OUTSOURCING IN HEALTHCARE, CHANGES IN SUS MANAGEMENT AND WORK RELATIONS IN A NEOLIBERAL BRAZIL

Anderson Iacer Bueno Carneiro[1]

Caio Murilo Leite[2]

Rafael Santiago[3]

Abstract: Labor relations have been adapting to new legislation and the market profile over the years, a way that broadens a debate in the health sector, correlating changes in the management of the Unified Health System (SUS) and the arrival of the provision of services, by the cooperative entities, with a contractual configuration,which reinforces the labor issue and expresses the scenario of neoliberalism in Brazil. The present research aims to raise the discussions present in the cited parts, having the versions, such as unions, associations and workers'representatives,which present a critical position and point to the precariousness of labor relations, fearing the lack of inspection of resources transferred in the current model, while public managers and service providers say they are able to meet the demands and contracts signed with municipalities and states, so that health outsourcing takes place in our country. Legislation in constant adaptation seeking to guide the quality assistance to the health user seeking a political and social balance. For this, a bibliographic review was carried out on the proposed themes, with the main and most recent articles found. In this way, it is considered that in a country that descends from slavery and exploitation of cheap labor, the problem is not that social spending fits in the public budget, but that universal rights fit in the psyche of the elites, who are indignant with basic rights offered the working class.

Keywords: Public Management. Health. SUS. Outsourcing. Work

1 Specialist in Health Planning and Management audit by Facuminas
2 Mechanical engineering from UTFPR
3 Nurse at the Federal University of Pará

INTRODUCTION

Working in Brazil plays a social role and reinforces the need to achieve the dignity of human beings, providing means of subsistence and organizing their quality of life. Throughout history, the labor sector has experienced different moments, changes in employment relationships, innovation in Brazilian legislation, permissibility of actions and policies to promote debate and market sustainability (PIALARISSI, 2017).

In the health sector it could not be different with the promulgation of law 8,080 of 1990. The achievement of the Unified Health System brings an ascendancy in the provision of services and in this, regulated by law 8142, of December 28, 1990, it provided for community participation in the management of the SUS, exemplifying the intergovernmental transfer of financial resources in the health area and fundamentally established other measures (SANTOS, 2018).

These measures were redundant for service providers and promoted debates with the participation of entities linked to the third sector, given that municipalities and states began to organize and decentralize health in Brazilian territory. Thus, the resources allocated to health funds can be applied to cover the services provided, both in primary care and in specialized care and the philanthropic sector (FISCHER; FALCONER, 1998).

These debates concern society and also professionals in the field, as studies indicate that the new work relationship, linked to privatization in healthcare, brings with it the social precariousness of work and reveals the fragility of labor policy in Brazil. These attacks are not only linked to working conditions, but also reveal a lack of investment to enhance the functionalism, which directly implies the public service offered to the population (PIALARISSI, 2017).

LABOR RELATIONS AND MARKET INNOVATIONS

Social and cultural factors must be remembered, such as the change in work and employment

relations, with the creation of the individual micro entrepreneur, which highlights a society that permeates the idea not so far removed from colonial and slave-owning Brazil. Since the abolition of slavery, Brazil has not ignored the difficulty in mapping and promoting social equality, as well as demonstrating resistance on the part of the market to improving labor relations with its people (AZEVEDO, 2019).

The neoliberal model of privatization demarcates the interests of the dominant classes, which involves keeping the growth and earnings of their establishments under control. According to recent research, one of the most profitable sectors in Brazil is health, which has considerable annual growth and demonstrates an even greater potential for leverage in the coming decades (REIS, 2018).

With the possibility of financing and costing, public managers begin to evaluate possibilities for contracting services by third sector entities. Entities that present themselves as NGOs , foundations, institutes and associations, offering health services or even administering and managing hospitals and public health services in a philanthropic or contracted manner. This is seen as an advance when thinking about outsourcing, as control is not solely in the hands of states and municipalities. Carefully, unions and entities representing Workers fear that this will harm work and employment relationships, making the services provided precarious (DRUCK, 2016).

On the other hand, public management states that the Third Sector organization has the competence and legitimacy to be linked to the SUS in a contractual manner, respecting the established contracts and legislation in force in the country. As a result, the participation of this sector becomes more present in the reality of many municipalities (DRUCK, 2016).

In view of this, there is a concern regarding the public resources used by these entities, which now have financial control over the services thus supplemented. Authors reveal that there is a need for supervision and watchful eyes from the audit courts, legislators and the Public Ministry. This form is one of the ways to maintain transparency and fairness in the bidding and execution processes for services. One question remains: will states and municipalities be able to maintain routine oversight of the resources sent to these entities? (DRUCK, 2016).

Workers reveal that the salaries and benefits offered by these sectors are most of the time lower and different from those that would be available to public servants, further instigating the debate on precarious work relations. Unions linked to the working class express difficulties in collective negotiations with employers and the impact of this debate appears to be long and persistent. Thus, it demonstrates the need to know the worker's profile and the working conditions to which he or she is being exposed (PIALARISSI 2017).

According to Franco and Druck (2009), it is highlighted that there are six types of precariousness in Brazil:

1. Vulnerability of forms of integration and social inequalities;
2. Intensification of work and outsourcing;
3. Insecurity and health at work;
4.Loss of individual and collective identities;
5.Weakening of workers' organization;
6. Condemnation and dismissal of Labor Law.

In health, other factors must be exposed, such as the loss of quality of services offered to the population and the deficiency of human resources management, which causes dissatisfaction on the part of professionals and patients (PIALARISSI, 2017).

Solutions should be debated by public administrators, managers and representatives of the working class, in order to guide the problems and organize strategies and suggestions for improvements (PIALARISSI, 2017).

GUARANTEE OF HEALTH CARE FOR THE POPULATION

Over the years there have been important changes in policies and guidelines related to the management model applied to the SUS, including financing configurations and resource reallocation.

Therefore, planning is essential for professionals to have working conditions and income, users to achieve the quality of care offered and service providers to achieve this balance (MENEZES, MORETTI, REIS 2019).

Emphasize that public health services are permeated by the responsibility of the state, using what is described in the Federal Constitution of 1988, in its "Art. 196 -Health is the right of everyone and the duty of the State, guaranteed through social and economic policies that aim to reduce the risk of disease and other health problems and universal and equal access to actions and services for their promotion, protection and recovery" (MENEZES, MORETTI, REIS 2019).

The social credibility of the social work carried out by social entities were foundations that contributed to the growth of the third sector, which reinforces the traditional values of Brazilian culture and thus there was improvement and strengthening of these which became part of the health promotion, protection and recovery services , as provided for in legislation and public health policies (MENEZES; MORETTI; REIS, 2019).

ESTABLISHMENT AND ORGANIZATION OF CONTRACTS

According to the terms of art. 198 of the Federal Constitution and art. 4th of Law No. 8,080, of 1990, the SUS is made up of health actions and services , provided by federal, district, state and municipal public bodies and entities, with the participation of the private sector in a complementary manner, through partnerships. or the purchase of services (SALGADO, 2017).

Concrete and emerging situations in the country in the field of health due to growing and more complex demands required legal-administrative alternatives for the provision of services to the population and complementing the direct action of the Public Power. Public-private cooperation requires the use of management methods and instruments, which requires exceeding previously established goals, highlighting the importance of ensuring adequate technical guidance and instrumentation for professionals, civil servants and public managers who conducted the planning

and negotiation processes. , implementation, monitoring, evaluation, supervision and control of the results of these contracts (SALGADO, 2017).

There are several models of contractualization and institutional performance in the SUS. The figure below seeks to investigate and exemplify two of these models through a flowchart, how it happens and how it proves to be functionally important.

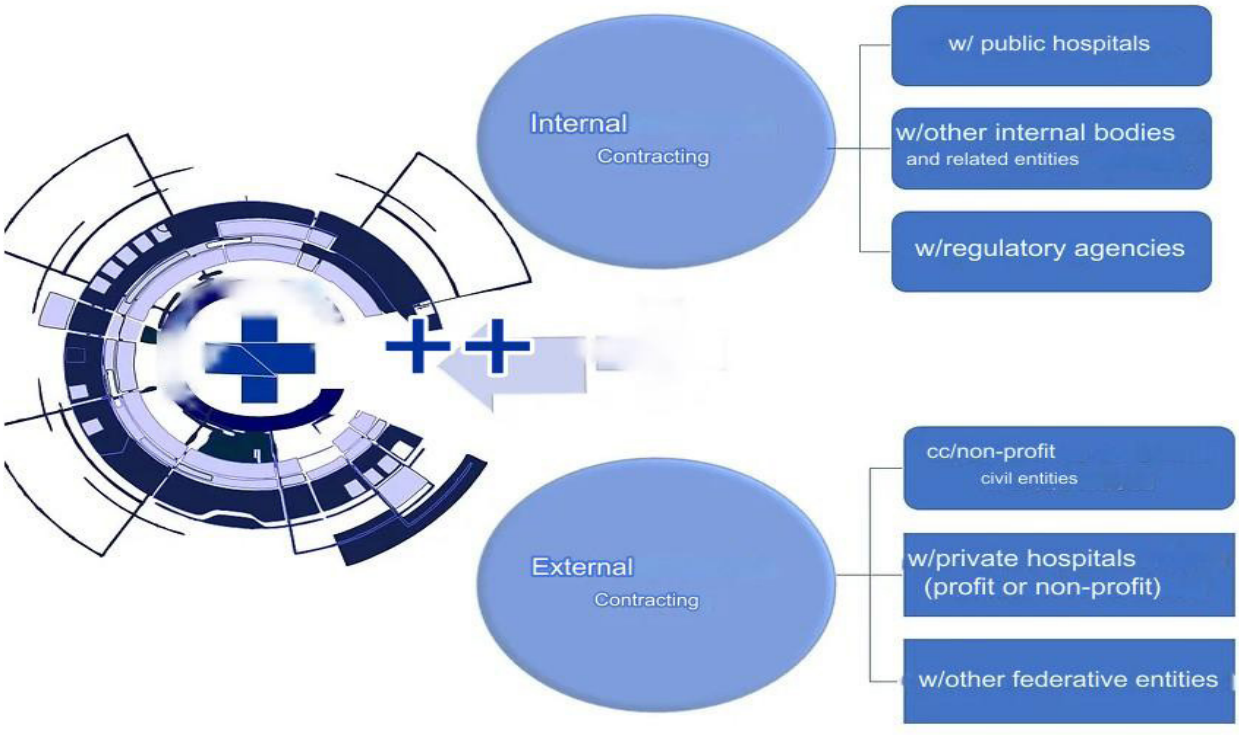

Figure 1. SALGADA, Valeria. Contracting in the SUS. Contracting models. Available in: https:// www.contratualizacaonosus.com/documentos-1. 2017.

The Flowchart presented stratifies internal and external contractualization and presents in an explanatory manner the differences between them, with: 1) internal contractualization being the model that takes place through a management contract or similar intermediary within the administration, between the SUS manager and entities linked to the Health Secretaries, with the purpose of meeting

previously established performance goals. It is important to highlight its administrative coordination and supervision functions provided for in item I of the sole paragraph of art. 87 of the Federal Constitution and Articles 19 to 28 of Decree-Law No. 200 of February 25, 1967. Its purpose is to encourage the contracted body or entity to adopt the results-based management model; and expand the government's internal capacity to implement public health policies in a coordinated and synergistic manner; 2) external contractualization that occurs between the SUS manager and private entities, preferably non-profit ones also with a public contract model directly with the following: Ministry of Health, State or Municipal Health Secretariats and their linked entities, providing compliance with the contractual object , including pacts and agreements between the parties. This is provided for in the National Program for Improving Access and Quality in Primary Care, and in the contracts signed with SUS managers (SALGADO, 2017).

OUTSOURCING REINFORCES EXISTING NEOLIBERALISM

To understand and distinguish liberalism and neoliberalism, it is important to note that classical liberalism advocates that the government does not intervene in the economy, respecting the functioning of the market in a free and unregulated manner (REIS, 2018). In neoliberalism, there is an inversion of this principle, in which the market becomes the standard for regulating government practices, limiting state intervention (REIS, 2018).

At the beginning of Fernando Henrique Cardoso's (FHC) government in 1995, the country faced a general oil strike that had a significant impact . This movement left a lasting mark on FHC's government program and revealed the political interests that dominated the Executive. Neoliberalism, which began discreetly with Fernando Collor de Mello, manifested itself more harshly during FHC's government, resulting in the defeat of the workers' union movement and highlighting the presence of neoliberalism in Brazil (REIS, 2018).

FHC came to be seen as an enemy of workers, which contributed to the election and victory

of Luiz Inácio Lula da Silva as president in 2002.

Lula took office for the first time in 2003 with the expectation of bringing remarkable social changes to Brazil. However, even with the victory of the Workers' Party, it was not possible to prevent the State's privatization policy and the reforms imposed by the IMF. The health sector was also affected by these reforms (REIS, 2018).

During the second decade of the 21st century, from 2016 to 2022, neoliberalism in the health area manifested itself intensely, highlighting the State's actions in favor of the market. An example of this was the adoption, during the Temer government, of an economic policy based on austerity, to the detriment of social policies. Furthermore, the implementation of a fiscal adjustment policy stands out, which froze public expenditure for up to 20 years. This scenario was established by the New Fiscal Regime (NRF), established by Constitutional Amendment (EC) 95, revealing the elements of new neoliberal project in Brazilian health (MENEZES,MORETTI, REIS, 2019).

Since Temer's administration, the Unified Health System (SUS) has been the target of proposals for structural changes, with the spending cap being used as a way to control and publicly expose expenses. visible, establishing a connection between austerity and collective interest. EC 95 created a sensitivity towards the expansion of expenses, making social policies merely an object of control (MENEZES, MORETTI, REIS,2019).

The health budget at the federal level was frozen for 20 years, being readjusted only based on inflation measured by the Broad National Consumer Price Index (IPCA). EC 95 disregarded the health needs of the population, population growth, demographic transition, the necessary expansion of the health network and the incorporation of technology in the health area (MENEZES, MORETTI, REIS, 2019).

Changes in the care profile, with the increase in the prevalence of communicable and non-communicable diseases and external causes, together with inflation in the health sector, higher than in other sectors of the economy, led to a decoupling of social spending in relation to revenue growth in the next 20 years. Even with an increase in federal revenue, there would be no additional resources for

investments in social policies. The basic principle of EC 95 was to prevent real gains from economic growth from being automatically directed to primary expenses (MENEZES,MORETTI, REIS,2019).

If this situation persists, with underfunding actions, it is possible that the SUS will become increasingly smaller and more precarious than what is currently available to the Brazilian population. These premises point to a possible return to an exclusionary health system, benefiting only a few. Even with outsourcing projects in the neoliberal model, it is not possible to predict the criteria that would be proposed for population stratification, nor the scope and quality of care that would be provided (MENEZES, MORETTI, REIS, 2019).

FINAL CONSIDERATIONS

The concepts presented so far refer to a past in which social policy did not aim to guarantee rights, but rather to maintain an individual logic based on dependence on social charity, mediated by the purchasing power of the bourgeoisie. It can be argued that, for a country with a history of slavery and exploitation of cheap labor, the challenge is not to make social spending fit into the public budget, but rather to make universal rights are internalized by the elite, who are indignant at the basic rights offered to the working class.

In this context, the images conveyed by advertisements emerge, which only perpetuate the fight against racism and other social issues from the old world, disguised as something new. In it, the public budget is disconnected from social obligations and commitments, serving only to naturalize the exclusion of workers and serve the interests of the market.

The market, in turn, observes the ineffectiveness and insufficiency of public authorities in providing health services and starts to use laws as guides to improve daily, offering opportunities for negotiation and outsourcing in the health area.

References

PIALARISSI, Renata. Precariousness of work. Health Administration Magazine, v.17, n.66, 2017.

REIS, Ana Terra. NEOLIBERAL DESERTIFICATION IN BRAZIL (COLLOR, FHC AND LULA). PEGADA-A Revista da Geografia do Trabalho, v. 19, no. 1, 2018.

AZEVEDO, Braynna Barbosa. Outsourcing in Brazil: an analysis of the changes brought by Law n.13.439/2017.

DRUCK, Graça. Outsourcing in public health: different forms of precarious work. Work, education and health, v. 14, p. 15-43, 2016.

ORGANIZATIONAL, Dutra Gestão. Challenges of government and third sector partnerships. Administration magazine, v. 33, no. 1, p. 12-19,1998.

SANTOS, Nelson Rodrigues dos. SUS 30 years: the beginning, the journey and the direction. Science & Public Health, v. 23, p. 1729-1736,2018.

MENEZES, Ana Paula do Rego; MORETTI, Bruno; REIS, Ademar Arthur Chioro dos. The future of the SUS: impacts of neoliberal reforms on public health - austerity versus universality. Health in debate, v. 43, p. 58-70, 2020.

SALGADA, Valeria. Contractualization in the SUS. Contractualization models.Available at: https://www.contratualizacaonosus.com/documentos-1 . 2017.