

## ORIGINAL ARTICLE

# Conception of the right to health of mid-level technical professionals of the mid-level of the Unified Health System in Brazil



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*Manuscript received: November 2017*

*Manuscript accepted: January 2017*

*Version of record online: March 2018*

## Abstract

**Introduction:** The right to health, one of the achievements guaranteed by the Citizen Constitution promulgated in 1988, came in response to the citizens' struggle for health reform in 1986. The guarantee of this right is established in the Unified Health System.

**Objective:** To analyze the conception of the right to health of middle level professionals of Unified Health System.

**Methods:** Qualitative approach research, through 2 focus groups involving 9 graduates of a Health Technical School of the SUS in the north of Brazil, from the courses of clinical analysis, dental hygiene and nursing, working in the Unified Health System.

**Results:** Three categories show the results obtained concluding concepts of health, the right to health and health conceptions; Health practices and access to care; and topics of training, health care and humanization.

**Conclusion:** The participants of this study have a conception of the right to health directed to the legislation, their concepts of health approach elements of Unified Health System policy, among others, promotion, prevention, humanization; their conceptions of health are strongly focused on the biomedical model centered on disease and medicine.

**Keywords:** health to right, unified health system, professional qualification, curriculum, healthcare personnel.

**Suggested citation:** Melo RMSB, Morais GB, Morais JB, Leite SN. Conception of the right to health of mid-level technical professionals of the mid-level of the Unified Health System in Brazil . *J Hum Growth Dev.* 2018; 28(1):95-104. DOI: <http://dx.doi.org/10.7322/jhgd.143886>

## ■ INTRODUCTION

Providing healthcare to the individual involves two subjects: the health professional (person legally established for care) and the user (person seeking care), they may differ in conceptions and worldviews, which make them think and act according to their beliefs and /or the role they play in the society.

The logic of health care permeates the right to health, which is internalized in social rights, as a right intrinsic to the principle of human dignity, which is closely related to life and social well-being<sup>1</sup>.

In this dimension, Dallari and Maggio<sup>2</sup> refer to health as a right of all, whose actions must be organized and efficient, to be disposed to the population, although it is evident the conflict between the discourse of human rights and economic conditions to provide care.

As a response of the State to the needs experienced by civil society, Mendes<sup>3</sup> insists that the discussion about the proposal for the organization of the Unified Health System (SUS) should start from the analysis of what needs the Brazilian population, according to Humenhuk<sup>4</sup> a set of legal norms aiming at health care, as part of second generation law: a social right to benefits, because it requires positive action on the part of the State, as well as a public and subjective right.

In this direction, Barbianni *et al.*<sup>5</sup> understand access to the various health services and resources as the cornerstone of the materialization of the right to health and the incorporation of SUS principles.

Constitutionally, in the articles 196 to 200, health is a *"right of all and duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and universal and equal access to actions and services for its promotion, protection and recovery"*<sup>6</sup>.

In this context, the SUS is established, based

on equality, equity and integrality, and is established organizationally by hierarchy, regionalization, resolubility, decentralization, social participation and complementarity of the private sector, principles that come from the movement of the Sanitary Reform /1986<sup>7</sup>.

The SUS brings the proposal to change the situation of inequality in health care to any citizen, without distinction, according to the Federal Constitution of Brazil - CFB / 1988 that ensures the promotion of the good of all, regardless of origin and other attributes<sup>6</sup>.

However, it is true that a quarter of Brazil's total income is concentrated in 1% of the Brazilian adult population, leading to a situation in which *"one thousandth of the population accumulates more income than the half of the poorest population"*<sup>8</sup>.

Cotta *et al.*<sup>9</sup> considering that inequality is not a phenomenon that is literally related to the lack of economic resources, but also associated with it, agree that when focusing on the field of health, it is necessary to consider the actions and postures that the health professional should adopt in front of the health-disease process, in order to relate competence to the diverse needs of the community, which makes education in the health field successful.

In the action of health professionals can still be seen as a result of historical construction linked to the inherited condition of exclusion, reproduction in some degree of this inheritance when on the one hand the professional conceives his actions not as its obligation and right of the user, and on the other, on many occasions, the service user accepting such a posture, for having the conception that the care given to him is given as charity.

Thus, this research aims to analyze the conceptions of right to health in the practice of the middle level technical professional in the Unified Health System - SUS.

## ■ METHODS

This is an observational and descriptive study of a qualitative approach, carried out in a Technical School of SUS - ETSUS, located in the North of Brazil.

The methodology adopted in this work was oriented by two focus groups guided by the logic proposed by Minayo<sup>10</sup>, Severo *et al.*<sup>11</sup>. Focus groups provide a qualitative analysis that is important for understanding the internal logic of groups, institutions and actors, it includes: (a) cultural values and representations about their history and specific themes; (b) relationships between individuals, institutions and social movements; and, (c) historical social processes and implementation of public and social policies. This approach considers belief, cultural relations and power, which is constructed in various ways in daily life<sup>10</sup>. From this perspective, Bauer and Gaskell<sup>12</sup> argue that qualitative research deals with interpretations of social realities.

Trad<sup>13</sup> states that, when organizing the focal group, attention should be paid to the necessary resources, including moderators, participants 'and groups' definition, selection process and length of time, in order to succeed in this proposition.

Participants were school leavers identified through analysis of the conclusive lists provided by the institution. In the period of data collection ETSUS had 132 graduates, being distributed in 84 Technicians in Clinical Analyzes, 28 Technicians in Nursing and 20 Technicians in Dental Hygiene.

Based on the norms to conform focus groups, it was established as inclusion criterion those professionals who were working in the SUS, totaled 12 graduates, 3 of the participants were absent at the moment of doing the groups, left a total of 9 participants.

The format of these groups had the representativeness of the 3 training areas chosen for this study and followed the orientation of the literature regarding the formatting of small groups, thus making two groups, one composed of 4 and the other by 5 graduates, respectively.

The focal groups agenda comprised four moments, the first three were the formal invitation to the public institutions linked to the graduates, the presentation of the coexistence group / norms and the icebreaker section. Finally, in the fourth moment, the questions asked were applied.

For the data collection, a structured script was used composed of 12 questions that guided the work, varying according to the direction of the discussions, such as: “What is your understanding of” Right to Health “? Who has the right to health? How has the technical training offered by ETSUS contributed to their work practice in order to contemplate the “Right to Health” of the citizen?”

The meetings took place on the premises of the institution on different and sequential days, April 29th and 30th, 2009, and developed in approximately two hours each and every day.

## ■ RESULTS AND DISCUSSION

Initially, a total of 12 participants were appointed to focus groups; of those, there was a 25% absence, and of the 75% that were present, 66.7% were female and 33.3% male. The average age of the graduates was around 40 to 47 years, 55% of them from the Protestant Christian religion.

These were recorded and later transcribed to analyze the statements of each participant, using the technique of content analysis proposed by Bardin<sup>14</sup>, which resulted in the definition of three categories. Note that the recordings were destroyed at the end of the study.

The research was submitted to the Committee of Ethics in Research with Human Beings of the University of Vale do Itajaí, and approved under No. 39/09 of February 20, 2009.

Also, in order to respect the anonymity of the participants, the technicians were identified as TE1, TE2, TE3... TE9.

In this stage of the research the categorization of the analysis was performed in a total of three categories according to the steps of Bardin<sup>14</sup> and gathered a set of testimonies referenced by the focus groups, by reason of the common characters, under a given title, summarized in Table 1.

**Table 1:** Thematic categories according to the technique of data organization. Brazil, 2017.

<b>Analysis Categories</b>	1. Concepts of health and the right to health and Conceptions of health
	2. Health Practices and Access to Care
	3. Training contents, Health Care and Humanization

### Concepts of health and the right to health and Conceptions of health

Life experiments, unique to people, provoke sensations that can trigger responses embodying the improbable or the unusual. In this perspective, living the concept is always linked to a problem related to this experiment. Regarding health, it is possible that its concept of origin does not conform scientifically, which makes it accessible to all, bringing a common but rejected thinking, relating physical exercise and diet<sup>15,16</sup>.

However, in the old age, Dallari and Nunes Junior<sup>16</sup> refer that the Greek term *hygieia* represented health and encompassed the condition of the person who is well in life. Complete wellness in physical, mental and social, not simplified the simple absence of diseases is a concept of health established by the World Health Organization - WHO<sup>17</sup>. Such a concept, Bezerra and Sorpreso<sup>18</sup>, due to its comprehensiveness, subjectivity and imaginary of fullness, caused great questions. Vasconcelos and Santos<sup>19</sup> show similar thinking when they point out that it is necessary to understand how illusory and baseless it is to achieve full health. For Araújo *et al.*<sup>20</sup>, the incorporation of the concept of health that shows the conjuncture in which most people are inserted allows an objective interpretation.

In this context, the technicians expose a comprehensive health concept bringing with it physical, mental, spiritual, emotional, as well as legal / constitutional aspects. The graduates advance towards a conceptualization of the right to health that transcends the care base reaching the individual and environment.

“...is well financially, physically and psychologically ... physical, social and mental well-being.” (TE2)

“Health ... is not having financial

problems ... family; Having leisure, pleasure, mental health, socializing with other people, interaction.” (TE6)

“For people to be healthy ... they need to be emotionally well It’s all important ... everything has to work perfectly, from a dwelling to the emotional, the moral, the physical.” (TE8)

“...health ...I will take to the spiritual part. Sometimes we want so many things and we do not have, because we lack the peace of God! And when all this is balanced we can be healthy.” (TE9)

“The right to health ... encompasses the environment, the people. I have the right to have a food that is not harmful to me, to drink water that is not harmful to me... the right to health... encompasses the environment, the people.” (TE1)

“...because the Federal Constitution says that health is a right for everyone and the duty of the state and the family... The right to health is paramount, but it does not happen.” (TE6)

“...health is also education. The health must be inserted in the school ... since the preschool or in the first grade already must be listening about health, conscientization to the little citizens.” (TE3)

In this way, expressed health concepts accommodate the person in its plurality, with their relationships and links, in line with the rules governing the SUS and the World Health Organization (WHO), which, according to its Constitution of July 22, 1946, admits as objective the attainment of the highest level of health possible, by

all peoples. To that end, it defined each government as responsible for the health of its people, which can only be achieved through coherent sanitary and social measures<sup>17</sup>.

As Buss<sup>21</sup> points out, approaches in this field were already present in the world, passing through Canada, USA, Great Britain, Sweden, Colombia, New York, Cairo, USSR. Thus, in the 70's, the relevant records conformed the Lalonde Report, the Alma-Ata Declaration and others; in the 1980s, it was the turn of the Black Report, Toronto Healthy 2000, the Ottawa Charter among others; In the 1990s cite the Sundsvall Declaration, Jakarta and other records.

In these circumstances, the study participants identified a health concept aligned with the WHO, considering the individual and its surroundings, and the Unified Health System. Health is therefore a collective value, a good of all, and should be each to enjoy it individually, without prejudice to others and jointly with all<sup>17</sup>.

Aith *et al.*<sup>22</sup> also reinforce that it is from the paths adopted by the State, respecting and enabling social participation in normative decisions with universal access and equality in the services rendered in the constituent services of SUS, that reaches the legal concept of health, an effective extension of this right and the size of the State's duty.

The above argued by the authors is therefore pertinent to one of the dimensions of the first concept of citizenship developed by Marshall in 1950 in the book *Citizenship and Social Class*, that is, social citizenship which included a series of social rights. In periods of unemployment and illness, in the twentieth century, allowing the presence of people in the processes of economic and social well-being of the community<sup>23</sup>.

It should be noted that in addition to the levels of economic and social well-being, technicians also address the issue of spirituality, recognizing the broader conceptualization of health. This, as a necessity of the people to be settled by the State acting in the various interfaces, corresponds to a constitutionally established right, so verbalized by the technicians rescuing the intersectoriality, human dignity, knowledge of the laws and the appropriation of information, as well as the tax payments.

Leite and Mafra<sup>24</sup> identified in a survey about the trajectory and perceptions of the SUS users in the access to medicines by the judicial route that, in the available studies, the understanding of the right to health by the users is still little explored; however, it is the thinking of the leaders of health processes - professionals and managers, in addition to researchers, that comes. Participants, in the majority (39%) did not have the knowledge that they could claim the drug without having to judicialize.

As in Brazil, Mitano *et al.*<sup>25</sup> treat in their study that the right to health is also constitutionally assured and is inserted in the Constitution of the Republic of Mozambique of 2004 (Article 49) defined that all citizens have the right to medical care and sanitary, and the State is also responsible for promoting and defending public health, although it is not clear how the country should offer such services equitably.

The authors report that the financing of the Mozambican national health system is one of the lowest in the Southern African region, and that about 66% of its expenditures are externally dependent. Thus, the authors understand that there is an asymmetry between the health policies predetermined by the State and the current practices, and also perceive that the focus on equity and quality is incipient<sup>25</sup>.

In this direction, Mendes<sup>26</sup> asserts that in Brazil the percentage of total health spending is 47% by the government, while in the private sector the contribution is 53%, thus conforming the segmented aspect of the health system Brazilian.

Health and disease do not have a unique meaning for everyone, because the existence of individual, religious, philosophical values, as well as temporal, spatial and social aspects, integrate an entire conjuncture<sup>27</sup>.

However, in the concepts and conceptions of health brought by the research technicians, it is observed the interaction of the agent with the social phenomenon once it is built of socially representative constructions, which allow understanding and interpretation of the reality studied<sup>28</sup>.

Gomes *et al.*<sup>29</sup> report that the perception of health as a phenomenon is effective from the lived experience of the health-disease process, associating the various determinants (social, cultural, biological, among others) inserted in daily life and history of life.

Thus, proposing healthcare assistance implies deciding on actions that are consistent with the peculiarities inherent in each population, otherwise it will fall into a vicious cycle of attention that is not aligned with the needs of users. This syntony encompasses cultural meanings showing that the language of disease is not only about the sickness and dying of the body, but language directed to society and to historical social relations<sup>10</sup>.

## Health Practices and Care Access

Talking about health presupposes positions in the direction of national health policy accompanied by knowledge that materialize the model of care proposed by SUS.

However, considering the various aspects, economic, social, political and cultural, discussing health by combining such approaches may be a not so simple exercise. Although it may be difficult to present, this process provides critical reflections on the practices carried out<sup>30</sup>.

The practices adopted are not always aligned with the organizational proposal of the national health policy oriented through established flows and processes. It can be seen through the testimonies of the participants a certain preference for working in the health field linked to the guarantee of the Law, but also they use the favoring of their peers mediated by the distribution of medicines and technical acts going through the parallel path (friendship) to reach or SUS; they question about the SUS user by the private health care service and associate prevention, cure, rehabilitation and the right to health with the payment of taxes.

"The citizen came with a request...

from a private doctor... I said: citizen... it was not even for you to have gone private;... it's your right! The state already had [...] to secure everything!" (TE1)

"People go to my house to check the blood pressure; I do not know why (laughs), but my neighbors are almost all hypertensive, so they ask: do you have a captopril, an ontenegro?... It's because they have to sleep in the queue. I do what I can do!" (TE8)

"...asking for medication is from the family to the neighbors. They ask for medicines to see me [...] In my house, people are always going to take an injection [...] people think we do not do it because we do not want ." (TE4)

"...I live in an area next to BR 364 and people ask me for medicines. I say I only get the medicines with the prescription; A neighbor said: I went for a tooth extraction and it was not removed because my blood pressure was up there. You do not make it easy for me? I said no! What if you die in the chair?" (TE5)

"We explained that if SUS does not cover that service, the unit takes responsibility and transfers it to another health unit; We never say that it does not." (TE4)

"We help those people, especially those with low incomes. In the itinerant, we see how much these people need us." (TE3)

"...at the moment that we are professionals we have to do things right; One day we can become patient and there? ... when you become a patient, sick, we want to demand right now with all rancor or anger because you know ..." (TE7)

"In my case, I feel sorry for the patients. Sometimes I get to be taken care of, but there is complaint. Its not just to be charitable and the person who will treat the pain does not agree to it!" (TE5)

"...tax money is for what? To pay the employee, to have income to pay for that exam, the doctor, everything that includes the expense, as they say... nothing is free... It is important for us not to be alienated, accommodated, if we can involve individual enlightenment" (TE7).

"...usually when they look for me, they ask for medical advice. No prevention, just the curative part. When I give an explanation, they do not want to know!(TE9)

"...you work there, you can get the result, the clinical report?... can you help me do this type of exam?... it's exactly like that, they look for us to facilitate the service... a way which is wrong (laughter), but we try to help our way, right? (TE7)

"People do not want health but just medicines!" (TE5)

"...there is usually one that indicates: the Brazilian way!... the health care that the population has right is in the preventive,

curative and rehabilitation... the population is entitled to all of this." (TE9)

Although they refer to the legal aspect, the research participants make clear the connection between the right to health and the issue of access, simplified in obtaining the consultation, and medicine that is out of the dimension of promotion. Note the difficulty that the user faces with regard to access to health care.

No different, Silva and Motta<sup>31</sup> in a study carried out with the objective of knowing the users' perception about health policy in primary care, identified the lack of relationship between the concept of prevention and health promotion, although there should be association between the two.

In addition, as of the 1988 Constitution, the right to health was embedded in social rights (Article 6), recognized as the right of everyone and the duty of the State, as well as ensuring universal and equal access to health promotion, protection and recovery of health (Article 196)<sup>6</sup>.

However, even with the arrival of the SUS and all its proposal, we have to consider the Brazilian health system that mixes diseases of contemporary with communicable diseases (which are no longer a problem in more developed societies), mental illness and violence in general; And also the concern about the way in which health expenditures are effected. Thus, it should be noted that most financial transfers by the federal agency are linked to the programs of the Ministry of Health, so that these resources can not be redirected for other purposes. Therefore, the municipalities only execute the policy defined by the federal sphere, creating constraints to the administrative independence of the managers<sup>32</sup>.

Due to this logic, and also in the view of the study technicians, access to care through the SUS still does not contemplate a society with sufficient access and the bottlenecks of services stimulate the growth of demand for private assistance, which may be due to lack of credibility of services offered by SUS, among other vulnerabilities<sup>33</sup>.

Assured by the Federal Constitution of Brazil, the participation of third parties in health care is expressed in Articles 197 and 199. Therefore, in view of the need to contract complementary health care by the public power, this practice occurs preferentially with non-profit institutions<sup>34</sup>.

Thus, the complementarity of the SUS is based on the healthcare needs of the SUS users, materializing and justified by the SUS's proven lack of sufficiency in offering health services in line with the needs of users that the private body is prepared to proceed with this offer. Such user needs relate to the individual's singularity, considering each one in its peculiarities, conferring the attributes of equity. This is defined as the non-existence of systemic differences, which is capable of recovering ethics and justice in relation to distributive values and rules, recognizing that people are unique and different from each other, admits the adoption of different treatments with compensate for these inequalities<sup>35</sup>.

In this expression, the practice of study participants according to their peculiarities, roots and life baggage is perceptible in such a way as to reproduce the thematic

asserted by Da Matta<sup>36</sup> and the way the Brazilian acts to ensure, by refuting the bureaucracy, the their intent, asserting their rights, using their personal relationships or the strength of the knower with whom they are speaking.

In this context, the Brazilian assuming a dubious position, reflected in this strategy, can both signify conformism to the unjust and unacceptable, as well as the survival of the experienced in the day to day<sup>37</sup>.

### Training contents, Health Care and Humanization

The democratization resulting from health reform and contextualized in the public health policy of Brazil requires a harmonious performance between the way of care and health management. Thus, allowing subjects to participate in the process refers to the guarantee of their role both in health and in the training of SUS workers, shifting the sanitary practice over the subject and towards the subject<sup>38</sup>.

Thus, the educational process is made explicit in the condition of helping people to walk in the direction of learning, since they will never be complete in any stage of their formation, but with an attitude to lead it to the end of their existence<sup>39</sup>.

In this line, with the advent of SUS, the national public health requires the complicity of the practices of the professional agent with service. In this sense, according to Batista and Gonçalves<sup>40</sup>, this exercise is concretized by *“articulating the knowledge and renewing the capacities to face the increasingly complex situations in the work processes, given the diversity of professions, users, technologies, relations, organization of services and spaces”*.

However, it is important to say that the field of health seeks for its mid-level technicians, new formative references in the perspective of promoting students and workers to practice critical and reflective thinking, in order to become competent to care for the other, applying the Knowledge with resolving potential<sup>41</sup>.

Following the approval of the Law of National Education Guidelines<sup>42</sup> and their respective complementary legal instruments, a new modality in the educational field was instituted in Brazil. In reference to Professional Education, said Law is considered a milestone in its form of treatment, by the comprehensive way that the topic is approached, and by the flexibility allowed to the system and the students.

In this sense, the technicians studied perceive the new learning process as a reinforcer for their practices, based on the knowledge learned in the training modeled by the SUS, bringing the triad of knowledge, encompassing know-how, how to do it and personal skills. In this tendency, it is understood that the processes of updating and training added to the technical education are positioned as articulators and potential differentiators in the direction of the materiality of the critical and reflexive being expected in SUS.

It is expected to minimize the asymmetry between the one who is transmitting the knowledge and the student. It is a relation between the knowledge and the doing where the transmission of knowledge is developed in the logic that there is on one side of the process a holder

of knowledge and on the other side that does not know it<sup>43</sup>.

“...the whole population has the right to health. When we are silent we are being conniving. There are a lot of people to be consulted because the doctor goes out, goes home, has lunch... the dentist, goes home to dinner... and many people are waiting; Those of us who are familiar with it, and who are in daily life watching the audience, we should put our mouths on the trombone and do our part.” (TE4)

“...health is also education. Health should be inserted in the school ... since the preschool or in the first grade already must be listening about health ,conscientization to the little citizens.” (TE3)

[...] in the part related to humanization, at the beginning and end of the Course, and also when we were trainees, we took into practice the humanization, the right of the citizen and there we were already practicing. Doing the procedures with another view. It was theory and practice and every moment of it was wonderful! (TE9)

[...] With the technical training we know more the SUS ... we study the legislation. We were employees, but we did not have access to information; We learn, that we are public servants, we are there to comfort the pain of our neighbor; We did not know about our rights and in technical courses I consider that we have learned the least about our space; Including the question of ethics and practice, was desired, but the other knowledge was well emphasized and contributed a lot; Even when people are complaining we have some argument; and it was useful to have more awareness of what the SUS is. (TE6)

[...] The training that the school gave me made me more human! When I get looked for, I can not take it anymore with a “ face ache”. The school taught to treat others well; dealt with humanization. (TE5)

[...] When I have to talk about this school, I am thrilled; I remember the moments I spent here ... the discussions with colleagues in the classroom, all aimed at professional growth, the growth of citizenship; Here I learned health, citizenship, duties, rights..... I left this school, not the same that I entered. -(TE1)

[...] I owe everything to school ... the practice of work in order to contemplate the right to health that through my knowledge I was able to know the health system that is SUS that I did not know ... I read a lot and who did not learn was because they did not want to, because the school taught right ... when we have the knowledge is easier to help people in both professional and practical, Everything is easier! (TE8)

Batista and Gonçalves<sup>40</sup> working with four groups of people, identified in two of the groups that individuals have the desire to learn other experiences and realities in healthcare, understanding that in this way they are repositioning their sanitary practices towards a better qualification.

Therefore, the changes in learning involve collective construction, participative and pertinent to local realities, considering also the unique baggage of each professional of what they know about the SUS, since it influenced the rupture of the professional practice of the supported by technical-theoretical knowledge of the body and the disease, for example<sup>40,44,45</sup>.

It is also necessary to understand health as a result of a set of actions for disease prevention, health promotion, healing and rehabilitation, materialized through the plurality of knowledge and interdisciplinary and multiprofessional teamwork, including networking<sup>44</sup>.

In the case of interdisciplinarity, it is observed when there is the alignment between the discourse and the practice of the studied technicians, rethinking about the spaces of the health practice and the academic spaces, which possibly bring, besides the development of comprehensive care judging by the bond and the listening, the other effective responses to the population in the event of their attendance in any of the care areas<sup>46</sup>.

Thus, in addition to the challenges inherent to the changes necessary for training and the work process, it was the creation of health workers' training schools in health institutions that attempted to face the changes, bringing the insertion of the curricula compatible with the model social and epidemiological of Brazil<sup>47</sup>.

Contrary to the process, at the time of the institution of the SUS, the reorientation of the health care model materialized, however, its workers still had a traditional, fragmented training, unbalanced with the SUS proposal, since it was faster Education reform<sup>7</sup>.

In this dimension, the concern with the training of health professionals is very explicit at the time of the 9th National Health Conference, held in the period

from August 9 to 14, 1992, in Brasília (Brazil), which associated the need to review curricula in a way that is consistent with social, ethnic and cultural realities and the epidemiological context, proposing general training with integral vision and social commitment.

Thus, along with the challenges inherent in the changes required for training and the work process, it was the creation of health workers' training schools in health institutions that attempted to face the changes, bringing the insertion of the curricula compatible with the model epidemiological partner of Brazil<sup>48</sup>.

Within this horizon, the purpose of the SUS-ETSUS Health Technical Schools should be to professionalize workers employed in health services that do not yet have the necessary qualification to carry out their functions. Thus, in 1999 there were 26 institutions, and the northern region experienced a great emptiness so that to professionalize and certify the workers of this region, courses were held for auxiliaries and technicians through the Nursing School of the extinct Public Health Services Foundation Of the Ministry of Health - SESP Foundation<sup>7</sup>.

At present there are 40 Technical Schools of SUS/ Training Centers, covering the entire national territory, distributed as follows: North region - 5 schools and 2 training centers; In the west center, are 3 and 1, respectively; Northeast has 8 schools and 4 training centers; West center are 6 schools, 6 training centers and 1 core training; In turn, the south region has 3 schools and 1 training center<sup>49</sup>.

It was found that most of the researched professionals can not apply the training proposal defined by the ETSUS signed in the reversal of the biologist paradigm, which may result from the conflict between the training (traditional and technician) acquired by the mediators of learning (nomenclature adopted by the formation of SUS, replacing the term teachers) leaders the courses and the new model of training (by competencies) to be provided to the educating professionals, leading to believe in the urgent need to train those mediators.

## ■ CONCLUSION

It can be concluded that health professionals in this study showed a conception of the right to health according the legislation, although they also associate it with a response to the payment of taxes.

As for the concepts of health, the technicians refer to the elements of the Unified Health System policy, among others, promotion, prevention, humanization; although

they mention the constituents that shape the expanded concept of health, pointing to education, employment and housing, is clearly showed, that their health concept is strongly focused on the biomedical model, centered on disease and medicine, making it difficult to reduce the distance between what is practiced and the one proposed by the Unified Health System.

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## Resumo

**Introdução:** O Direito à saúde, uma das conquistas garantidas pela Constituição Cidadã promulgada em 1988, veio em resposta aos movimentos de luta dos cidadãos pela Reforma Sanitária em 1986. Na proposta do Sistema Único de Saúde a garantia desse direito está estabelecida.

**Objetivo:** Analisar a concepção de direito à saúde no contexto do profissional de nível médio do SUS.

**Método:** Pesquisa de abordagem qualitativa, através de 2 grupos focais envolvendo 9 egressos de uma Escola Técnica em Saúde do Sistema Único de Saúde do norte do Brasil, dos cursos de análises clínicas, higiene dental e enfermagem, atuando no Sistema Único de Saúde. O tratamento dos dados foi por análise de conteúdo proposta por Bardin (2009), com a definição de 3 categorias.

**Resultados:** Três categorias retratam os resultados obtidos congregando conceitos de saúde e de direito à saúde e concepções de saúde; práticas de saúde e acesso à atenção; e ainda, conteúdos da formação, cuidado sanitário e humanização.

**Conclusão:** Os participantes desse estudo demonstram uma concepção de direito à saúde voltada ao legislado e seus conceitos de saúde abordam elementos da política do SUS, dentre outros, promoção, prevenção, humanização; suas concepções de saúde estão marcadamente voltadas ao modelo biologicista, focado na doença e no medicamento.

**Palavras-chave:** direito à saúde, SUS, qualificação profissional, currículos, pessoal técnico de saúde.

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