


Bureaucratic state and health management training from a historical perspective: similarities and differences between Brazil and Spain¹


Estado burocrático e a formação em gestão em saúde em perspectiva histórica: semelhanças e diferenças entre Brasil e Espanha

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Abstract

The article described the historical context of health management training in Brazil and aimed at identifying similarities and differences between this training in Brazil and Spain, using qualitative approach and comparative method. Data sources included the scientific literature, official documents orienting interventions in health management training, and semi-structured interviews. Interviews were conducted with managers selected on the basis of currently occupying or having occupied management positions, besides experience and participation in shaping policies in health, totaling four managers in Brazil and six in Spain. Based on thematic content analysis, the results were related to the category of “institutionality” according to the following themes: health and education policy, management training policy, and professionalization. A common element was that Brazil and Spain both adopt health protection as a civic right through universal public health systems. The most significant difference relates to population coverage, nearly complete in Spain in the late 1990s. The study showed the lack of a national training policy for managers in both countries and that such a policy is essential for professionalization in health management. Although the theme of professionalization exists in Brazil, in Spain it has distinct institutional

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characteristics, having achieved important recent progress.

Keywords: Professional Training in Health; Health Management; National Health Systems; Comparative Study; Professionalization.

Resumo

Este artigo descreveu o contexto histórico da formação em gestão em saúde oferecida no Brasil e buscou identificar suas semelhanças e diferenças com aquela oferecida na Espanha. Adotou-se uma abordagem qualitativa da realidade e o método comparado foi empregado. Como fonte de dados, utilizaram-se a bibliografia científica, os documentos oficiais, que orientam as intervenções no campo da formação em gestão em saúde nos dois países, e a entrevista semiestruturada. As entrevistas foram realizadas com gestores selecionados pelo fato de estarem ocupando ou de terem ocupado cargos de gestão e que tenham participado da conformação da política de saúde, totalizando quatro gestores brasileiros e seis espanhóis. Apoiados na análise de conteúdo temática, os resultados se relacionaram com a categoria “institucionalidade” a partir dos seguintes temas: política de saúde e educação; política de formação de gestores; e profissionalização. Identificou-se como elemento comum o fato de tanto o Brasil quanto a Espanha adotarem a proteção à saúde como direito de cidadania por meio de sistemas públicos e universais de saúde. A diferença mais significativa diz respeito à cobertura populacional, alcançada na quase totalidade na Espanha no final dos anos 1990. Evidenciou-se a inexistência de uma política nacional de formação de gestores nos dois países, considerada central para a profissionalização da gestão em saúde. Ainda que o tema da profissionalização esteja presente no Brasil, na Espanha assumiu contornos institucionais distintos com avanços significativos em período recente.

Palavras-chave: Formação Profissional em Saúde; Gestão em Saúde; Sistemas Nacionais de Saúde; Estudo Comparativo; Profissionalização.

Introduction

In Brazil, in recent years, the consolidation of the Brazilian National Health System (SUS) has seen significant obstacles in health management, including the lack of professionalism of managers, insufficient qualified staff, the political logic of clientelism in assigning professionals to administrative roles, and administrative discontinuity. These problems influence the provision of services and, consequently, the image of SUS (Paim; Teixeira, 2007).

Despite the existence of training programs, health management in Brazil is still an occupation in the process of becoming a profession, whose recognition would be given by the State, which would establish criteria for professional practice and accredit academic institutions to provide health management training (Kisil, 1994).

In an interview to Conill, Giovanella and Freire (2011), Gilles Dussault, an expert in human resources in health, considered the degree of professionalism and the corresponding depoliticization of the administration of public services (including health) in countries of Anglo-Saxon model as the main difference in relation to countries of Latin culture, such as Brazil. For him,

Meritocratic systems for the selection of managers [...] favor a more rational management, based on administrative rules, not on political criteria. An older tradition is observed in health management training and designation of professionals for administrative roles based on skills and experiences that fulfill specific requirements for the role. (Conill; Giovanella; Freire, 2011, p. 2890)

Other aspects mentioned by Dussault that set these countries apart would be their greater autonomy for the selection of managers by service providers in relation to the central bodies of the health system, and the lower staff turnover in roles such as hospital director, supporting management continuity and implementation of health policies.

Malik et al. (2010) reported the importance of professionalizing health management training in Brazil was already discussed in 1970s, and that,

in 2004, the concern about this theme was clear, considering the large number of programs in the area, offering different contents and durations. Ministerial Directive 2.225/2002, of the Ministry of Health, was a milestone, as it regulates the administrative roles of hospitals belonged to SUS, establishing professional qualification criteria for the management of hospitals of different sizes, regardless of their legal nature (Brasil, 2002). However, according to Malik et al. (2010), this requirement was withdrawn two years later, after a significant number of courses and qualified professionals.

Changes in the implementation of health policies and human resources training, in health needs and staff requirements also led to changes in managers training, including those related to management and understanding by some actors of the provision of health services as a business area. All these factors influenced the professionalization of the sector (Malik et al., 2010).

The number of courses increased across the country provided by academic institutions whose activities complied with the Ministry of Health, state secretariats and international agencies, associations and councils (Tanaka et al., 1999). In the second half of the 2000s, special support was provided by the Secretariat of Labor and Health Education Administration, of the Ministry of Health, together with the World Health Organization.

This theme became more relevant with the set of political, economic and social changes observed in the last decades in different countries, where the State reform involved a growing penetration of management knowledge from the private sector in the public sector. According to Paula (2005), one of the milestones of this logic was the emergence of the new public management in the 1980s, with impact on health systems and management training.

Health management training remains an underexplored issue in our country. Different public or private initiatives of management training lack details on trajectory and institutionality. In this sense, considering the few studies on health management training conducted so far, investigations comparing this training in other

countries with more experience can provide a better understanding of the main issues related to this theme in SUS. Spain, the country selected for this comparison, has a national health system with varied courses in health management and has published recent academic studies on its health system functioning.

Given the considerations above, this study sought to answer the following questions: What are the historical milestones of health management training in Brazil and Spain? What are the similarities and differences in the historical context of health management training in these countries?

This article, as part of the doctoral thesis titled *Management training in universal health systems: similarities and differences between Brazil and Spain*, developed by Cunha (2018), aimed to describe the historical context of health management training offered in Brazil and identify similarities and differences when comparing this training in Brazil and Spain. This study has three sections: the first section addresses the aspects associated with structuring of professionalized bureaucracy through the State and the developments of its relationship with society; the second and third sections discuss in a comparative perspective, health policies and training of managers, and its professionalization.

Methodological strategy

Professional training in health management is a social and historical construction that takes place in a context involving different social agents, interests and projects. Understanding it in its complexity of meanings attributed by these different agents in this historical path leads to the adoption of a qualitative approach to reality.

The comparative method has been used in different knowledge areas, more recently in public health (Conill, 2006). This study adopted Conill's perspective (2006, p. 564) as the author considers that "comparing means looking for similarities, differences or relations between phenomena that may be contemporary or not, occurring in distinct spaces or not, in order to better understand them."

Spain was selected due to its expressive number of master's degree programs focused on health

management training, as discussed in a study that described the common elements in the international experience of master's degree programs in public health (Hortale, 2006).

In order to answer the study questions, scientific bibliography on the subject, documentary research, and a semi-structured interview were used as sources of data. Documentary research was focused on official documents (relevant reports, studies and legislations) that guide health management training in both countries. Interviews were conducted with managers of the Brazilian Ministry of Health (three managers and one former manager), and managers from the Ministry of Economy, Industry and Competitiveness of the Ministry of Health, Social Services and Equality and societies of health managers of Spain, totaling six interviews. The criterion of interviewee selection was: a professional who has held or holds an administrative role, with experience and participation in formulation of health policies in their countries. In-person individual interviews were scheduled, recorded with interviewee authorization, and transcribed.

Based on a thematic content analysis, as reported by Bardin (2010), this study presents the results related to the category 'institutionality' captured while reading the interviews and documents. For this reason, the following themes were used as a codification unit: health and education policy; manager training policy; and professionalization. The study was approved by the Research Ethics Committee of Escola Nacional de Saúde Pública Sergio Arouca, under protocol nº 1.402.603.

Bureaucratic State and professionalization of managers

The field of health is inserted in a broader context of historical, political, economic and cultural determinations that shape society. Understanding health management training means considering factors related to the different aspects of society, including one that has become a distinctive feature of modern societies: their bureaucratic character (Campos, 1971).

In recent years, bureaucracy has spread to all dimensions of society, present in both capitalist

and socialist systems. This circumstance would be related to the process of society member expansion and the greater complexity of different associations between individuals to reach certain goals. Whether in political parties, labor associations, government institutions or health units, bureaucratization will have similar impact on work process and the autonomy of individuals and their degree of independence and participation (Motta; Bresser-Pereira, 1986).

The work developed by German sociologist Max Weber (1999) was central to help understand the bureaucratic organizations from the birth of the State, in its most expressive character: rationality. In a rational State, two aspects would be critical to its functioning: specialized administrative staff and rational law (Weber, 1999).

Regarding the first aspect, through administration the modern State would effectively exercise domination. Such administration would be performed by contracted staff, who would deliberate on daily life needs and issues. Increased socialization led to growing bureaucratization. As a result, bureaucracy reached the mass army, the municipal administration, the Church, and private companies.

Then, monarchical and democratic State modernization goes through "progress towards bureaucratic administration staff based on an employment agreement, salary, pension, career, specialized training and division of labor, job skills, documentation and hierarchical order" (Weber, 1999, p. 529).

In Brazil, the State democratization process took place with broad mobilization and formulation of a new Federal Constitution in 1988 (CF88), named 'Citizen Constitution.' Carneiro (2016) considers the CF88 as an update of Weber's perspective about building professional bureaucracy as it incorporates a chapter on the subject of public administration. Despite this legal achievement, which represented an important progress in several areas (including health, due to the concept of social security that integrated health, welfare and care), the following period also presented political, economic and social disputes and challenges, with tension between intended changes and the authoritarian and liberal standards in force.

Understanding these challenges helps analyze the constitution of the Brazilian State and its bureaucratic organizations, as well as its historical relationship with society, based on the perspective of Nunes (2010) and his proposed grammars of clientelism, corporatism, bureaucratic insulation, and universalism of procedures.

These grammars were developed according to personalism, represented by clientelism, and impersonalism, which covers all other grammars and finds its epitome in the universalism of procedures. As reported by this author, clientelism is understood as privatization of public space, while bureaucratic insulation is the process that protects the technical core of the State from external interference, whether from the public or from other intermediary organizations, such as political parties, associations and trade unions, among others (Nunes, 2010). Then, it means “narrowing the scope of the arena where popular interests and demands may play a role” (p. 55). Corporatism involves formalization in laws and has a semi-universal character, since its laws refer to incorporation and control, and not a fair and equal treatment for all individuals. Universalism of procedures is opposed to clientelism and uses the conception of equality before the law, i.e., public benefits and burdens should be allocated according to general and universal rules and procedures, associated with the idea of full citizenship.

This grammar would favor universalism, equity and integrality, which are the SUS guidelines. For the health system to fulfill these principles and organize itself according to the health needs of individuals and collectivities in its territory, it would be essential to combine technical skills and staff protection from personalistic interests with political decisions of health care as a universal right. The changes produced by different governments throughout history, the achievements and challenges still present in public administration indicate a complex field of disputes, where the logic of personalism has prevailed, even in designs more focused on bureaucratic insulation and corporatism. Reversing this logic would involve mobilization of the whole society against personalistic interests, strengthening of control

agencies and consolidation of an institutional culture focused on public good.

Regarding health management, Campos (2017) proposes some ideas that should be considered for its unification and integration, focused on SUS operation and consolidation and elimination of patrimonialism and clientelism, including the creation of an interfederative autarchy, that is, a tripartite body comprised of all municipalities and states of the Union, named ‘SUS Brazil.’ It would support mechanisms of social control through Conferences and Councils, just as Regional Health Councils. It would also be based on the deliberative bodies constituted as Intermanagerial Committees, with the consensual designation by municipalities and the state of a Regional Health Secretary. For the purposes of this study, the author’s proposal emphasizes the professionalization management, which indicates that

In order to mitigate political party influences in SUS Brazil, it would be critical to limit the scope and extent of roles of free designation or trust in SUS. Health workers would be hired through a public exam and would start careers in SUS Brazil. In addition, it would be essential to define republican rules for the roles of head of health services and programs. An alternative is to hold internal exams among SUS Brazil staff for these roles, with specific exam sessions according to the theme and assignment. The roles of free designation would be restricted to secretary, minister and direct advisor. (Campos, 2017, p. 39)

It is understood that this proposal is part of the grammar of the universalism of procedures. By implementing this grammar, the Brazilian society would be closer to the changes proposed in health policies and moving towards a more just and democratic society project, which would imply adjustments to the role of the State to ensure health policy effectiveness.

This possibility is linked with the institutional approach addressed by Evans (1998), who considers the lack, and not the excess, of bureaucracy as an obstacle to development. In this perspective, bureaucracy differs from the view of citizens and

policymakers as 'synonymous with inefficiency or source of supply for privileged employees' and would be seen as a 'set of norms and structures that lead to competence' (p. 76), as reported by Weber.

According to Evans (1998, p. 63), in modern bureaucratic State,

corporate coherence requires officers in charge to be somewhat isolated from the demands of surrounding society. Isolation, in turn, is accentuated through a distinct and rewarding status for bureaucrats. Concentrated skills in bureaucracy through meritorious recruitment and the provision of opportunities for awards in long-term careers are also critical to achieve efficient bureaucracy.

Then, bureaucracy would function with insulation, keeping a certain degree of autonomy in relation to society. The author discusses the problem of separating the benefits of insulation from the costs of isolation, considering the State, in order to achieve efficiency, must be 'inserted.' Therefore, the issue of combining autonomy and social insertion is addressed. Evans (1998) recognizes that effective actions of the State must involve partnerships with civil society; however, setting a political and organizational process that enables specific States to achieve this capability is seen as a much more difficult task.

Health management training in the context of public policies in Brazil and Spain

Both Brazil and Spain have adopted health protection as a right to citizenship through public and universal health systems; therefore, health policy, as any other social policies, has demanded expansion of management skills and State actions in its bureaucratic organizations.

These actions were performed in one of the two main reformist spheres: the public administration, which started in the second half of the 19th century and was adopted in Weber's bureaucratic model. The other main reformist concept is the

'new public management, which emerged in late 20th century. Both of them were present in the Brazilian and Spanish reforms. One difference is that, in Brazil, these concepts had a late implementation when compared to the countries of Western Europe; and another difference is that the classical concept of bureaucracy had a partial or inconclusive implementation in the Brazilian context (Carneiro, 2016).

An administrative organization of the Brazilian federal government, with the creation of a Public Service Administration Department in 1938, considered a milestone in the adoption of Weber's bureaucratic model, and the creation of compulsory exams were not able to avoid the 'grammar of personalism,' as reported by Nunes (2010). Therefore, a lack of professional bureaucracy led to multiple 'administrative bodies, of different forms of legitimacy and meritocracy, without dialogue among them, with ineffective personnel management' (Abrucio; Pedroti; Po, 2010, p. 52).

Under the CF88, measures for public service professionalization did not achieve the expected effects. According to Abrucio, Pedroti and Po (2010), this legislation partially resulted in increased State corporatism. As reported by these authors, after these negative factors of the CF88 were detected and studies were conducted in an attempt to learn from international experience, a proposal was developed by the Ministry of Federal Administration and State Reform (Mare).

These authors report that the reform proposed by Mare was based on a managerial model aiming to implement a results-oriented public administration, proposing an institutional engineering to create a non-State public space. Then, a number of organizations have been created according to the logic of public-private partnerships. Despite its influence on the institutional design to this day, Mare, which was abolished in 1999, was not able to coordinate the whole process of State reform.

In a study analyzing the configuration of bureaucracy in the Ministry of Health regarding staff recruitment process, Costa (2011) highlighted that, in 2005, one third of the administrative staff of the Ministry of Health consisted of career civil servants and two-thirds were hired as temporary

or outsourced staff, a result of 24 years without any public exams for civil servant recruitment. In the same year, exams were resumed due to strong pressure from the Public Labor Ministry to eliminate irregularities in the federal public administration, which meant a 13% increase in total of civil servants in the Ministry of Health between 2005 and 2011. Because it is the body in charge of formulating and coordinating health policy in the country, the author reports, as a consequence,

strong vulnerability of the programs and projects developed by the Ministry of Health at each change of administration of the sector. Such vulnerability has become an obstacle to the consolidation of an institutional memory due to a lack of knowledge about the historical process of health policy. In addition, the absence of a structured career plan and the predominance of external staff in administrative and coordination roles resulted in internal staff disincentive and, consequently, conflicts between civil servants and external staff holding roles in the Ministry of Health. (Costa, 2011, p. 153)

This reality is related to the fact that, in Brazil, the roles in commission or of free designation, which in the federal government are included in the System of Top Administration and Advisor Roles (DAS), are filled by both bureaucracy from public exams and external staff, classified as position-based roles. According to Cavalcante and Carvalho (2017), this system, which has a high level of discretion of the manager, differs from the career-based public model, in which the commission roles are filled by civil servants with formal employment bonds with the public administration, in line with Weber's organizational model.

These authors reported the publication of Decree nº 5.497/2005, which established that 75% of DAS roles of levels 1 to 3 and 50% of level 4 roles should be filled exclusively by civil servants, reinforces the need to reformulate the idea that DAS roles in federal public administration should be massively assigned by political criteria (Cavalcante; Carvalho, 2017). The authors emphasize that hiring professionals with no link with the public administration is not

a problem, indicating that democratic oxygenation is a positive aspect. In this sense, they claim that a balance of both civil servants and external staff is recommended. Regarding career civil servants, they consider 'the participation of civil servants not only results in appreciation of bureaucracy, but also tends to generate greater continuity, coherence, and ensure impartiality and objectivity to public policies' (Cavalcante; Carvalho, 2017, p. 17). For the authors, one of the challenges of professionalization refers to recruiting professionals for commission roles from the implementation of more transparent and impersonal criteria.

One of the interviewees, head of a postgraduate program and an associative entity, reported that at the beginning of the SUS implementation, the designation to roles of the Ministry and health secretariats considered the tradition and competence of managers combined with political trust. The results obtained by Costa (2011) agree with this point of view, i.e., the roles in the Executive Secretariat and the Secretariat of Health Care, of great political weight in the Ministry of Health, were assigned according to technical criteria, allowing the presence of trained managers with experience in management and public health culture and a relative degree of autonomy, favoring not only the construction of some internal coherence and corporate identity in the State apparatus, but also stability of the new institutional structures required for SUS implementation. However, for the same interviewee, it is different today. For him, in recent years, different roles of SUS have been filled by exclusively political criteria, often recommending people with no experience or training in health.

In Spain, three aspects related to tradition and influence are observed in the organization and culture of the National Health System (SNS) administration. The first aspect, related to the original culture of the social security system, refers to the fact that the institutions have their own legal and organizational personality, with specific autonomy of health services, independent of the general public administration. The second, in the context of redemocratization, in early 1980s, was based on a common public administration and

standardized the whole public sector, including health, with a bureaucratic and unifying trend in terms of staff. The third aspect, starting in the 1980s, but with a greater expression in the 1990s, was the public enterprise managerialism, which joined a varied group of ideas, including a more efficient management to fulfill the demands of the population (Freire, 1999).

For Repullo (2012), as a result of the international economic crisis and the financial restrictions imposed on the national health systems in Europe in early 1980s, even though countries had different health systems, concepts associated with managerialism were adopted, which attempted to introduce a corporate logic to achieve greater efficiency in national health systems.

For the author, the managerial model was based on hospitals that sought to be inserted in a commercial context, just like companies, particularly in the United States (Repullo, 2012). After 1983, this model was implemented by Margaret Thatcher in the British National Health Service, following a recommendation of the Griffiths report (Griffiths, 1983), which influenced different countries, including Spain.

With the end of dictatorship and the transition to a democratic government, international references on management, especially the British model, became present in the Spanish macropolitical agenda and played an important role in the health reform, guided by discussions produced between 1976 and 1986, when the General Health Law was published, which created the SNS in Spain (Repullo, 2014).

When analyzing these traditions and influences, a role played by a member of the staff stands out: the social security health inspector, hired through a public exam, presenting specific knowledge and decision-making skills based on reasonably and formally specified rules, approaching professionalization of public administration. Later, this model changed. In 1983, with the publication of a Government Presidency Order, the administrative roles were no longer exclusively filled by social security officers, but also by care professionals (Laita, 1991). Prior training is no longer considered an admission criterion and, in 1999, through a change in Royal Decree (RD) n° 521/1987, the

requirements of public exam were suspended. With these changes, health organizations were no longer run by their own staff, and their members were moved to other roles and not replaced, gradually reducing the staff and becoming vulnerable to managers designated by political criteria. With RD n° 521/1987, the Government Councils disappeared, and single-member management with its discretionary model of role designation consolidated (Freire, 1999, 2006).

Also, in both Brazil and Spain, public health and medical care were organized by different institutional apparatuses. A historical analysis helps understand the importance of the latter, of a social security and corporate nature, with strong centralization, and the important role of the Ministry of Social Security and Social Assistance in Brazil, and the Ministry of Labor and Social Security in Spain, which were organized from institutes responsible for such implementation. Although this fact can be considered a similarity between the two countries, it also has a significant difference: the care network coverage of the Spanish social security system. In it, 'the ASSS [Social Security Health Care] was progressively expanding its population coverage (82% of total population in 1978) and its facilities, allowing to extend it to the entire population' (Freire, 2006, p. 38, translated by the authors). This coverage reached almost the entire population in late 1990s and was the basis for the SNS implementation.

Then, although both countries adopted health care as a right to citizenship, to be offered by public systems funded by taxes, the population coverage is very different when comparing the two countries.

In Brazil, the service network of the social security when SUS was implemented did not have broad population coverage. In 2013, in primary care, coverage of the Family Health Strategy reached 56.2% of the population (Malta et al., 2016). Also, 24.4% of the Brazilian population in 2017, according to data from the National Supplementary Health Agency, has private health care plans offered by employers or funded by their own resources (Brasil, 2019). This result shows that, despite the population coverage in primary care of a little over half of the Brazilian population, some of these

people, who exclusively depend on SUS, still find obstacles to access and use SUS services due to lack of investments to expand the provision of public services at all levels of health care. The limits of SUS coverage and equity were addressed by Conill (2017, p. 6). For this author,

Currently, the Brazilian health system is a universal system with duplicate and unequal coverage: while the low-income population uses SUS, users of the supplementary segment can constitutionally use both, with the right to waive tax.

In Spain, the SNS would allow universal access through the network of services of the Spanish social security system covering the whole country (Freire, 2006). Recently, full coverage and the universalism logic of the SNS had a change with Royal Decree-Law (RDL) nº 16/2012, which can be considered a step back as it applies a concept of affiliated and beneficiaries, defined by a contribution to social security (Repullo, 2012). In June 2018, the new government of Spain expressed its commitment to recover the universality of the SNS by revoking RDL nº 16/2012.

Similarities and differences in manager training: training and professionalization policy of health management in Brazil and Spain

Regarding the background of health manager training, three main similarities were observed between the two countries. The first, in the first decades of the 20th century, refers to training initiatives linked with public health agencies: the National Health Department in Brazil and the General Health System in Spain. In Brazil, courses began with the creation of public health schools, the first one was the Faculdade de Saúde Pública, of Universidade de São Paulo (USP), inaugurated in 1929 (Kisil, 1994). In Spain, the Escuela Nacional de Sanidad (ENS), was created in 1924, returned to the training of staff for the bodies under the General Health System (Carrasco, 1998).

Another similarity is that hospital management training was structured later as a result of

growing centrality of hospitals in health care; transformation of their charity profile, and training of physicians and nurses on the adoption of an organization profile, with mechanisms and rules to meet a growing number of social security beneficiaries; higher costs resulting from specialization and sophistication of medical practice; and search for quality (Marcondes, 1977). In Brazil, this specific training started in 1951, when the first specialization course in hospital management was created to fulfill the need for managers when the USP Hospital das Clínicas (Kisil, 1994) was created. In Spain, these courses started in 1964, based on the requirements of Law 37/1962 about hospitals, which established the need for training and qualification of managers, and required prior training in specific cases (Laita, 1991).

The third similarity refers to the creation of courses in health management schools. In Brazil, they appeared in the second half of the 1970s, with emphasis on two courses: the Program of Coordination and Support for Education in Health Care Administration in Latin America and the Caribbean, of 1979, developed by the Pan American Health Organization with the support of the W.K. Kellogg Foundation; and the Health Administration Programs. In Spain, in the 1980s, 'business schools' were created, which were linked with private training centers or universities (Lamata, 1998).

The analysis of the history of health management courses in both countries revealed the main elements of their institutionalization. Although both countries currently offer different and traditional training courses, they did not originate from a national training policy. In Brazil, this issue is illustrated by the speech of a head of a postgraduate program and an associative entity: *I do not see a policy of manager training or systematic financing. I think manager training courses are very poor, very occasional, with no continuity* (Interviewee 2).

Offering courses was an initiative from the institutions themselves, for different reasons - some were the result of governmental incentives not specifically dedicated to the health management area, such as the Federal University Restructuring and Expansion Support Program, related to

undergraduate courses; others were related to the perception of required training courses, search for professionalization and market demand, the latter referring to a course offered by a private institution.

In Spain, training health managers was a concern when Escuela de Gerencia Hospitalaria was created in 1970, which was later integrated into the ENS, and when the Schools of Autonomous Communities (CCAA) were developed. The creation of courses linked with the public education system was closely related to the political-institutional development of the health system and the perception of the importance of this training closer to the reality of health and public management, and in this field of education.

The absence of a national training policy in this area is related not only to the role assumed by the State, a baseline cause, but also to a number of factors, including initiative of institutions to create courses, individual responsibility for seeking such training, lack of training and career paths, non-definition of program content, and non-requirement of prior training to assume administrative roles.

In Brazil, filling roles of different levels of administration through public exams are exceptions to the rule, representing an unbalance between manager training and designation of roles in SUS.

However, the interviewees considered health management training as critical to assume such roles. One of the interviewees, who is the chairman of a science and technology institution, related the importance of this training to increased complexity and specificity of health organizations. With today's increasing technological implementation, knowledge specialization, search for access universalization, with efficiency and quality, the need to deal with budget allocations, among other factors, health management started to demand a certain group of skills to handle these challenges. Therefore, it becomes distant from improvised actions. In this sense, the interviewee presented the following question, as he addressed the management of a national health institute: *Would anyone in one's right mind give a BRL 300 million machine to an unqualified person? An industry of BRL 300 million in Brazil is medium sized* (Interviewee 3).

The existence or absence of a national training policy is directly related to the professionalization of management. Although this theme has been a concern in both countries, some significant differences were observed.

In Brazil, there is no normative basis regarding the need for training to fill administrative roles. As a result, health management roles are designated by political recommendation, without requiring any qualification.

Another important aspect is that incentive to manager training is related to the priorities and policies implemented by a given government. The proposal with the best structure aiming to promote an articulation between manager training at different levels of government was the SUS National Program for Administration Development, created by ministerial directive nº 1.311/2010 (Brasil, 2010) and discontinued in 2012 with the new central government.

It should be noted that Proposed Law nº 8.440/2017 was submitted to the Plenary of the Chamber of Deputies, which, among other aspects, foresees technical training and prior experience of at least three years for the roles of head, management and advisor in SUS. This proposed law is in evaluation process (Brasil, 2017).

In Spain, Law nº 37/1962, the Ministerial Order of the Ministry of Labor of 1972 and RD nº 2.082/1978 are considered as regulatory frameworks for health management training. Four years after its creation, an order from the Supreme Court canceled RD nº 2.082/1978, and its content could not be developed. This fact extended the absence of national regulations on the subject (Laita, 1991). Regarding the theme of professionalization, a group of documents, including reports and recommendations, suggest growing mobilization of managers, researchers, politicians and governmental staff. Although some initiatives have not become reality, a key aspect reported by a manager of the Ministry of Economy, Industry and Competitiveness would be the process of building changes based on the relationship between the agents involved, and how such initiatives would contribute to the expansion of a climate of opinion. Important steps or 'reformist waves' in the construction of

these changes have been identified in at least two documents: Recommendations of the Advisory Council on Good Government Code for Basque Public Health (Comunidad del País Vasco, 2010) and Proposals of the Health Economics Association (AES, 2014).

According to the AES (2014), effectiveness, legitimacy and authority of managers demand professionalization and contractual stability. In other words, like other reports and notices produced by companies, authors and councils, AES points out in its book that politicization and turnover of high and middle management roles cancel the authority of managers in decision making processes to promote the necessary changes, productivity and elimination of issues related to inefficient performance. Confrontation towards professionalization of administrative roles has been a central theme in Spain, aiming to achieve the 'good government' attributes.

In general, the scenario is favorable for the recommendations and proposals in the Spanish experience to promote results in professionalization of management. The moment now is considered by Interviewee above as a window of opportunity due to the support from the legislative power, with the professionals and awareness of 'good government' understood as one of the achievements for the professionalization of managers in Spain. A manager from a Spanish associative entity illustrates this perspective:

I believe awareness is a progress. [...] all stakeholders, all agents of the health system, including citizens or the media, are already convinced that there should be professionalization of health centers and that such professionalization improves the health system. (Interviewee 7)

The challenges reported by the same interviewee include a probable resistance of political actors, who currently designate managers by political affinities. For him, *professionalization has a long way ahead because politicians prefer to see their hospitals, or their health system, run by political friends rather than professionals* (Interviewee 7). A relevant achievement, which incorporates the

conceptions present in the documents mentioned above, was the recent law approved in Madrid (Law nº 11/2017, of December 22), which addresses 'good government' and professionalism of the management of centers and organizations of Madrid Health Service (Comunidad de Madrid, 2018), which is focused on eliminating political clientelism in the designation of health managers and which may drive reforms in other CCAA and other countries, such as Brazil.

This law was based on Resolution nº 24/2015 (Asamblea de Madrid, 2015), which listed the five essential components for 'good government' and good public management, which are: collegiate bodies (Government Council) in all centers and organizations of the Madrid Health Service (Sermas); professionalization of the administrative and managerial roles; strengthening of advisory and professional participation structures; development of good government/good management instruments; and greater autonomy and responsiveness to Sermas health centers and institutions.

The attributes of 'good government' refer to a high degree of transparency, accountability, democratic participation and a culture of ethics in the public service, and are focused on results (effectiveness, efficiency, efficacy), meaning good decision-making procedures based on the rules of democratic participation, respect for laws, accountability, transparency, among others (Freire; Repullo, 2011).

The aspects to achieve 'good government' in the health system include the presence of collegiate bodies of the government as the highest authority in the areas and districts of health or hospitals, to which executive managers should report. These bodies are able to select managers. All documents report a perspective of a certain recovery of collegiate bodies of the government in a similar way to the Administrative and Facultative Boards foreseen in the regulations of the Ministry of Labor of July 7, 1960, for the functioning of the social security health institutions (España, 1960).

Professionalization of an occupation is not limited to the development of academic programs, it also involves the creation of associative entities. In this sense, an important specificity was observed

in the Spanish reality, where societies work towards training and professionalization of management, such as Sociedad Española de Directivos de Atención Primaria and Sociedad Española de Directivos de la Salud. The latter adopts professionalism as its primary goal and understands the qualification of managers as a broad action that involves training, experience, ethical values, skills and leadership (Guerrero Fernández, 2017).

Final considerations

This article addressed the theme of training in health management, particularly related to its institutionality, using historical elements from two countries: Brazil and Spain.

Management training is provided in a context of conflicts and disputes, inserted in a broader context of the State's relationship with society. Modernization of the concepts of classical administration became evident in both countries. In Brazil, the creation of professional bureaucracy was updated with the CF88, as it included a chapter dedicated to the subject of public administration. In Spain, this theme is discussed in many documents, proposals, measures and Law nº 11/2017 of the Community of Madrid.

In Weber's formulation, bureaucratic administrative staff is one of the central points of the bureaucratic State functioning. For the author, impersonality and the search for application of universal rules by these individuals would constitute a precondition for the consolidation of a democratic State.

These civil servants, when isolated from the demands of society through a 'bureaucratic insulation' achieved with the State professionalization and the adoption of procedures such as a public exam, would help avoid a personalistic logic. However, this fact has a contradiction. Bureaucratic insulation presents itself as a protection of the State from excessive pressure from stakeholders; however, such insulation prevents fulfillment of social demands, such as those related to health policies.

Then, the most coherent perspective with the implementation of SUS is the universalism of procedures, which is based on the norms of

impersonalism, equal rights before the law, which would mean the benefits and public charges should be allocated according to general and universal rules and procedures, associated with the idea of full citizenship, which would imply the State autonomy, and in turn, fulfillment of social demands, with control mechanisms to be run by health councils, among other possibilities. That is, it would depend on making it permeable to society, taking into account the complexity and dynamism of the health sector as a living system.

In this sense, the 'good government' attributes are considered here as a condition to achieve the universalism of procedures. Then, for the 'good government' to become a daily practice of management in the implementation of a public and universal health system, it could be included in manager training, required for professionalization of management. In this sense, the authors of this study believe the institutional developments and significant progress towards the professionalization of health management, recently achieved in Spain, can bring elements to be considered in the context of SUS defense and strengthening.

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