PROGRAMA CEGONHA CARIOCA: SERVICE CONTRACTUALISATION BY SOCIAL ORGANIZATION

PROGRAMA CEGONHA CARIOCA: CONTRATUALIZAÇÃO DO SERVIÇO POR ORGANIZAÇÃO SOCIAL PROGRAMA CEGONHA CARIOCA: CONTRATUALIZACIÓN DE SERVICIO POR ORGANIZACIÓN SOCIAL

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ABSTRACT

Objective: to analyze the controversies of the management model in the implementation of the *Programa Cegonha Carioca*. **Method:** this is a qualitative, descriptive study, with life narrative method, with 15 participants among nurses of prenatal care, of the module Transport and Program Managers (nurses and physicians). Data were produced from open interview. The interviews were simultaneously recorded and transcribed, grouping them by thematic units, with emphasis, in this article, on the narratives addressing the implementation of the program and the service contractualization. **Results:** the study included the narratives that marked the creation and deployment of the PCC, highlighting the controversies in contractualization of resources by Social Health Organizations (SHOs) for its operability. **Conclusion:** the life narratives allowed identifying and analyzing three major controversies in the management model that marked the implementation of the *Programa Cegonha Carioca*: the unconstitutionality of management by SHOs, the autonomy justified by the efficiency and quality of service and the flexibilization of the labor force, which leads to instability of the professional working in the PCC. **Descriptors:** Health Policy; Nursing; Obstetrical Nursing; Women's Health; Maternal-Child Health Services; Health Programs and Plans.

RESUMO

Objetivo: analisar as controvérsias do modelo de gestão na implantação do Programa Cegonha Carioca. **Método:** trata-se de estudo qualitativo, descritivo, com método de narrativa de vida, com 15 participantes entre enfermeiros da atenção pré-natal, do módulo Transporte e Gestores do Programa (enfermeiros e médicos). Realizou-se a produção de dados a partir entrevista aberta. Gravaram-se e se transcreveram simultaneamente as entrevistas, agrupando-as por unidades temáticas, e se destacaram, neste artigo, as narrativas que tratam da implantação do Programa e a contratualização do serviço. **Resultados:** contemplaram-se as narrativas que marcaram a criação e a implantação do PCC, destacando-se as controvérsias na contratualização de recursos por Organizações Sociais em Saúde (OS's) para a sua operacionalidade. **Conclusão:** evidencia-se que as narrativas de vida levaram à identificação e à análise de três principais controvérsias no modelo de gestão que marcaram a implantação do Programa Cegonha Carioca: a inconstitucionalidade da gestão por OS's, a autonomia concedida com a justificativa de eficiência e qualidade do serviço e a flexibilização da força trabalho, que leva à instabilidade do profissional atuante no PCC. **Descritores:** Política de Saúde; Enfermagem Obstétrica; Saúde da Mulher; Serviços de Saúde Materno-Infantil; Planos e Programas de Saúde.

RESUMEN

Objetivo: analizar las controversias del modelo de gestión en la ejecución del *Programa Cegonha Carioca*. **Método:** este es un estudio cualitativo, descriptivo, con el método narrativo de la vida, con 15 participantes entre enfermeiros de atención prenatal, módulo de Transporte y Gerentes del Programa (enfermeros y médicos). Los datos fueron producidos a partir de entrevista abierta. Las entrevistas fueron grabadas y transcritas simultáneamente, agrupándolas por unidades temáticas, destacándose, en este artículo, los relatos relacionados con la ejecución del programa y la contractualización del servicio. **Resultados:** se contemplaron las narrativas que han marcado la creación y despliegue del PCC, destacando las controversias en la contractualización de recursos por las Organizaciones Sociales en Salud (OSs) para su operatividad. **Conclusión:** las narrativas de la vida condujeron a la identificación y análisis de tres de las principales controversias en el modelo de gestión que caracterizó la ejecución del *Programa Cegonha Carioca*: la inconstitucionalidad de la gestión por parte de OSs, la autonomía concedida con la justificación de la eficiencia y la calidad del servicio y la flexibilización de la fuerza de trabajo, lo cual conduce a la inestabilidad de la actuación profesional en el PCC. **Descriptores:** Política de Salud; Enfermería; Enfermería Obstétrica; Salud de la Mujer; Servicios de Salud Materno-Infantil; Planes y Programas de Salud.

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INTRODUCTION

Health in Brazil, as well as in Rio de Janeiro, is characterized by recurrent problems, difficult to control and related to: lack of access to comprehensive care in the humanized perspective; small number of vacancies because of poor public space; instability and precariousness of public health services and, especially, the lack of human, material, supply and logistic resources; the delay in service of the programmed demand, including the spontaneous demand, with long queues, often without care coverage and increased capacity beyond the scheduled service, causing overcrowding and the attention focused on the poorest people.¹

In women's health care, the situation worsens, with when there are complicating factors of assistance: the pilgrimage of pregnant women, with an exhaustive journey to seek health care and their greater exposure to risks; the vagueness of the unit of reference and counter reference to ensure delivery care by denying the institutional link between prenatal and maternity and the refusal to attend to pregnant women at some units that do not have the necessary conditions for the implementation of government proposals.¹

In this context, the City Health Department of Rio de Janeiro (SMS/RJ) created the *Programa Cegonha Carioca* (PCC), in March 2011, a strategy for the eradication of the complicated pilgrimage of pregnant women and to encourage the accomplishment of prenatal care, reducing the rates of maternal and child mortality in the municipality through the organization and qualification of prenatal care, delivery and birth¹. This measure was subsequently included in the guidelines of the *Rede Cegonha*, established by Decree of GM, MS, 1,459, of 24 June 2011.²

The management of the *Programa Cegonha Carioca* opted for hiring a Social Health Organization, a practice that has been growing as a model for the management of health services. Nurses were hired for the operationalization of all the PCC as a strategy of resignification of the care mode in obstetrics.³

OBJECTIVE

- To analyze, in the narratives of nurses and managers of the *Programa Cegonha Carioca* (PCC), the controversies of the management model in the implementation of the program.

METHOD

A qualitative, descriptive study, using the life narrative method, which requires an intense fieldwork and ambiance with the social subjects requiring support for documents on the PCC, which complemented the information. The life narrative uses the life history, narrated to the

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interviewer as evidenced by the participant, leading the researcher to focus on the point of convergence or divergence of humans, in their social, culture and praxis conditions, as well as the structural social relations and historical dynamics.⁴

The study site were a Basic Health Unit (BHU) in Rio de Janeiro and two municipal maternity hospitals that serve as bases for the ambulance transport of the PCC for delivery and birth. There were 15 participants: five nurses working in the prenatal care at the BHU, five nurses who worked in the transport/ambulance module (from prenatal to maternity) and five PCC managers (three doctors and two nurses).

The data were collected from January to April 2014. The research began after the participants' signature of the Informed Consent Form, and applying an instrument to characterize the professionals' profile. Furthermore, the professionals' work in the deployment of the PCC was recorded, varying from 11 months to five years. Of these, two managers, a nurse and a doctor reported having participated in the scope of planning and organization of the Program, prior to deployment. Moreover, among the other participants, the majority have worked in the program since its deployment, totaled three years between 2011 and 2014.

Regarding the labor aspects of these participants, 12 of them were employees with contracts signed with Social Organizations (SO's) and three, as government workers exclusively. Furthermore, five of these twelve accumulate government works, with three in the city of Rio de Janeiro and two in other municipalities in the state, in addition to one professional who had two employment contracts of different OSs, working in the transport module and at a maternity ward of the municipality.

After characterizing the 15 participants, the open interviews adhering to the life narrative method were carried out with the following guiding question: "Tell me about your story as a nurse/manager in the implementation of the *Programa Cegonha Carioca*". The narratives were analyzed as recommended by the method, simultaneously with data collection, with the consolidation of the thematic units by means of the comparison of the narratives between themselves and with each other, and the subtraction of meanings, obtaining the construction of an analytical category.⁴

The interview had a uniqueness to allow further information contained in the biography of participants and its association with the situation studied. As the life narrative method,⁴ one highlights the establishment of a bond between researcher and researched in the context in which the relationship develops. This study occurred

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from a broader research project, written by the study advisor, which addresses the “Professional Training in Women's Health: Study Integration to Work”, approved by CNPq.

The study was developed following the ethical norms in researches involving humans, being approved under opinion 284/11 of the Research Ethics Committee of the City Health Department of Rio de Janeiro.

RESULTS

The professionals' narratives raised questions relating to the implementation of the PCC, in relation to its beginning, planning, organization and operation and the management proposal of the service in the PCC. In this context, the managers' reports show that the harmful pilgrimage had to be eradicated, justifying the creation of the program; and the professionals who focused lack of knowledge about the PCC philosophy and planning, recording, including a great contradiction regarding the proposal of service management for its accomplishment.

The program planning, according to the managers' narrative, included three main goals: reduction of maternal and child mortality, eradication of pilgrimage and improvement of the quality of the reception at the maternity, even without conditions due to lack of objective data for its verification. These goals justified the initial definition of binding of the pregnant woman to the maternity, registering the importance of beginning with the reorganization of prenatal care in the Basic Health Units (UBS). In Brazil, without the PCC, the mother of this BHU would be linked to a maternity hospital of reference, assuring her, in this way, the continuity of care from a restructuring of the Regulation National System (SISREG), which could not happen due to lack of bed guarantee in maternity wards for a scheduled and spontaneous coverage of pregnant women, which is illustrated below.

That one where, if the woman needs to be hospitalized, or undergo any procedure, she is released from the maternity [...]. That harmful pilgrimage, “we’re full, girl, you have to go to another (maternity)”, that one that the guard says “no vacancy, bye!”, this had to be eradicated [...]. To this end, we are speaking of a heavy structuring of SISREG, network restructuring, then, it took a year to do this whole logistics and planning. (Manager 2)

The lack of the binding from prenatal to delivery, plus the disorganization of the entrance door to the healthcare system somehow were responsible for perpetuating the “pilgrimage”. And then, at the end of 2009, and in the early months of 2010, it began to gain form and the name Cegonha Carioca, this action plan for this new cycle of management. The first name was “SAMU Cegonha” and then, it became Cegonha Carioca, this name was born when some

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actions that comprised the Cegonha were already being put into practice. (Manager 5)

After justifying the need for restructuring the network as part of the PCC planning, which, according to the speeches, started in 2009, the City Health Department of Rio de Janeiro (SMS/RJ), in October 2010, launched the public notice for partnerships with Social Health Organizations (SHOs) for the management, operation and implementation of health services and actions of the *Programa Cegonha Carioca*, without which its accomplishment would not be possible. Therefore, since the creation of the PCC, the municipality adopted a management model of contractualization of resources and services through acts of public administration and the institutions that represent them; on one side, the contractor (municipality/government/financer) and, on the other side, the hired institution (SHOs/companies/provider), thus establishing methods and instruments for financing resources and services in the PCC without governmental character and which, in the managers' words, there would be no problem in adopting this strategy, on the contrary: it would be the right way to ensure financial resources for the practice of the program.

I do not see a problem in relation to the management by SHO because everybody, in a certain way, ends up being government agents. (Nurse Manager 3)

The department has an option of this management mechanism; today, I appreciate it as a wise decision and, particularly, for Cegonha Carioca, which had to buy layette, hire ambulance and had logistical aspects very specific and difficult in direct administration. Can you imagine delaying the public tender and not having a layette? The mechanisms of direct administration are challenging, then, when there is this specificity of ambulance, layette, then, there is the management and operational contracting; what the SHO does is driving these operational issues. (Medical Manager 5)

This manager's report continues.

There is a consolidation of some principles that have been built in delivery care in the last 15 years that were maintained; the mayor changed, the secretary changed, but this was kept, then, I firmly believe the stability of these achievements that were consolidated here. Specifically, in the Cegonha, I would never defend a direct administration for the layette and to the ambulance. These are very clear activities. Throughout Brazil is like this, as activities that may be in a management contract. (Medical Manager 5)

Most interviewed managers and nurses reported having contractual binding of different SHOs and some of them, mostly those who work in prenatal care, were not opposed to the type of management and their contracting by the SHOs and not by public service exams, imposed by the

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municipality of Rio de Janeiro and, consequently, their work in the program, highlighting that, according to the narrative of these professionals, the quality of the assistance does not depend on the type of professional binding, since it works and is effective.

A government worker doesn't care, as they are virtually immune to resignation, it makes a difference. Not all professionals because I've already seen government workers treating a patient well, but it is a very big difference. (Prenatal Nurse 1)

I think that, from the moment the program works, is working and has competent professional, I think that it doesn't matter if the professional is hired, federal, state worker, I don't think it matters, the important is to ensure the quality. (Prenatal Nurse 3)

I think that, if it's working, effective, I see no problem at all. It's worked, that's what matters for the population. (Prenatal Nurse 2)

Now, in relation to politics, I get afraid when there is change of government; the program is wonderful, I think it should keep going, but we know that these things are very complicated. I see that these SHOs, these things can be working out, but, from the moment they aren't interesting anymore, even if they're meeting goals, if the government changes, or if this government is not interested anymore, they end up. (Transport Nurse 1)

During the narratives, the professionals that were opposite to the type of management and hiring of public health services by a SHO were nurses, in their majority, and indicated, as the main argument, that this type of contract contradicts the provisions laid down in the Federal Constitution (CF 1988) where the lack of public service exams would deny them a labor stability, reducing the labor cost, also disarticulating the concept of a bond between the professional and the user and, as a consequence, denying the quality of management and attention so called by governments.

Unfortunately, as the SHO is a social organization, it's responsible for managing the human resources to a final activity (?), and if we think with the logic of the constitution, our current model is the opposite of what the health system recommends, in which we need to have a team of government workers who will be able to manage their professional team and monitor and evaluate how it's working, but that's not what we see in fact; the SHOs is not a management model compatible with what the Constitution advocates. I can't tell you how it works the assessment of how the money passed by the government has been spent, what we have as feedback are the reports of the ombudsman, which publishes qualitative data. (Transport Nurse 2)

I am a government worker from Caxias and I am hired by a SHO from here. My hiring was through an exam (?), a selection, I had an exam, evidence

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of title, for a hiring, so, well, I think it's very convenient for the government. Because, although our salaries are higher in this type of contract, we worth less, we don't have labor stability, you work over a production goal, and, if don't achieve the goal, you may be dismissed, if your manager doesn't like your hair today, she can dismiss you, so we are always vulnerable, I think that especially the nurse, which is a not so valued profession, which has many health professionals, and which quickly manages to get . So, I think that, with the SHO, the government work will end. With the it, we have no bond, how can you bond with a professionals that can be dismissed any time without any government guarantee (Prenatal Nurse 4).

I think it is complicated because, sometimes, you want to work in a way and, as an employee of the SHO, you have a job that is different from the Constitution. If you don't follow that line, the desired model, you are easily discarded; this is complicated, your employment is always at stake, sometimes, you want to make one thing you think it's right, but for the program, is not right and you're limited. (Transport Nurse 4)

If this SHO keeps going, because I don't know, it changes at each government, sometimes the SHO changes, the program changes, it depends on the government, so, this is also very unstable, the contract ends and has to be renewed, so they hire another SHO to put the transport into practice, then starts that all over again and this has an impact on the quality... Sometimes, you may be in a company, and then, not anymore, and so happens the turnover, which is very bad for the worker, we have no stability and we know what happens in Rio and other Brazilian states. (Nurse Transp.2)

DISCUSSION

♦ Controversies in the management model: the non-State public management of the Programa Cegonha Carioca

The Programa Cegonha Carioca (PCC) was idealized two years before its deployment (2009), comprising three modules of action: the first one relates to the reference and linking of prenatal services in Basic Health Units (UBS) with the municipal maternity hospitals; the second concerns the safety of the transport of pregnant women in labor to the maternity and the third refers to reception at the maternity with risk classification by nurses in maternity wards, whose implementation required financial, human and material resources.⁵

In the context of the implementation of the Programa Cegonha Carioca, the pilgrimage of pregnant women, and overcrowding of maternities, and these problems had a direct relationship with the lack of a regulatory and reference system, with the need for adequacy of care attributed to overuse and underuse of services, precisely what caused the harmful

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pilgrimage, since women passed by a self-reference, seeking care at maternity hospitals of greater complexity and understanding that the same had more resources, assigning the responsibility of access to health services for women.⁶

The situation faced by women while seeking a safe delivery leads to feelings of fear in relation to normal delivery and, as demonstrated in the present study, many are hurt and feel dissatisfied regarding the care received at health services.⁷

The PCC was implanted by means of linking and referencing, driven by the need to restructure health services, by the city hall of Rio de Janeiro, which, for some managers, had already been planned since the end of 2009. The PCC, since its idealization, according to the narrative, as a fundamental requirement to its operationalization, imposed the management of the program, which is public, by a non-governmental organization, in this case, a Social Health Organization (legal person governed by private, nonprofit right), to ensure services, human and material resources, supplies and logistics for the management contract.⁵

Through this kind of management of activities of public policies, and the financial transfer for management of resources, the logic of the private sector, market, and the relentless pursuit of profit are followed, unlike what Federal Constitution advocates, which establishes, in Article 199, paragraph 1, the participation of private institutions in order to complement the UHS; however, what happens is the replacement of the control and management with transfer of State responsibility for Social Organizations.

Studies in the field of social sciences⁸ point out the unconstitutionality of the management of the public service by a SHO, and the positioning of the Federal Public Ministry/MPF, from the Health Working Group, the Federal Prosecutor for Citizen Rights, corroborates this view and emphasizes the non-compliance of the constitutional rule that determines the provision of UHS services directly by public authorities (article 196, caput), being the private sector an attachment to public interests.

Law 9,637/98 establishes the creation of Social Organizations, whose activities shall be directed to education, scientific research, technological development, the protection and preservation of the environment, culture and health, thus becoming activity means and not final; however, what happens is the transfer of responsibility from the public governance for the private sector, with the official justification of more efficient and lower cost services.⁸

The government arguments for the maintenance of SHOs converge with the defense made by managers (especially doctors) and nurses

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participating in the survey, who characterize the management by SHO as a political strategy to offer access to health service with the guarantee of resources necessary for the attention to women during pregnancy, delivery and birth. The management contract signed in the *Programa Cegonha Carioca* proposes the support to resource management, implementation of activities and health services to be developed by the SHO; however, when delegating this responsibility to the Social Organization, the public government also grants it freedom in the management of resources.

With the bestowal of the management of the *Programa Cegonha Carioca* to a Social Organization, it has the power to hire personnel without the need for a public service exam, to acquire goods and services without bidding process and not to account for State's institutional controls, as provided for in Articles 70, 71 and 74 of the Federal Constitution. In this sense, the management of the public health service by SHO, which, in managers' opinion, facilitates the operationalization of the program, on the other hand, opens space to inefficiency and higher costs due to financial and managerial autonomy, in view of the frequent accusations and scandals involving the SHOs.

The autonomy afforded to Social Organizations also leads to the flexibility and precarization of labor and, consequently, the opening of new changes in the way of hiring and structuring services, contributing to the heterogeneous structure of nurses' labor market, which occurs in the *Programa Cegonha Carioca*.³

The PCC manages the transport and reception modules to the woman; however, the Basic Health Units, which comprise the prenatal care linked to the maternity, are managed by other social organizations, which contributes to the heterogeneity pointed out previously, characterizing employments and differentiated workload, hindering the linearity and integration of professionals and service, for a network attention, and directly affecting the service precariousness.

Some interviews demonstrated the defense of the service contracting by the SHOs, for the work of nurses in the PCC, which opens a draining of the debate on social and political dimension of the public service exam, i.e., a government employment in the health service, where nurses from the program have no guarantee of continuity in their work, also hindering the bond between the professional and the user.

On the other hand, the narratives raise the typification of the population as a spectator of the UHS, when reporting that what matters is when the population sees the service working, i.e., the final result, which differs from Federal Law

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8,142/90 that regulates and establishes the community's participation in the management of the Unified Health System, seen as essential in the formulation of public policies and accomplishment of the UHS, in order to meet the real needs of the population, also favoring the reduction of social inequalities and the construction of citizenship and democracy.⁹

The management model adopted in the *Programa Cegonha Carioca* is based on liberalism, taking the path to the health commodification¹⁰. The analysis of the implementation of a program of public health in Finland, in association with the private sector, showed a reduction of control by national authorities on the work of health promotion in the municipalities, resulting in losses for the activities of health promotion¹¹. In this sense, the guarantee of quality and efficiency at health services, proposed with outsourcing, differs from the recurrent problems in management by Social Organizations, which make the service precarious and denote the failure of this management model.

As last controversy, the management adopted in the *Programa Cegonha Carioca* affects and weakens the transition of obstetric model proposed nationally. Humanized and qualified care for women in the pregnancy-puerperal cycle brings positive results in their delivery experience¹². This requires the appropriate use of clinical and non-clinical interventions, in addition to the strengthening of the infrastructure and health network, designing better health outcomes and positive experiences of women.¹³

CONCLUSION

The life narratives allowed identifying and analyzing three major controversies in the management model that marked the implementation of the *Programa Cegonha Carioca*: the unconstitutionality of management by SHOs, the autonomy justified by the efficiency and quality of service and the flexibilization of the labor force, which leads to instability of the professional working in the PCC.

The unconstitutionality becomes clear in the management by Social Organizations where they do not comply with their complementary role legally established, becoming responsible for a service that should be of direct public administration, with the characterization of a private management model in a public health service, in which professionals do not report the philosophy of the program, but the defense of the proposal of management by SHOs.

In the managers' defense of hiring employees of the PCC as a guarantee of the program, by means of employments imposed by Social Health Organizations, three findings of concern were revealed: the need to protect the labor market; to

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propose a management model that values the participation and social control, thus going in opposite direction of the Uhs, not respecting the Federal Constitution and the Health Organic Law (8,142/90).

The methodological reference of life narratives represents a facilitator and the key to achieving a diversity of participants, thus, offering opportunity and chance to speak to these actors regarding their participation in the implementation of the PCC in relation to the contractualization as a management model. The history reported by professionals working in the pre-natal, in the transportation of this service to the maternity and managers (physicians and nurses) at the SMS/RJ level and programmatic areas, showed controversies inherent in the implementation of the program and of the management model adopted that are experienced and, until then, had not been described in scientific studies.

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