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Pathways to Sanitary Surveillance: the challenge of health care surveillance

Caminhos para a Vigilância Sanitária: o desafio da fiscalização nos serviços de saúde

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ABSTRACT

This debate problematizes the questioning presented by the Central of the Hospitals of Minas Gerais about the lack of standardization of the work of the Sanitary Surveillance (VISA). The case was analyzed under the logic of the technical and social division of labor, under two dimensions: the technical-scientific, which involves the necessary technologies to assess the risk; and the political-administrative organization of work, related to the operational spaces and the political-administrative levels of the State. With regard to technical-scientific actions, there are still problems with no solution. The standardization and qualification of the actions of VISA are directly related to the existence of a National Policy of Permanent Education, as well as to a satisfactory infrastructure and adequate human resources. In addition, it is also necessary to develop educational activities for the regulated sector in order to explain that the inspection actions are permeated by elements of uncertainty, allowing different points of view on the part of the "experts" who carry it out. And that the dimension of "risk management" is permeated by conflict and controversy, especially when the consideration of alternatives to what to do with assessed risk considers the public and the private. In this context, it concludes on the difficulties that VISA finds to fulfill its mission.

KEYWORDS: Sanitary Surveillance; Health Services; Health Risk; Continuing Education

RESUMO

Este debate tem por objetivo problematizar o questionamento apresentado pela Central dos Hospitais de Minas Gerais sobre a falta de padronização do trabalho da Vigilância Sanitária (VISA). Analisou-se o caso sob a lógica da divisão técnica e social do trabalho, sob duas dimensões: a técnico-científica, que envolve as tecnologias necessárias para avaliar o risco, e a organização político-administrativa do trabalho, relacionada aos espaços operativos e aos níveis políticos-administrativos do Estado. No que tange às ações técnico-científicas, depara-se com problemas ainda sem solução. A padronização e qualificação das ações de VISA estão diretamente relacionadas à existência de uma Política Nacional de Educação Permanente, bem como a uma infraestrutura satisfatória e recursos humanos em número adequado. Além disso, se faz necessário, também, desenvolver atividades educativas para o setor regulado visando explicar que as ações de fiscalização são permeadas por elementos de incerteza, possibilitando diferentes pontos de vista por parte dos "peritos" que a realizam. E que a dimensão da "gerência do risco" é permeada pelo conflito e controvérsia, em especial, quando a ponderação de alternativas sobre o que fazer com o risco avaliado considera o público e o privado. Nesse contexto, conclui-se sobre as dificuldades que a VISA encontra para cumprir com sua missão.

PALAVRAS-CHAVE: Vigilância Sanitária; Serviços de Saúde; Risco Sanitário; Educação Continuada

INTRODUCTION

In the context of the debates that preceded the 2016 municipal elections in Brazil, special attention was paid to the question of Public Health. Not surprisingly, in some capitals like Rio de Janeiro, São Paulo, Belo Horizonte, Porto Velho, Macapá and Aracaju, more than half of the voters rated health care as the most problematic area[1].

In that sense, the Union of Physicians of Minas Gerais[2], in partnership with the Medical Association and the Regional Council of Medicine of Minas Gerais, promoted a debate with the candidates to the second round of the elections in the city of Belo Horizonte, state of Minas Gerais. One of the entities that attended the debate, the Central of the Hospitals of Minas Gerais, presented the following question[2]:

> Considering that Health Surveillance inspectors carry out their inspections in our hospitals in different manners, in the same environment or conditions, that is, for the same type of problem different behaviors are adopted according to the expert who performs the inspection; and considering that these inspections should be based on standards, rules and legislation, we ask: in your administration, what will be done to make inspections follow a standardized process, once hospitals intend to comply with these rules and laws?

It is important to note that, in the midst of many serious health problems, health surveillance should be emphasized. The concern of the regulated sector with health surveillance inspection actions causes some discomfort. The question raised by the Central of the Hospitals of Minas Gerais, entity that brings together the Association of Hospitals and the Union of Hospitals, Clinics and Nursing Homes of the State of Minas Gerais, concerns the work of health surveillance.

The organic law on health[3] defines health surveillance as a set of actions capable of eliminating, reducing or preventing health risks and of intervening in health problems caused by the environment, the production and circulation of goods and the provision of services somehow related to health.

Thus, action on current and potential risks, aiming at health protection and prevention of diseases and injuries, recognizes the work in health surveillance as part of the productive process of health[4], which is essentially characterized by the provision of services, and it is its workforce that ensures its quality and effectiveness[5].

The health surveillance work has some particularities due to the nature of its objects of intervention and the exclusively state-run and disciplinary character of its actions. Its objects of intervention can be understood as complex objects that are situated between science, health and the market[4]. Thus, the hybrid nature of these objects is identified as being, at the same time, livelihood and merchandise[4]. As a consequence, the health surveillance work process is permeated by contradictions generated by interests, often antagonistic, between Public Health and the market[4].

In order to get a better understanding of the elements that make up the health surveillance work process, Souza and Costa[4] proposed the following systematization:

> Work object: products, services, processes and environments of interest to health;
> Work means: material instruments, technical and legal standards and knowledge mobilized to carry out the work health control;
> Work agents: agents of the state who act in the institutional apparatus of health surveillance;
> Work product: control of sanitary risks on products, services, processes and environments of interest to health;
> Work purpose: protection and defense of Collective Health.

The authors[4] also proposed to study the work process of health surveillance considering the technical and social division of labor under the two dimensions that compose it: the technical-scientific and the political-administrative organization. According to them,

> "The selection made from these dimensions would incorporate technical-sanitary and political-administrative aspects to account for the objects of control, in view of the necessary measures to guarantee full health protection actions."

Considering the aspects presented, this debate will address the question asked by the Central of the Hospitals of Minas Gerais, based on the conceptual proposal of the social and technical division of labor, in its two dimensions, the technical-scientific, that would involve the necessary intervention technologies to assess the risk, that is, the audit. And the political-administrative organization of work, related to the operational spaces and the political-administrative levels of the State, for this study, the consequences of the inspection.

DISCUSSION

Risk assessment in health services: the inspection

The Brazilian Federal Constitution of 1988[6] gives public relevance to health-related actions and services. This means the public administration is supposed to perform regulatory activity, through the inspection, control and regulation of this activity. In this way, health inspection actions are health surveillance prerogatives that cannot be delegated. Their purpose is to protect and defend the health of the population.

They rely on their Police Power, which is based on the principle of the predominance of the public interest over the private. This power is fundamental to impose rules and standards of behavior and, through inspection, to verify their compliance[7].

In this sense, health surveillance can be defined as a field of State intervention able to adapt the productive system of goods and services of health interest to the social demands and to the needs of the health system[8].

In order to do so, it uses work means that include a set of techniques and instruments used in concrete health surveillance actions. These methods are advancing as health surveillance is structured and consolidated.

In this context, the decentralization of health surveillance actions to the municipalities has contributed to overcoming the traditional instruments of command and control, evolving from a bureaucratic and legalist approach to one more focused on protecting the health of the population[9].

Thus, the health surveillance body of Belo Horizonte[10], in the years 2004 to 2006, aiming to take a "quality leap", was reformulated through the implementation of the Management Plan, an instrument designed based on the methodology of *Plan; Do; Check and Action* (PDCA). The main strategies of this plan are the implementation of the Health Surveillance Computerization Program (Health Surveillance Information System - Sisvisa) and the rewriting of the Sanitary Code. In the design of the Computerization Program, all the inspection scripts were revised, updated and standardized, in a huge effort of the health inspectors of Belo Horizonte.

Despite this standardization, there may occasionally be abuse of the Police Power by public agents who exceed their legal limits and the competences attributed to health inspection[11]. In 2008, Oliveira and Dallari[12] detected the dissatisfaction of the regulated sector with the work of the health surveillance professionals, in interviews with Health Advisors aimed at learning more about their experience with health surveillance. It should be clarified that public, philanthropic and private hospitals have a seat in the Municipal Health Council and expressed their position saying:

> "And when the inspector arrived his main intention was to punish the hospital [...] to fine it. So my experience is marked by poor relationships with health surveillance professionals, they often lack sensitivity[12].

As the Central of Hospitals observed in its question, inspections should be based on standards, rules and legislation. Considering that health surveillance uses legal instruments, which are prerequisites to its operation, the legislation and technical standards used integrate a system of health standards that represent scientific and technological knowledge, as well as the interests of Public Health.

In this perspective, the Brazilian Health Surveillance Agency (Anvisa), which also integrates the Unified Health System (SUS), through Resolutions of the Collegiate Board of Directors (RDCs), publishes technical regulations that address issues related to health services, such as: RDC n. 63, of November 25, 2011[13], which aims to establish good practice requirements for the operation of health services; RDC n. 15, of 15 March 2012[14] laying down requirements of good practices for the operation of services that process health products and RDC n. 36, of 25 July 2013[15], which aims to institute actions to promote patient safety and improve the quality of health care services.

Thus, the professional practice of health surveillance implies an increasing demand for updated information and scientific knowledge; it requires knowledge of various fields of expertise and specific knowledge, much of which is not included in health professional training courses or other professions that also work in health surveillance[7]. Considering that it is the responsibility of the SUS to coordinate the training of its employees[5], it is then necessary to question whether health surveillance workers have had access to up-to-date scientific information and knowledge, training and continuing education, or rather, if they have access to a Continuing Education Policy.

Furthermore, the lack of a National Health Surveillance Policy[8] hinders the full functioning of the National Health Surveillance System (SNVS), formed by the federal agency, states and municipalities - as an articulated group, with coordinated action between management levels also affecting the qualification of health surveillance workers. It should be noted that Law n. 9.782, of January 26, 1999[16], responsible for the definition of the SNVS and the creation of Anvisa, establishes that promoting the development of human resources for SNVS is one of the competences of the agency.

In the absence of a National Health Surveillance Policy, the Sanitary Surveillance Master Plan (PDVISA)[17] was designed to fill the gap. The PDVISA should be understood as an instrument for choosing the priorities of health surveillance. In this sense, the PDVISA presents some guidelines related to education management: Promotion of the education of professionals who work in health surveillance; Harmonization of work management and education in health surveillance with the guidelines of the National Policy on Labor Management and Health Education; and Promotion of access to scientific knowledge that is relevant to regulatory actions for SNVS professionals. PDVISA guidelines should be implemented through the Health Surveillance Action Plans, and these Action Plans should describe the program to be followed over a one-year period.

Thus, at the time, the response to "the poor training of health surveillance professionals"[12] was given with the proposal of Local Action Plans for Health Surveillance in 2008[18] and 2009[19]. These plans pointed to the problem of "insufficient knowledge on various fields of health surveillance"; the indicator of the problem "difficulty in acting in the inspection routine"; the health risk resulting from "unsatisfactory quality in health surveillance actions and services"; and the operation/action of "technical training health inspectors" in: endoscopy, intensive care unit (ICU), hospital laundry, surgical block, article reprocessing, cytopathology laboratory, chemotherapy, medical radiodiagnosis and dentistry, hospital pharmacy, hemotherapy assistance, radiotherapy and nuclear medicine, laboratory of clinical analysis and pathological anatomy, hemodialysis, infection control, hemodynamics, among others.

It is important to point out that this "technical training of health inspectors" was assigned to health inspectors too. In this way, the inspector chose the topic of his or her interest, studied the laws in force, related articles, Anvisa reports and, of course, his or her practical knowledge. These inspectors then multiplied this knowledge among other fellow inspectors[12]. Thus, what was observed was a huge effort on the part of health surveillance professionals to seek a self-referenced, self-produced "technical training". On the one hand, encouraging these professionals to reflect on everyday reality can be extremely positive, on the other hand, to attribute to these workers the responsibility of developing a "pedagogy" (a didactic-pedagogical structure) that gives them a technical, scientific and ethical nature is extremely perverse[12].

At the same time, there is a growing need for technical and scientific updating for the inspectors in order to keep abreast of the technological changes that are reflected in the fast transformation of the productive sector, which have often not yet been addressed by their respective normative production[7].

> "We know that it is law enforcement, but some minor details could be overlooked [...]. The sanitary issue goes beyond the text of the law... Sometimes it's a matter of common sense! We meet, speak technically, but the health surveillance is still very resistant[12]".

By not ignoring "minor details", health inspectors act according to the prescription of risk regulation systems, mostly scaled to conservative levels of risk - by safety margin. This upsets some economic analysts, especially when it comes to small security gains in exchange for high investments[8]. Furthermore, according to Beck[20], denying the existence of risks does not make us overcome them.

According to the Central of the Hospitals of Minas Gerais[2] (highlighted by the authors):

> "Considering that inspectors of the Health Surveillance **carry out their inspections in our hospitals in different manners**, in the same environment or conditions, that is, for the same type of problem different behaviors are adopted according to the expert who performs the inspection [...][2]".

Costa[7] explains that the various real situations that present themselves for health surveillance decisions are not always framed by the law, implying a capacity for judgment and discretion, with ethical sense and public responsibility. Inevitably, the judgments involve considerations of a different kind than the scientific and political ones[8]. And, in this way, distinct conducts can be adopted by health surveillance inspectors. While on the one hand, lawyers argue against the use of subjective criteria, devoid of strong technical reasoning[11], on the other hand Lucchese[8] pointed out that the risk assessment has several elements of uncertainty which give rise to different points of view on the definitions and assertions that the "experts" should have.

According to Beck[20], the semantics of risk is related to the modernization process. The industrial production of modern society has consequences, and decisions about uncertainties and probability are gaining importance. A whole science of risk is based on probabilistic calculus, which implies taking into account the opportunities and hazards[21].

In this context, Paz et al.[22] recommended that the topic related to the perception of risks inherent in health services, especially to hospitals, be incorporated into actions of Continuing Education. For Costa[23], aiming at an effective action of health surveillance agents in the health services, it would be necessary to structure a "sanitary intelligence". Therefore, there is a clear need for institutional investment in the training of health surveillance workers to prepare them to respond adequately to the challenges of their daily work.

In this sense, some studies have been done, like the "Guidelines for the Management of Education in Health Surveillance in the Continuing Education Policy of the SUS"[5], of Anvisa, which presents proposals, within SNVS, for the management of education and work. This document proposes that the three SNVS federated entities be responsible for ensuring the implementation of the Education Management Policy articulated to Work Management in health surveillance, under the coordination of Anvisa.

Or, the study called "Challenges and Strategies Prioritized by the Cycle of Debates on Health Surveillance 2015"[24], which recognizes as challenges: inadequate infrastructure for health surveillance actions, shortage of professionals, work overload [...] (challenge 10); the policy of permanent/continuing training in the work processes to accompany the modernization of the regulated sector and new technologies [...] (challenge 11). The study proposes some strategies to face the prioritized challenges, of which we highlight[24]:

- To build a National Work Management Policy in Health Surveillance - establish guidelines to adapt teams to the local reality, define professional profile, promote dialogue with the Ministry of Education (MEC) for training processes, and with society and managers for the strengthening of the health surveillance service (Strategy 66).
- To clarify the Police Power so it is not an element of controversy between professionals, population and the regulated sector (Strategy 68).
- Define a public human resources policy to deal with the training and education of health surveillance inspectors, with the creation of a systematic and permanent continuing education program and technical training for health surveillance professionals, with education plans for the employees and accountability of the three components of the SNVS. Anvisa must structure the National Policy of Continuing Education in Health Surveillance, creating continuing education plans in all spheres and in partnership with educators (Strategy 70).

However, the situation of municipal health surveillance workers requires immediate action. It demands that the proposals be put into practice right away, in order to ensure the access of these workers to education. Thus, the second edition of Anvisa's Integrated Programming for Professional Training and Education of the SNVS 2017 (Capacita-Visa)[25] aims to consolidate the management of education in health surveillance, in compliance with the principles and guidelines of the SUS. According to Anvisa, the courses should contribute to the training and improvement of professionals working in the SNVS, according to the particular diversity of each Brazilian region.

In order to contribute to the effectiveness of the Capacita-Visa program, this study suggests associating this strategy with the Interfederative Pact[26] proposed by the Tripartite Interagency Committee (CIT), which establishes the indicators in the national agreement of goals. With the national objective of improving the regulatory framework and health surveillance actions, indicator 20 establishes: percentage of municipalities that have at least six groups of health surveillance actions. This indicator is composed of the groups of actions identified as necessary to be implemented in all Brazilian municipalities throughout the year, since these are essential actions for the proper performance of local health surveillance work. They are (highlighted by the authors):

(i) registration of establishments subject to health surveillance;
(ii) inspection in establishments subject to health surveillance;
(iii) **educational activities for population**;
(iv) **educational activities for the regulated sector**;
(v) receiving complaints;
(vi) handling complaints;
(vii) establishment of administrative investigation procedures.

In this sense, it is recommended that Anvisa identify in the Interfederative Pact[26] an opportunity to contemplate the Continuing Education of Health Surveillance workers, considering it "essential to the work of the local health surveillance body", necessary for all municipalities.

Thus, it may be pertinent to include a new element in items (iii) educational activities for the population and (iv) educational activities for the regulated sector: Continuing Education activities for health surveillance workers. Since there is an offer of training courses by Anvisa, there is no reason not to agree with all municipalities that their workers participate in the activities of Continuing Education. This triad of actions would have the potential to take the quality leap that health surveillance needs so badly.

The political-administrative organization of the work: the consequences of risk assessment

The second approach to the question asked by the Central of the Hospitals of Minas Gerais[2], considering the conceptual framework of the social and technical division of labor[4], concerns the dimension that incorporates the political-administrative aspects to the consequences of surveillance.

Lucchese[8] acknowledged this stage as that of risk management:

> "There is a more political-administrative orientation in the process of weighing policy alternatives and selecting the most appropriate regulatory action, integrating the results of risk assessment with social, economic and political concerns to inform a decision on what to do with the assessed risk".

Hence the perception of the Central of the Hospitals of Minas Gerais[2] that: "For the same type of problem different practices are adopted according to the expert who carries out the inspection...".

Lucchese's[8] concept for the 'risk management' dimension explains the adoption of distinct approaches by the 'experts', in addition to revealing that the conflict and the controversy are also inextricably linked with the nature of this process[8]. Beck, quoted by Ianni[27], explained that in the risk society, whose contours are evidenced in this study, subjects and institutions that experience and face situations of insecurity produce different and diverse possibilities of political consensus.

The recession that devastates the country has affected various sectors of the economy, including the health care sector. In addition to the adverse scenario, we must take into account that hospitals have been dealing with insufficient funding for some time due to the high cost of procedures and technological incorporation[28]. In this way, the unfavorable economic situation of the country and the work of health surveillance in public health policies, with clear social responsibility, have played a decisive and selective role in regulatory actions. Thus, the selection of actions is oriented to the most appropriate actions, but to the most feasible ones, especially when the alternatives involve public and private interests.

Should health surveillance close down all public hospitals that do not have good operating conditions, disregarding the social and political consequences of this action? Issues like these, which are common in the routine of health surveillance agents, require them to put up with the several types of pressure[7]. Consequently, they generally opt for more lenient regulatory actions and, in this sense, avoid the application of pecuniary infractions, delaying the shutdown of hospital sectors or even the hospital as a whole.

Preferably, they choose the modality of Injunction, Penalty Warning, a less severe type of punishment provided for in the Municipal Health Code of Belo Horizonte[29]. Although its main objective is punishment of irregular conduct, it has no pecuniary effects. Even so, it is common for public hospitals to resort to the Board of Health Surveillance Judgment requesting the cancellation of the warnings. Among other reasons, they claim budgetary constraints for the provision of the public health service and the principle of contingency reserve. The effectiveness of social rights would be conditioned, according to the contingency

reserve theory, to the reserve of what is financially possible for the State, since they are classified as fundamental rights dependent on the financial possibilities of the public budget[30].

And when they lose the legal deadline to appear before the judicial body, there is still the possibility of declaring themselves a legal entity under public law, *Fazenda Pública*, using the Code of Civil Procedure that guarantees them a period four times longer for their defense and twice as long for their appeals. It is no coincidence that Lopes and Lopes[9] observed the poor effectiveness of health surveillance in making hospitals respond to their requests.

If, on the one hand, public hospitals do not respond to the regulatory actions of health surveillance, on the other hand, health surveillance itself finds its difficult to carry out these actions.

Considering that the effectiveness of the health surveillance service is directly related to the fulfillment of its regulatory actions, the case study on health surveillance, law and health protection[10] analyzed inspection scripts related to the inspection actions; specifically the initial inspection, drafting of tax documents and return inspection; carried out in the hospitals of Belo Horizonte from September 2004 to December 2005, and involved the analysis of fifteen hospitals selected by random criteria: five private, five contracted/subcontracted to the SUS and five public hospitals.

The difficulty of health surveillance in carrying out inspections in public hospitals was verified. Of the five public hospitals inspected only one obtained return inspection. The lack of systematization in the control actions in public hospitals hinders the agility and effectiveness of these actions. Thus, we confirmed the paradox pointed out by Lopes and Lopes[9], "that inspections are more frequent in establishments with better sanitary conditions".

This neglect of the State - represented by health surveillance - toward the State itself, represented by public hospitals, has harmful consequences for the population. According to Beck[20], with regard to the susceptibility to risk, class situations and risk situations overlap. In this way, health surveillance fails, proving to be a fragile instrument in the protection and promotion of the health of the population that most needs the care provided by the SUS.

Law n. 6.437, of August 20, 1977, quoted by Lopes and Lopes[9], exempts the Public Administration from having a license to operate, however, the same law states that such services are subject to the same requirements in terms of facilities, equipment, assistance and technical responsibility. However, what happens is that the risk assessed, the quality and safety of the processes, and the health products and services are being ignored in favor of the dictates of the economy and the bureaucracy. It should be noted that, for SUS hospitals, or rather, for the population that receives the services provided by the SUS, health care is provided based on the "contingency reserve"[30].

It was also verified in the case study that the private hospitals fulfill 100% of the health surveillance requirements already in the first return after the inspection. This prompt reaction indicates that, for the competitive private health care market, immediate compliance with current sanitary regulations is vital to their own survival on the market.

Additionally, in the logic of capital accumulation, only the hospitals that invest and update their internal management processes and incorporate new and harder technologies, thereby increasing the importance of sanitary control performed by health surveillance[22], are competitive. In this way, the risks are identified and diagnosed through the inspection. Then these hospitals proceed to the regulatory actions, performed and recorded on tax documents. When compliance is confirmed by the return inspection, the establishment is granted the Permit of Sanitary Authorization (licensing).

For the subsystem of supplementary health, the permit is also the first requirement to participate in accreditation processes. These processes allow the permanent and continuous improvement of health care, since they aim to reach the highest quality standards, as well as guarantee the permanence of the establishment in an extremely competitive market, which values excellence in service[31]. Thus, the surveillance actions implemented by health surveillance in private hospitals effectively fulfill their mission of protecting and promoting the health of the population, even though this population is the beneficiary of private health care.

CONCLUSIONS

The question asked by the Central of the Hospitals of Minas Gerais regarding the lack of standardization of the work of health surveillance was analyzed in this debate, based on the logic of the technical and social division of labor, under the two dimensions that compose it: the technical-scientific and the political-administrative organization. That is interpreted by this study as the inspection and the consequences of the inspection.

With regard to enforcement actions, there are old problems that remain unsolved. The standardization and qualification of health surveillance inspection actions are directly related to the existence of a National Continuing Education Policy in Health Surveillance, which will promote access to scientific knowledge that is relevant to regulatory actions, as well as to a critical understanding of the real meaning of Police Power by SNVS workers. They are also associated with a satisfactory infrastructure and adequate human resources for health surveillance activities. After all, it is their workforce that ensures quality and effectiveness.

However, in the context of the Society of Risk, the result of the dispute between knowledge and ignorance, the true and the false becomes a mystery. Science becomes more and more necessary, but less and less sufficient. More knowledge will not be able to solve the problems; on the contrary, reflectively, the production of more knowledge produces new uncertainties,

that is, new problems[20]. This, therefore, requires new rules, new RDCs to deal with new uncertainties and "experts" will continue to have to make decisions. "Decisions that might well have been different"[20].

It is from this perspective that we find it necessary to further develop educational activities, health education for the regulated sector, aiming to explain that the inspection actions, whose objective is the risk assessment, are permeated by elements of uncertainty, which allow different points of view from the "experts" who perform them. Moreover, the dimension of "risk management", that is, the consequences of inspection are, due to the uncertainties of the knowledge produced, pervaded by conflict and controversy, especially when the consideration of alternatives on what to do with the risk depend on public and private factors.

We found, therefore, that the technical standards used by health surveillance, considering the dimensions of collective interest, are not fully respected. And the certainty presupposed by normative expectation does not withstand an unfavorable economic context. We also verified that health surveillance still cannot fulfill its mission of protecting and defending the population's health, especially when it comes to those people who most need the SUS. With that, the doctrinal principle of equity is disregarded.

In fact, there is disrespect for all SUS principles. The constitutional principle of guaranteeing universal and equal access, in this case, proved to be extremely wicked when dealing with health surveillance actions. As shown, actions are effective especially for the segment of the population that has access to private health care subsystems. And the completeness of the health surveillance actions does not come about, since there are flaws both in the dimension that incorporates the technical-sanitary aspects and in the dimension that concerns political-administrative aspects. We conclude, therefore, that health surveillance finds difficulties in its mission of promoting and protecting the health of the population.

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Conflict of Interest

Authors have no potential conflict of interest to declare, related to this study's political or financial peers and institutions.