



CHANGES WITH THE CREATION OF THE UNIFIED HEALTH SYSTEM: ORAL LIFE HISTORY

MUDANÇAS COM A CRIAÇÃO DO SISTEMA ÚNICO DE SAÚDE: HISTÓRIA ORAL DE VIDA CAMBIOS CON LA CREACIÓN DEL SISTEMA ÚNICO DE SALUD: HISTORIA ORAL DE VIDA ÚNICO

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ABSTRACT

Objective: to know the changes that occurred in the health assistance, through rescue of the oral life history, since the Unified health system foundation till nowadays. **Method:** a descriptive study, with qualitative approach, using the life narrative method of a deponent, through the field notebook and semi structured interview, conducted at the Rio Grande do Norte State University. Data were analyzed by the thematic analysis technique. **Results:** after analysis, emerged the category: <<Changes with the unified health system>>. The deponent specifics his living during the 1970's and the 1980's, which caused huge changes at the policy, the health and the Brazil formation **Conclusion:** the life history of the deponent allowed the approach to changes that need to be thought about after the conception of a new health assistance type. **Descriptors:** Unified Health System; Public Health; Community Health Nursing.

RESUMO

Objetivo: conhecer as mudanças que ocorreram na assistência à saúde, por meio do resgate da história oral de vida, desde antes da construção do Sistema Único de Saúde até os dias atuais. **Método:** estudo descritivo, com abordagem qualitativa, utilizando-se o método da narrativa de vida de uma depoente, a partir do caderno de campo e entrevista semiestruturada, realizada na Universidade do Estado do Rio Grande do Norte/UERN. Os dados foram analisados pela Técnica de Análise temática. **Resultados:** após análise, emergiu a categoria: << Mudanças com a criação do sistema único de saúde>>. A depoente especifica sua vivência nas décadas de 1970 e 1980, de grandes mudanças na política, na saúde e na formação no Brasil. **Conclusão:** a história de vida da depoente permitiu uma aproximação com mudanças que precisaram ser pensadas após a concepção de um novo modelo de assistência à saúde. **Descritores:** Sistema único de Saúde; Saúde pública; Enfermagem em Saúde Comunitária.

RESUMEN

Objetivo: conocer los cambios que se han producido en el cuidado de la salud a través del rescate de la historia oral de la vida desde antes de la construcción del Sistema de Salud hasta la actualidad. **Método:** Estudio descriptivo con un enfoque cualitativo, utilizando el método de la narración de la vida de un declarante con diario de campo y la entrevista semi-estructurada, realizado en la Universidad del Estado de Rio Grande do Norte. Los datos fueron analizados mediante la técnica de análisis temático. **Resultados:** Después del análisis, surgió la categoría: <<Los cambios con la creación del sistema único de salud>>. El declarante especificó su experiencia en los años 1970 y 1980, los principales cambios en la política, en la salud y en la formación del Brasil. **Conclusión:** la historia de vida de la declarante permitió una aproximación a los cambios que necesita ser pensado después del diseño de un nuevo modelo de atención de la salud. **Descriptores:** Sistema Único de Salud; Salud Pública; Enfermería en Salud Comunitaria.

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INTRODUCTION

The changes in health care provided by the State to the population occurred gradually, through various health care models, and also significant changes in management, in work processes and health professionals. In this perspective of changes, this study comprises the life history of a witness from the health NIMASW model to the creation and consolidation of the unified health system (UHS).

In the mid-70s, during the military regime and before the creation of the UHS, came the National Institute of Medical Assistance and Social Welfare (NIMASW), which was responsible only for the health of workers who contributed to social security and their dependents. The NIMASW was characterized for paying medical and hospital care. In contrast to this, those individuals who did not have an employment activity, let their health at the mercy of the Ministry of Health, which already existed at that time, categorized by its assistance campaigner.¹

The health system NIMASW was considered exclusionary for a large part of the population because they hadn't universal character. Taxpayers workers were entitled to assistance in their illness, but many barriers were present for others. Then, there was the necessity of a formal employment to be guaranteed the health care, even when this care had no quality.²

Therefore, it is important to say that the active politics at that time privatized the NIMASW services through contracts made from pension funds, stimulating the performance of the hospital care. Thus, the health actions was developed by specialty, with no integration, hindering the continuity of care.³

The years passed by and the health did not improve, workers contributed and did not have a medical care with quality; the self-employed, domestic and farm workers had no right to health and lived at the mercy of diseases. Soon, people began to manifest and started the first social movements in favor of the right to health.⁴

A movement that was essential to trigger great changes was the Brazilian Health Reform. This happened in the mid of the 70's and 80's, and was proposed in a time of intense changes, intending to be more than a sectoral revolt. The revolt aimed to serve for the democracy and citizenship consolidation in the country. The reality of the late 70s and early 80s, was still of exclusion for most citizens to the right to health.⁴

As a result of the Health Reform Movement in 1986, took place the VIII National Health Conference (NHC), proposing a model of social protection, to guarantee the right to full health. Soon after came the 1988 Constitution, known as the Citizen Constitution, having as one of its brands the Unified Health System (UHS), and with it the recognition of many rights of citizenship. Health begun to be recognized as a right for all, and as a duty of the State.⁵

Thus, from the social movements and the discussions of health reform, came the creation of the unified health system in 1988, from the Brazilian Federal Constitution. Since then, the UHS has passed by many changes and challenges in search for attention to the integral health and human.⁶

The UHS as a result of the health reform movement, can be considered as a result of struggle, achievement and hope because to be created, a crowd of people turned a proposal created in their own society, a part of a social protection system.⁷

There were many important events in the building democracy course in a country whose society has always been marked by a governmental authoritarian and hierarchical structure and by the private predominance of the population; these characteristics reinforce the forms of social inequalities. Thus, the relationships that were always present were the favoritism, patronage, protection, cooptation or oppression relations, depending on the degree of inequality that separates the social groups in relation or conflict. Therefore, it can only be continued and implemented a democratic health policy if this entire social structure really fall.⁸

Despite the achievements, the system still has some weaknesses, such as problems with the management of health services; lack of management with the financial resources and political affinities in the choice for management positions; deficiency in the inputs supply and a poor and inadequate infrastructure. Moreover, the hegemony of the biomedical model also presents itself in the professional mentality and users' practice.⁹

This study aims to understand the changes that have occurred in health care through the rescue of life oral history since before the construction of the Unified Health System to the present day.

METHOD

A qualitative study, using the method of oral history, at the oral history mode of life.¹⁰

The qualitative research focuses on individuals and the environment in which they are inserted with their complexities without any control posed by researcher. Therefore, it is based on the argument that the knowledge of individuals are only possible with the description of human experiences, as it is lived and as it is expressed by those who live.¹¹

The oral history of life is defined as a record of personal experience following a procedure in which the interviewer interfere as little as possible, acting as a stimulant, and the witness is free to speak of their experience. It is took care of prints and subjectivities, and the individualization is the key.¹⁰ It is given to the subject the freedom to expound freely about their personal experience related to what is being asked by the researcher.¹²

Before recording, they must be enrolled in a field notebook identifying data (project name, date, interviewer's name, employee name, interview location) and during its implementation, it should be recorded that the interview will have a conference and that nothing will be published without the prior consent of the employee. The cutting issues should be formulated preferably at the end of the interview.¹³

After the interview, there is the necessity for change from the oral report to written text to make it available to the public. Therefore, it is necessary to the transcription, textualization and transcreation steps.¹⁰

The population survey sample is composed by a professor of the graduate course in nursing at the Rio Grande do Norte State University, in Caico campus, who experienced the implementation process of UHS. This deponent was chosen based on the purpose of this study and on the individualization characteristics of the of the method of the oral life history, presented herein, being the respondent qualified to give contributions to research questions through the account of her life story. Through the thematic analysis emerged only one category: changes from the creation of the unified health system.

As information gathering instruments were used the field book and semi-structured interviews. The field notebook was filled before, during and after completion of each interview, in which was recorded all data from the deponents, both personal data and data about the interview; because they are of great value to any questions that might arise and that, for some reason, were not recorded.

This research started from the release of the opinion of the Rio Grande do Norte State

University Ethics Committee, by the approval protocol no. 025/11 and CAAE 0018.0.428.000-11. The term of content was signed by the deponent.

The data were analyzed using content analysis technique, in the form of thematic analysis, based on the themes that emerged from the subjects' reports and presented meaning units able to denote the reference values and behavior models present in the narratives.¹⁴ The anonymity of the interviewed was preserved by Isabel dos Santos pseudonym chosen by the deponent.

RESULTS

Despite all the advances and achievements of workers, health care and health surveillance was not yet a right for everyone. If the population were not tax payer, they couldn't get free care. The Medical and hospital expenses had to be paid on their own, translating the privatist thought.

There was no free hospital care and if they couldn't afford, the population were at the mercy of the of professionals and almshouses goodwill, which had very little to offer.

In the following speech, we can see some features of the health model NIMASW:

I was working at the hospital that was linked to NIMASW, a really privatist model, and a patient came to me with a penicillin prescription achieved in a charity home, but he had no taxpayer card. So I could not apply the medicine, because it was the hospital standard, and this made me angry. The health model that existed before the UHS was totally assistance. The importance to knowing the patient's life conditions, their developing activities, food and history, or community characteristics, was unknown or simply ignored. I was getting disenchanted for this assistance (Isabel dos Santos).

That sense of outrage specified by the deponent was linked to the new discoveries and the new thoughts arose in the health area, which contributed to a change in the existing thinking on health and assistance given to the population.

Thinkers and scholars from that time began to question the dynamic of health models and started some revolts and claims.

On the one hand occurred this disenchantment by the way that the patient was treated, and also for the devaluation of nursing professionals from the assistance area. On the other hand, we had been gaining ground in the preventive medicine and in the public health movement. And I charmed with the new thinking about health, which was seen not only as the

absence of disease, but thinking about the individual well being and the environment in which he is inserted. I was part of the fighting moves [health reform], participating in militancy as a student and the discussions for the creation of a system that could guarantee quality health to people (Izabel dos Santos).

The deponent specified moments lived by her, as nursing student and newly registered nurse, during the 1970s and 1980s, which were of great revolutions and changes in policy, in the health area and the health training area in Brazil.

The movement of the health reform and the VIII Conference were result of essential social movements at that time and the creation of the Unified Health System.

The speech below shows that the deponent was part of this story and of the discussions that led to UHS:

I participated in the struggle for the unified health system construction, which was very important for my training in my opinion, for my decision to change and even qualify me as a sanitarian nurse and also participate in the social medicine at the time. (Izabel dos Santos).

With the introduction of a new health system that turns its attention to actions that go beyond medical assistance, the health concept, previously seen only as the absence of disease, achieves a change. Thus, this concept has been expanded, now interpreted as a complete state of physical, mental and social well being.

This thoughts and concepts transitions is well explained in the contributor study speech:

We were from then on, with the understanding that there was a new way to understand and to deal with health, health seen not only as the absence of disease, but health seen positively, as quality of life (Izabel dos Santos).

DISCUSSION

The government was reaching a thought of social security for the population, increasing their responsibilities regarding the health and turning to an ever-increasing scope of its actions related not only to medical and hospital care, but also relying on the sanitarian care.

In 1966, took part the unification of Social Security, Retirement and Pension Institutes and the National Social Security Institute (NSSI), a fact that standardized services and benefits, dispensing workers from the management area. It marked the government's entry as the main actor of the

social security policy, and also to the regulation. In addition, was formed the insurance of work accidents (1967) and the social security to rural workers extension (1971), to the maids (1972) and to autonomous (1973).¹⁵

Thus, the Social Security was gradually reaching all the working classes, providing them with many rights, in addition to medical care.

In 1977 it was created the National System of Social Security (NSSS), which followed a rationalized and efficient formula, but with the privatist features, centralized and exclusionary with the policyholders. This consisted of three institutes: the National Institute of Medical Assistance and Social Welfare (NIMASW) for medical care; The NSSI, for the benefits and the the Financial Management Institute of Social Security (FMIS) for the financial control.¹⁵

The NIMASW was established to provide health care only to taxpayer workers and their dependents, excluding the remaining portion of the population. This, along with its private hospitals, developed assistance with hospital-centered character, which the only interested was in the healing of individuals, with no continuity or comprehensive care.¹

The hospital-centered/curative privatist was a widely used model at the time. This consists of a biological/individual approach and appears when you have a small view of the disease process, without coordination with social determinants. In this curative medical model are disregarded the emotional, psychological, cultural, economic and social determinants that affect the people's health status.¹⁶

The country was under double vision of a system divided between welfare medicine and public health. The first had actions aimed at the individual character of health of formal workers and turned primarily to urban areas, being in charge of pension institutes. Public health, under the command of the Ministry of Health (MOH), was mainly directed to the poorest sectors of the population, and its main target was the preventive care activities.¹⁷

Given this situation, the population and the scientific community started to revolt with the current healthcare model because it did not have universal access, excluding a huge part of the population to the right of health. Moreover, the existing models did not continue equally causing to health any improvements. From this, the society began to organize movements for the assistance to a decent health.

The student movement was essential and important in the last century with its presence on the political scene at the time of the dictatorship in Brazil. Succeeded, for a time, be the social actor of greater strength and organization, attracting other groups and social movements to fight for better conditions of life and health.⁴

The pension crisis, the country political democratization and the population pressure for better housing, infrastructure and sanitation conditions were enough to start a mobilization among students, health and education professionals. In addition to these people, also the sanitarians, political and expressive people of the community participated in this movement known as Sanitary Reform.

The movement begun in the 1970s, idealized by some intellectuals linked to preventive medicine, who dedicated themselves to understand the current health care model and criticize its dynamics and practices. These movements have established a new way of thinking about health, turning to the social sciences, the Marxist theory, the dialectical and historical materialism, dividing the focus given to the biological sciences and the study of the diseases transmission ways.¹⁸

The conference discussed and approved the unification of the health system, the expanded concept of health, the citizenship right the state duty, developed new system's financial bases and the creation of institutional institutions for social participation.¹⁵

The VIII Conference paved the way for the health care reorientation and public health, showing that health would gradually improve.

In 1988, the new Brazilian Constitution was enacted, which established in its Article 194, health as part of social security, "an integrated set of initiative actions by the government and society made to ensure the rights to health, pension and social assistance" thereby, health came to be regarded as a universal right and the State duty (article 196). Then a move towards decentralization and regionalization of health services started in order to ensure this system effectiveness.⁴

The UHS is governed by a set of principles and guidelines valid throughout the Brazilian territory, which guarantee the decentralization of services, comprehensiveness in care and the community participation. The UHS was established by the so-called Organic Laws of Health. Those laws were enacted in 1990, Laws 8080 and 8142, were legal basis of organization from the new health system in Brazil, the UHS.²

The Organic Health Law 8080 established the UHS principles and guidelines: Universal access to all care levels, health care equality, without prejudice or any kind of privileges, Completeness of assistance, understood as an articulate and continuous set of actions and preventive and curative services, individuals and collective, required on all system complexity levels, community participation and political and administrative decentralization with a single management in each government sphere.¹⁹

With its creation, the UHS left eternal marks on the health right registered in the Charter Magna.²⁰ In this scenario, the health is not seen only with a biological focus anymore, and now is seen in a fully was as in the social, economic, cultural and biological context.

The extended health concept was decisive for that the services begun to see not only the individual, but the environment, the family and the collective. Fact that changed the thought that the disease was the only target problem, dividing its attention to the life quality, the citizen's work and family as well as their community and the infrastructure problems and operational faced by the community.²¹

If the health concept has changed, some approaches about the disease and the sickness have also changed. The health problems that before were related to a unique cause - divine punishment, demons possession or some microbiological factor - model so-called as unique cause model, have been now related to multiple causes - social, psychosocial, biological, chemical and physical aspects - known as the multi cause model.²¹⁻²²

The changes occurring in the economy, politics, society, the scholars thinking and popular uprisings generated by the poor infrastructure conditions in the country have contributed to significant changes in health in Brazil. These changes have improved the way to treat disease and, especially, the way to face health.

It is possible to understand that the achievement of a qualified and well distributed health care was only possible with the creation of a health system able to cover all the health and disease process. This system would encourage activities and strategies to promote health, to prevent disease and to provide all the necessary framework for the disease detection, treatment and cure when it is possible.

Thereby, the state also had to mobilize itself and create strategies, policies and programs to effective the UHS, aiming to decentralize the health care, consolidating its

principles and guidelines. The UHS has also enabled the growth of some health professions and medical specialties.

From this significant system growth and for the number of professionals involved in its operation, nursing had access to some programs created by the Ministry of Health and consequently gained autonomy and many responsibilities to the population health.

CONCLUSION

The deponent's life story allowed us to get closer to all the UHS creation process and to the changes that needed to be thought after the new health care model conception, which required a new profile as for the professionals and services as for the government and managers.

During this study, it is evident in some parts how much the Brazilian people suffered under privatist health models and the attention to biological and technicalities health, and how hard it was for the population to work in the health area before the expanded concept pervade the scholars thinking and spread among professionals and services; Period when the UHS hadn't been considered.

The deponent collaboration was extremely important for the study, providing a greater excitement and liveliness of the facts, because the work included the materialization and feelings from her words. She experienced the changing process in thinking that has contributed to a new health model and had the opportunity to participate in programs that made possible the UHS consolidation.

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