains professionals and controls their practice but it can cause conflicts, market reserves, and corporate interests. Adjusting the health work regulation model to the public interest requires improving the participatory collegiate bodies that act in its regulatory process (such as the CRTS and the Permanent Negotiation Table of SUS) so they become more democratic and participatory and their deliberations more greatly influence the regulatory decisions by the competent authorities of the Ministry of Health, the Professional Councils and the Ministry of Education.

The search for out-of-court solutions to regulatory conflicts between health professions also configures a necessary path to be followed either by reinforcing the competencies of the aforementioned and existing collegiate bodies or by creating other spaces to negotiate and administratively deliberate these conflicts. It is necessary to find smarter ways to balance corporate interests with the public interest in policies without needing to resort to the Judiciary in cases of conflict. The supremacy of the public over individual or corporate interests must always prevail as a basic hermeneutic rule for solving these conflicts, to ensure either effective, safe, and food professional services or the adequate execution of public health policies.

Still, in view of the inalienability of the Judiciary to resolve conflicts within the scope of the Brazilian Democratic Rule of Law and since the current model gives rise to a routine judicialization of regulatory conflicts between health professions, it is also recommended that the Executive draw nearer the Judiciary so they can engage in technical discussions on the types of conflicts surrounding the regulation of judicialized professions and the best ways to articulate solution between powers.

Finally, the emergence of digital health and artificial intelligence and their inevitable incorporation into health work in the 21st century will demand an agile and effective regulatory capacity from the Brazilian State so it can quickly update itself to the advances of health technologies and their consequences for work in the area. Thus, the appropriate regulation of telework in health, the protection of personal data within the scope of the current large health databases, and the adequate regulation of training and professional practice for the use and application of new health technologies using artificial intelligence stand out as urgent regulatory issues.

Thus, regulating health work in complex and unstable times such as the current one requires an in-depth critical reflection of the current Brazilian model of regulation, creativity for effective innovative solutions, and courage to implement innovations that can balance corporate and economic interests with the public interest inscribed in the CF, the Brazilian legislation, and SUS public policies.

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Authors' contribution

The author was responsible for all conception stages of this study.

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