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Articles

Magic or enchantment? Management committees in the Brazilian National Health System and changes in healthcare modes

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In a qualitative research about healthcare production in the health networks, the role of management committees in an experience of change in the government of health was evaluated. Using a cartographic approach, we found that the activation of the committees by the government aimed at a double task: to promote institutional democracy and to create governability for the proposed change. Nevertheless, the committees' agendas were predominantly restricted to technical or professional matters, and there was some tension involving several of the network actors. On the other hand, there were encounters in which intra- and inter-team pacts were experienced, through symmetrical and co-authorial relationships: an analyzer that we called "a-significant enchantment". We conclude that the management committees can configure themselves as scenarios for a change, and to that end, we propose to make them pregnant with Permanent Health Education tools.

Keywords: Comprehensive healthcare. Permanent education. Health management. Healthcare reform.

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Introduction

The management of changes in the area of health has been a central concern of governments that support the implementation of the SUS (Brazilian National Health System) since the first movements of the "healthcare reform" in Brazil[1,2]. Would these changes - especially regarding modes of care - happen "magically", as it is frequently desired and even promised by those involved in an electoral dispute? If not, what possibilities are there for this set of desired events? Is it possible, in certain social scenarios, that some kind of "magic" is engendered, enbling new caregiving movements? In this article, we will investigate specific aspects of changes in healthcare modes: the bet on other modes of governing such changes.

It has been considered that the implementation of management committees (MC) may play a central role in such an agenda. It is believed that MC are democratic spaces of dialogic, solidarity practices that enable the formation of consensuses around a project[3]. However, it is known that they can become "hard" spaces with hidden agendas, things that are not said, and tactics to impose verticalized projects whose character is merely instrumental; spaces in which themes related to healthcare tend to be unimportant in the agenda or even be absent from it[3].

In a research entitled "National Observatory for the Production of Different Modalities of Care in the Context of Implementation of Thematic Healthcare Networks in the Brazilian National Health System (SUS): An assessment of those who seek care, those who provide it, and those who use it"[4], carried out in a city in the southern region of Brazil, the researchers studied, as one of the investigation axes and assuming the inseparability between care production and health management in the SUS, the role of the MC in the change in the area of health. The researchers also investigated the multiple possibilities of offering and conducting strategies of change in the modes of governing health work. They analyzed what happened in the MC found in the fieldwork by examining healthcare production in the level of the micropolitics that was formed in encounters among researchers-managers-workers-users of services of that network, whenever live networks of existence[5] were configured in the world of health work and care. The actions of change also desired to affect these live networks of existence, in the perspective of inducing some actions and/or restraining others.

Based on the events that the encounters in the field produced, the researchers identified tensions related to the political spaces-times necessary to the changes, in view of those that were already there: on one side, the government pressuring its management instruments into producing results related to work processes in the shortest possible time; on the other side, the spaces-times of each team, of each service, of the various management levels, and of users, all of them with their actions engendered from other needs and projects, many of them contrary to the new governmental project. The present article provides and problematizes partial results of this research focusing on the MC, discussing them based on an analyzer that was called a-significant enchantment.

Methodology

Our study was a qualitative research with a cartographic approach. "Cartography"[6] is understood here as a strategy of collective production of knowledge based on lived

experiences, which demands a view that is not restricted to knowledge-representation and is committed to the right to difference, being attentive and open to multiplicity. Furthermore, researchers themselves are also analyzed in all the stages of the research process[7,8]. In this mode of investigation, not only the researcher's neutrality is left aside, but a "double interference" is also admitted - research interfering in the field and research interfering in the researcher - as an ethical-methodological strategy. "Interference" is understood here in the perspective according to which, as there is no impartiality, every change should preferably be subtle and slow. The aim should not be an intervention as such, nor should anyone bet on a re-cognition. Thus, we propose that this study was also an "interference research"[9,10].

The fieldwork in this city followed some stages[4]: 1. presentation of the research in the different management levels and in its management committees, followed by an invitation for the individuals to be part of the team of researchers; 2. demonstration of interest in the research on the part of services managers; 3. presentation of the research to services workers, followed by the invitation for them to be part of the team of researchers; 4. request of narratives of cases considered by workers as "difficult or complex", or cases in which they alleged there were no more possibilities of care.

From the collective processing of such narratives, what we called "guiding users" were selected, that is, users whose follow-up enabled a cartographic approach to the health networks[11]. The methodological tool "guiding user" was employed to travel through the points of the health network that each user accessed and also through those that, consensually, should have been accessed, as well as their critical nodes, blind spots or invisibility zones. Above all, the researchers focused on the connections that the user made outside institutional spaces, but that were significant to care production: the live networks of existence that were constructed across the world of health work and care[5].

The investigation occurred through the production of encounters held during thirty months with teams and MC of primary care units, emergency units, psychosocial care centers, specialties centers, centers for HIV/AIDS guidance and counselling, street primary care teams, and Social Work reference centers (CRAS, CREAS), among others[4]. In the MC, the researchers, whenever possible, asked some questions, such as: "Where do you talk about these users?", "Who helps you face the problems?", "What do people talk about in the management committees?", "Who participates in these encounters?", "Is there a space in them for people to know what each other does, to problematize, invent, and also to discuss, negotiate and agree on new things?"[4].

The empirical material that was produced encompasses many aspects related to healthcare in the health networks. To extract, from this material, aspects related to modes of managing the change or transformation in the area of health based on formal governmental institutions, a conceptual key was forged here, articulating two analyzing elements: magic and a-significant enchantment. The former enunciates a form of transformation similar to the one performed by the magician, who, in the eyes of those who are watching him, skips stages, jumping to the desired result expressed as an illusion. The latter, in turn, is the main concept-tool of this analysis, used here as an analyzer: "a-significant enchantment". It is based on some propositions made by Carlos Castañeda[12] and by Giles Deleuze and Felix Guattari[6]. In this other form of transformation that is performed collectively, the term "enchantment" means production

of desire in the condition of a collective enunciation, and the attribute "a-significant" has the function of indicating that there is no previous intentionality nor a glossary of a priori meanings. Changes viewed as a-significant enchantment, in this study, regard movements in the territory of what is non-intentional, non-rational, and non-cognitively representable of reality, but is affirmed as a desiring creation.

Our hypothesis is that the MC can effectively be productive devices to the management of change in the area of health, depending on the way in which these groups are engendered and operated. In this article, the group of main leaders was designated by the letter G in upper case, and the other managers and workers of the service network, among other social actors, were designated by the letter g in lower case[13]. Both G and g were used in the condition of collective subjects and, like Matus, we assumed that all of them govern, a formulation that corroborates a certain conception of Permanent Health Education: the one according to which "everybody manages"[14].

Fieldwork was carried out between May 2014 and December 2016 in the public health network of a city in the southern region of Brazil. The researchers' field diaries and the multi-voice narratives collected in the encounters were the structuring raw material for the selection of the reflections presented below. The research that originated this article complied with the recommendations of Resolution no. 466/12 of Brazil's National Health Council, and the project was approved by a Research Ethics Committee under no. 27159214.9.0000.5291. The study was funded by the Ministry of Health.

Results

One of the central aspects of the project for the management of the researched network at the time was a revival of the classic attributes of "primary care", especially concerning the coordination of care[15]. Thus, the objective was to achieve a certain technical-clinical excellence (services portfolio, healthcare matrix with a clinical focus, etc.) allied with efficiency/effectiveness in the provision of services (flexibilization/amplification of access, regulation in several spheres, etc.). This project tensioned many teams of the primary care network that had been operating a model in the city studied here for more than a decade. The model was said to be guided by lines like the Programmatic Actions[16] and Health Surveillance[17], among others, but, in practice, according to the interpretation made by some G members at that moment, it was still bureaucratized and less efficient than it could be[4]:

> the primary care network was organized only to meet the demand of the programs or to decentralize the hospital. [...] Now we started tackling the main "symptom" that was visible in the primary care network: restricted access. [...] We proposed to the teams that they should assist everyone who needed. We invested a lot in the nursing clinic [...] We changed the services portfolio to amplify the offers that existed at the units [...], we created a new structure in the Department for primary care. (fragments of field diaries).

This thesis was corroborated by some problems pointed in the demands of the health units[4]: "From 2006 onwards, [...] the Emergency Units became overloaded, while at

the Primary Care Units, approximately 90% of the consultations were from programs." (fragments of field diaries). Therefore, the new government detected problems from a certain point of view, and proposed measures to face them in the technical dimension: qualification of the clinic and interventions in the network flows. G was sure that this would be an efficient strategy to make new work processes happen.

The health districts were seen as an important space to implement changes like this. However, in the state they were found by the new government, they were evaluated by G as structures equally centered on the dominant managerial rationality[4]: "Their action in the assistance agenda was restricted to the Taylorist model of supervision of the Primary Care Units: there was a management agreement between the district and the units based on sets of indicators that monitored production." (fragments of field diaries). Even so, G understood that the districts would be a strategic space to the installation of "real" committees[4]: "It is the district that [...] articulates the necessary support to the network. It is necessary to build a path in management in order to face the challenges of changing the model." (fragments of field diaries).

G members also analyzed the scenario beyond the managerial level: "There is a very structured culture based on authoritarian rules that castrate people's freedom; but this is being tackled, people are starting to have freedom to do things differently." (fragments of field diaries). Thus, the transformation of the traditional administrative meetings of the management teams in all the spheres of management, by means of the implementation of "real" MC, aimed to accomplish a double task: on the one hand, to implement "institutional democracy" to the whole set of the network's workers, the central point of the political discourse and electoral commitment; on the other hand, to create conditions so that the G group enhanced its capacity to govern the proposed change.

The strategy chosen to activate the district MC, which, in turn, would activate the local ones, was that of the "institutional supporter": technicians directly connected with G that would promote a "contagion" of ideas and desires, but were also summoned (perhaps due to the character of the change?) to check if there was compliance with new protocols, norms and procedures, always in the perspective of improving the functioning of management[18]. Although they were imbued with a democratizing mission, these supporters frequently faced a strong opposition and alleged that the shared management strategy was seen either as absence of a project or as weakness.

Generally speaking, the visited committees did not have "an emancipatory perspective [...] of dialogic, solidarity practices, aiming at the construction of a consensus"[3]. In fact, these spaces seemed to be primarily inhabited by agendas that were external to them, bureaucratic and, in general, defined by (or - quite often - attributed to) G. In addition, there were some authoritarian summoning calls of which, perhaps, the G leaders were not even aware. That is, symmetrical relationships did not predominate in the MC. Even if a symmetry was apparent, it was so because of what was not said.

The research also showed there was little space, in the major part of the encounters, to debate the local daily reality. Sometimes, a complex case was discussed, but the theme of care was invariably restricted to clinical aspects of cases narrated from the worker's standpoint, excluding the user's perspective and their live network of existence, resulting not in the accumulation of reflections to rethink practices in general, but in the solution to "that case", based mainly on a previously constructed repertoire of

answers, a level that was probably affected by normativity. Thus, we observed a strong presence of discussions restricted to the realm of technical or professional actions, to the detriment of a common dimension to all (including users). In addition, we saw teams hostage to a routine full of tasks, justifiable by the "demand", but which did not generate reflective learning and produced a feeling of frustration and distrust regarding a possible change of this reality. Magic did not seem to happen in those spaces-times.

On the other hand, in the daily routine of the services there were also elements of the proposed change being accepted and already happening, even though in a small scale, in services that G pointed as "models" to be followed. During the research, we found that some of these experiences had already been happening even before the new government, as some teams already discussed their daily discomforts and problems or longed for an institutional approval to be able to do it. In one of the encounters produced by the research, when the teams of an Emergency Unit and of a Primary Care Unit met to debate the situation of a guiding user, the research team could easily discuss themes like the user's way of life, how he constituted himself in his live network of existence, what he viewed as a problem beyond his disease, and everything that affected the team in the provision of care. At moments like this, the researchers experienced an intense collective production of care management, and such interferences became central to the construction of the guiding users. New intra- and inter-team pacts proved to be possible. A-significant enchantment, we would say.

Most of the times, the research field was inhabited by teams and users in the exercise of their self-government[19], resisting interventions that, according to them, were formulated in a centralized way, and systematically deconstructing, in their daily practice, G's discourse: it was evident that there was a strong tension between G and many of the g. The proposal for the qualification of Primary Care, for example, which included meeting the spontaneous demand in a more efficient way, was frequently viewed by the local teams as a simple "no more queues operation", or as a deliberate extinction of the "programs", that is, of the only actions they viewed as "health promotion". In tensions of this kind, governmental interventions seemed to be received as projects of "someone else", operated as a demand to those who had not formulated them.

Discussion

Often, when a group of people assume the position of government and is committed to the project of the SUS and of healthcare reform[1,2], they try to produce a fast change, as if it were "magic", because they expect that reality will effectively improve and health will be produced for users. This stance was evident across the entire field of the research, in the posture - of palpable optimism - adopted by many G members in view of the proposed changes. However, we believe that, in such processes, there is always a non-negligible risk of governing in the "moral" level because, even if it is not said, the expectation is that workers in general will "automatically and unrestrictedly adhere" to the new project[20].

During the field period, the expected "magic" took a long time to happen, and many g continued performing their practices - some of which produced care, others did not - in spite of G's proposals. Many times, G seemed to disregard the lives that were effectively lived by workers and users[21]: a posture that not only expresses the

distance between these worlds (government x healthcare), but which tends to prevent G from recognizing the other projects in dispute - both in management and in care production spaces - as legitimate[2,21]. If magic was not possible, a-significant enchantment seemed to be even more distant.

Thus, we found that the bet on the "management committee" agenda in itself, although it opened important possibilities here and there, was not sufficient to guarantee the desired change, and new research hypotheses were created during fieldwork, according to the cartographic proposal. Aiming to overcome both the dominant managerial rationality and the self-management of groups, Campos[23,24] proposes the amplification of institutional or organizational democracy, by means, among other actions, of a certain balance between production of degrees of autonomy and healthcare responsibility. This process should be articulated during planning activities, agreement on goals to be achieved, and evaluation. This method, which the author calls co-management and, at least in the macropolitical level, is undoubtedly relevant, powerful and coherent, was exhaustively used by the "institutional supporters" connected with G. As we reported above, it gave visibility and supported desires and initiatives that happened or were waiting to happen. However, it did not seem to facilitate the dispute, in the multiplicity of reality, with corporate or professional-centered projects and with certain authoritarianisms that constituted the very machinery of government. That is, the "self-management" that the co-management project intended to neutralize, which sometimes produced care and sometimes was not centered on the user, remained free in its agenda of preventing any change from happening, refusing to assume its "healthcare responsibility".

Is it possible that the interdictory tensions were emerging precisely because, in changes of this nature, it is necessary to surrender to multiple times, like the institutional, the political, the historical[24], and because, in those social scenarios, perhaps there are other times and desiring projects to be considered? Or because the MC inevitably had, in the figure of the "coordinator", a governmental connection[3] that crystallizes his relationship with the other workers as asymmetric? In its cartographic approach, the research team produced, at each step, more questions than answers. The researchers also questioned the managerial practices they had previously experienced when they were health managers, including the experience of one of the authors in a previous stage of that same government. Thus, this self-analysis produced interferences of the research in the researchers and was viewed as an investigation tool.

When the managerial practice was taken as the object of a shared reflection, firstly with the teams, but also with G in general, it was possible to explore new meanings and new possibilities of mutual interferences, and also to propose that a higher symmetry coefficient in committee relationships opens spaces-times to singularities and even to the invention of new configurations of the government project, amplifying its authorship[25]. It is important to bear in mind that workers and users, no matter if they had desired the change or not, are the ones who will experience it and will be its key agents. This implies stating that any change, if it is not permanently problematized/processed with them, tends to be received with discomfort and even rejected, because no one considered the different times that individual and collective subjects need to be able to leave their instituted territories, risking new movements whenever they, once more, desire to do it. When a group of people become the new government, a-significant en-

chantment, we propose, can be engendered simply by taking into account the meanings of the various modes of feeling/thinking/doing that are already installed in the lives of workers and users, as well as the previous investments that were accumulated there. Only after this is accomplished can any change be negotiated.

This seems to be a key point that any management that aims to implement something like an "institutional democracy" must consider: taking the micropolitical level of life into account. Ignoring or neglecting this dimension of the desiring collective production implies betting on changes of this nature based only on a representational plan of social reality. Consequently, the institutional supporter, in the perspective proposed here, should be more than an operator of the strategic agenda of G in the territory. On the contrary, the supporter should move from the place of "strategic" (the government's world) and open passages/openings in themselves to let them be pervaded by the world of the other (health teams)[11]. This radicalization of democracy in the organization of health implies that this supporter should be capable of facilitating the dialog between these two worlds. And, why not, the supporter should always include a third world, the world of users, aiming to potentialize the porosity of spaces-times in different levels of management and of the G government itself. Furthermore, the institutional supporter should treat the problems/discomforts mentioned by those who work and by those who use as central in the formulations of the techno-assistance model (techno as in "technological", not "technical"), and not as a lack of interest or a lack of information that must be dominated. Perhaps this is a way of breaking practices that were instituted by the management and disregard the experiences lived by health professionals and users, failing to consider them as the true living powers that produce care at each point of the health system. In fact, these experiences must be supported and potentialized[21].

A change in healthcare production presupposes an intense experience of new relationships and new possibilities of worlds, which demands, of all the individuals involved, interfering and allowing to suffer interferences in the world of health, a process we have called existential amalgamation[11], as the experiences that effectively produced care in this research have told us. We propose that the "government function" is immanent not only in G but also in multiple non-governmental spaces-times, because everybody manages. In spite of this, yes, the MC can become scenarios for the production of events in which providing care is the "soul" of collective actions in the area of health[26]. However, to achieve this, it is necessary to make the MC "pregnant" in order to transform them into "wheels" of negotiation, enabling agreements and flexibilities; or, maybe, to invest in making real practices of "squares" emerge in them, as, frequently, various groups involved in an intensive collective production were, so to speak, in an overt intercession[27,28]. Therefore, we propose that it is possible to make them become full of new meanings for the production of emancipatory changes and for the invention of new learning and care practices, following ethical modes of acting over the life of oneself and of the other - an a-significant enchantment that emphasizes the power of the live work in act, with effective symmetry, sharing, and protagonism of all the individuals involved, as desiring beings and co-authors, and in all spaces-times, no matter if they are institutionalized or not[29].

The macropolitical dimension of a social reality, with its people, its physical structures, material resources, established norms and flows, among other components, is

quickly apprehensible by our retinas and apparently understandable by our cognitive equipment. Obviously, we agree, it should really be the target of interventions from the government, as lacks and weaknesses in this level negatively affect any health production project. However, we believe that every project of change must have effects on subjectivation processes and on the desiring production of groups, bearing in mind that user care is the non-negotiable center of gravity[19,29].

In this sense, would it be possible to engender powerful MC in terms of collective production, without, for example, altering the verticality of decision-making? We believe it is not possible. Horizontality and symmetry in relationships potentialize encounters between endless points of view and projects, from which inventions of other configurations to the project of change emerge, amplifying its authorship. This does not empty the strategic role of the G governmental leaders. From their place, G handle the macropolitical framework, which is fundamental but does not produce the change alone, and can guarantee, politically speaking, arrangements that enable these collective movements, as well as healthcare-related agendas - central, in our opinion, when the intention is to change the know-how-to-do in the area of health.

Anyway, the authors-researchers do not pretend to have answers and recipes to face the problems discussed here. We believe that one possibility to make this a-significant enchantment happen in the committees is the activation, in meetings among workers, users and managers, of Permanent Health Education strategies as a management toolbox[30]. Based on the ethical-esthetic-political project[g] developed above, change should be started from relationships, delicately, without untimely interventions, beginning with the discussion of what has already been experienced in the place where the change occurs, reflecting whether it is needed or not at that moment, and making it "with" the people, instead of doing it "for" them[18,25]. That is, we understand a-significant enchantment as a production of movements based on intensive encounters among all the people involved (managers, workers, users), not only gathering people "together", but having them play the role of main characters to "do things together" - the only way, we believe, that is capable of producing a change of such magnitude. The managing group that understands the multiple levels of social reality inevitably changes its way of governing and includes daily disputes not as insurgencies to be defeated, but as production - although, sometimes, they do not produce care in the beginning, as certain transformations can only be constructed in cooperation.

[g] This concept, in the context of this article, implies assuming that any action in the area of health (caring, governing, researching) must be grounded on the dimensions of "ethics" (users seen as the goal of any action, and users and workers seen as valid interlocutors), "esthetics" (intensities of the life and daily routine of work as guidelines for care, management and research practices), and "politics" (the privilege of collective spaces-times to promote the construction of change). In addition, any action in the area of health must view each and every life as worthy of being lived, crossing these dimensions. Inspired in productions such as the work of Felix Guattari, this concept has been used as an operator in the sphere of Collective Health and, in the reflection proposed here, as the agent of meanings to the change in the area of health.

Authors' contributions

Helvo Slomp Junior, Emerson Elias Merhy, Clarissa Terenzi Seixas, Kathleen Tereza da Cruz, Débora Cristina Bertussi, and Rossana Staevie Baduy participated actively in the research, in the discussion of the results, and in the review and approval of the article's final version.

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