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Challenges to the performance of health surveillance workers in health services

Desafios à atuação dos trabalhadores de Vigilância Sanitária nos serviços de saúde

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ABSTRACT

Introduction: Health surveillance (Visa) is a primary function of the State for the protection of individual and collective health through risk control actions, current or potential, present in the production of goods and services, and is part of SUS (Brazilian Universal Health System). Health surveillance of health services is part of Visa's scope of action for the control of risks and iatrogenic diseases in health services. **Objective:** To analyze challenges to the performance of Visa in health services. **Method:** The study, with a qualitative approach, integrates research funded by CNPq to analyze the sanitary control carried out by Visa in health services of primary and specialized care; the Focus Group technique was used with Visa workers from 8 Brazilian states. The speeches were transcribed and analyzed according to the thematic content analysis technique, systematized in two categories: Management and Organization of Services, and Working Conditions. **Results:** Problems and challenges were identified, such as: incipient planning of actions; difficulties in the organization of work, resulting from the turnover of managers, the lack of human and technological resources, and the lack of coordination and integration of the levels of the National Health Surveillance System. Dissatisfactions and challenges about working conditions, precarious employment conditions, low wages, incomplete teams and the need for public tenders and work valorization emerged. **Conclusions:** Visa's performance in health services requires overcoming multiple challenges, which permeate the integration of actions at different levels of management and training issues, incorporation of technologies and readjustment of work processes.

KEYWORDS: Health Surveillance; Health Worker; Health Services Management; Collective Health

RESUMO

Introdução: A vigilância sanitária é uma função precípua do Estado para proteção da saúde individual e coletiva mediante ações de controle de riscos, atuais ou potenciais, presentes na produção de bens e serviços, e integra o Sistema Único de Saúde. A vigilância sanitária de serviços de saúde é parte do escopo de atuação da Vigilância Sanitária (Visa) para o controle dos riscos e iatrogenias nos serviços de saúde. **Objetivo:** Analisar desafios à atuação dos trabalhadores de Visa nos serviços de saúde. **Método:** O estudo, de abordagem qualitativa, integra uma pesquisa financiada pelo CNPQ para análise do controle sanitário realizado pelas Visa em serviços de saúde da atenção básica e especializada. Utilizou-se a técnica de Grupo Focal com trabalhadores da Visa de oito estados brasileiros. As falas foram transcritas e analisadas segundo a técnica de análise de conteúdo temática, sistematizadas em duas categorias: Gestão e Organização dos Serviços e Condições de Trabalho. **Resultados:** Identificou-se problemas e desafios, tais como: incipiente planejamento das ações; dificuldades na organização do trabalho decorrentes da rotatividade de gestores, da falta de recursos humanos e tecnológicos, da ausência de coordenação e da integração dos níveis do Sistema Nacional de Vigilância Sanitária.

Emergiram insatisfações e desafios sobre condições de trabalho, precarizações dos vínculos, baixos salários, equipes incompletas e necessidade de concursos públicos e de valorização do trabalho. **Conclusões:** A atuação da Visa em serviços de saúde requer a superação de múltiplos desafios, que perpassam a integração das ações nos distintos níveis de gestão e questões de capacitação, incorporação de tecnologias e de readequação de processos de trabalho.

PALAVRAS-CHAVE: Vigilância Sanitária; Trabalhador da Saúde; Gestão de Serviços de Saúde; Saúde Coletiva

INTRODUCTION

Health surveillance is one of the most complex areas of public health. In Brazil, it is under the Unified Health System (SUS) and is responsible for health regulation, health protection, prevention and control of risks related to products, technologies, processes and services of interest to health. Because of their regulatory nature, health surveillance actions are the exclusive competence of the State, which, for the benefit of the public interest, makes interventions to regulate production-consumption relations in both private and public activities that pose risks to collective health[1].

Health actions and services in their various forms are subject to health regulation, enforced fundamentally by health surveillance bodies. As an arm of the State, health surveillance has police power[2] and is part of the National Health Surveillance System (SNVS) to conduct an articulated set of initiatives in the three levels of government. Studies have shown several irregularities in health services[3] and/or their products[4], hospital services[5] and diagnoses[6,7] as well as in basic health units[8], among others. This reveals the many shortcomings of service providers and of health control systems.

To fulfill their role and protect health, health surveillance bodies follow the theoretical constructs of risk, safety, and quality in health. However, these concepts can be difficult to operationalize in services of interest to health—where there are many uncertainties. Health services entail a wide variety of risks that include elements related to infrastructure, suitability of the environment, facilities and equipment, practices, procedures, and technologies.

In health services, there are risks of various natures. Some of these risks have increased as a result of scientific and technological development, the emergence of new products, and the technological density of the service itself. These are risks related to medications and other therapeutic resources, blood, blood products, equipment, medical devices, sanitizing products etc., and also related to various processes and practices adopted by healthcare professionals who, for various reasons, may make mistakes that result in adverse events that jeopardize the safety of users.

The negative effects of technology have raised concerns and driven changes in organizational models of health control in many developed countries, placing a greater focus on matters of health security[9]. Health security is a relatively new concept that can be explained as an acceptable estimate of a risk/benefit ratio related to a given object of interest to health. Products and processes under health surveillance have their own risks—hence the control—and benefits, except for, of course, tobacco products, which are also subject to health surveillance in Brazil. These risks are intrinsic to objects and appear along the objects' lifecycle—from production to consumption or the provision of services. They may arise from bad practices, intentional wrongdoing or fortuitous events. There is also the problem of healthcare waste management and its risks for healthcare workers, the environment, and the population in general.

The notion of quality can be understood as an intrinsic attribute, presumably expected from health-related products and services. Quality is the responsibility of both manufacturers and service providers, but it is up to the public health system to have laboratory capabilities, systems for reporting adverse events and technical complaints, among others. Health surveillance is responsible for designing and applying strategies and instruments to verify the quality of the goods supplied to the population[1] and to do the surveillance of health problems caused by them, since citizens and consumers have the right to receive quality products and services.

The work of health surveillance in health services was previously the responsibility of the states. It only began to receive attention from the federal administration after the creation of Brazil's National Health Surveillance Agency (Anvisa). Along with other conditions, the previous framework contributed to the consolidation of a very limited model of health control in health services, focused on granting permits and licenses based only on health inspections[1,10]. Overall, there are still many gaps that prevent actions that could contribute to quality and safety in healthcare. These gaps are made clear by the scarcity of indicators on the effectiveness of these actions[10].

Despite some progress[11], health surveillance still has many weaknesses, especially in subnational levels. This is particularly true for the health control of health services, a challenging task especially in hospital settings, where multiple conditions are at play and may lead to errors and consequent adverse events. A study with data from 133 hospitals on errors in diagnosis, dosage or administration of medications, incorrect use of equipment, hospital infections etc., revealed that 829 Brazilians die every day in both public and private hospitals due to adverse events that compromise the quality of care, cause physical and psychological suffering in patients, and ultimately increase the cost of care. In 2016, there were 302,610 deaths[12].

Considering the small number of studies on the topic of health services and health surveillance and with the purpose of contributing to the discussion, this study was guided by the following question: what are the main challenges for the work of health surveillance in health services? The objective is to assess the main challenges to the work of health surveillance professionals in health services.

METHOD

This study is part of a research project called Health Surveillance in Primary Care (PC) and Specialized Care (SC) in Brazilian states, approved and funded by the National Council for Scientific and Technological Development (CNPq), Universal Notice MCTIC/CNPq n. 28/2018, whose objective was to analyze the health control done by state and municipal health surveillance bodies in health services in PC and SC, with a view to improving health security and the protection of the health of the population[13]. This research involved states and municipalities in all five Brazilian regions, with the participation of health surveillance workers and managers of state surveillance bodies, coordination of state Primary Care and coordinating blood centers.

This is a study with a qualitative approach[14] that used the Focus Group (FG) technique[15,16] as a strategy to bring together health surveillance workers to discuss health surveillance initiatives in PC and SC services, with freedom and autonomy to share their reports and testimonies.

FG participants were recruited during the VIII Brazilian Symposium on Health Surveillance/Brazilian Association of Collective Health (Simbravisa/Abrasco), a nationwide event that took place in the city of Belo Horizonte, from November 25 to 27, 2019. Event attendants were randomly invited to participate in the FGs through printed invitations, handed out in the auditoriums and rooms of Simbravisa. The handouts had information about research objective, time and place of the FGs.

Data were collected in three FG sessions with 22 respondents and an average length of 1 h for each meeting. The meetings were held in rooms provided by the Simbravisa organization, with chairs arranged in a circle. All the respondents were encouraged to speak, including with questions directed at those who were not actively engaging in the discussion. However, we observed some differences in the speaking times of some participants, which can be explained by the mix of the FGs (see Chart 1), although the content of the three meetings was the same.

In the first meeting (FG1), participants from the Northeast (NE) and South (S) states had longer speaking times, which can be explained by the difference between the number of participants per state—NE1 (four), NE3 (two) and S1 (two), and only one participant from NE2 and another from S2. In the second meeting (GF2), the longest speaking times were used by SE1 and NE3, with three and two participants respectively. In the third and last meeting (FG3), although four professionals from S1 participated, there was a balance in participation and speaking time with the participants from N1 and NE4.

The sessions were conducted by a moderator and three or four observers who participated in all FGs, without any hierarchy or subordination between the research team and the respondents. Field diary records were made and used to support the analysis and interpretation of the material. The discussion was guided by a script with four questions about: health surveillance activities in health services; health surveillance actions in hemotherapy services; health surveillance actions in PC; and the conditions of constitution and operation of Patient Safety Centers in PC and SC services (Chart 1).

The FGs included professionals with several backgrounds and different education in health and related areas (nursing, dentistry, medicine, veterinary medicine, law and physics), from eight Brazilian states and four regions. All participants signed a Free and Informed Consent Term. Their participation was audio recorded

Chart 1. Composition of focus groups, according to number of participants and regions of Brazil. Belo Horizonte, 2019

Focus group date	Number of participants	Number of states by region in Brazil
FG1 (11/25/2019)	10: NE1 (4), NE2 (1), NE3 (2), S1 (2), S2 (1)	3 states from the Northeast (NE)
		2 states from the South (S)
FG2 (11/26/2019)	06: NE1 (1), NE3 (2), SE1 (3)	2 states from the Northeast*
		1 state from the Southeast (SE)
FG3 (11/27/2019)	06: N1 (1), NE4 (1), S1 (4)	1 state from the North (N)
		1 state from the Northeast
		1 state from the South*

Source: Prepared by the authors, 2021.
FG: focus group; NE: Northeast; S: South; SE: Southeast; N: North.
The numbers in each acronym represent different states of the same region, for example: NE1, NE2, NE3, NE4: four different states in the Northeast region. And the number in parentheses, after the acronym, for example: NE1(4) corresponds to the number of participants, in this case, four, per state/region/focus group.
* States represented in more than one FG meeting.
[a] Term used by Abrasco's Health Surveillance Working Group (GTVISA) for participants in the Brazilian Health Surveillance Symposium.

and later fully transcribed. The transcripts were prepared by research participants as volunteer scholarship holders, pharmacy and public health undergraduates or planning and management residents. There was no record of the transcription time of the FGs, however, all transcripts were reviewed by the researchers of the group.

Records and transcripts were treated according to the thematic content analysis technique[14]. The pre-analysis involved four researchers individually skimming the transcripts and categorizing the data; then, we proceeded to the collective categorization work. This step enabled the aggregation of the data into units of analysis, with the description of the characteristics of the data, which were grouped into two thematic categories: Service Management and Organization and Working Conditions, and, later, the identification of subcategories, as shown in Table 2, to enable approximations with the objective of the study. Findings related to these categories and subcategories appeared in the three FG meetings.

This project was approved by the Ethics Committee of the Institute of Collective Health of the Federal University of Bahia, according to opinions n. 3.423.630, n. 3.819.357 and CAAE 12491019.2.0000.5030.

RESULTS AND DISCUSSION

The thematic categories and subcategories result from the classification of the corpus produced by health surveillance workers who participated in the FGs (Chart 2). The participants did not limit their discussion to the questions of the script and addressed various problems and challenges they face in their everyday work. To maintain the anonymity of the FG participants, the excerpts were randomly classified using an alphanumeric record.

Service Management and Organization

The Service Management and Organization category accounted for most of the statements about challenges. Related to this category, a set of themes that stood out during the FGs were identified and grouped into thematic subcategories: planning, work organization, coordination and integration of actions, rotation of managers, and standardization of procedures.

Participants described action planning as an incipient practice and said that, when it exists, it is often disregarded in face of other demands prioritized as more urgent by the management. Participants associated the difficulty in following the work schedule with the excess demands made by internal managers and the Public Prosecution, as shown in the following excerpts:

> [...] there can be no planning if all we do there is deal with emergencies and put out fires, right? Most inspections are not planned, things just happen and you have to deal with reality, that is the difference (NE1, FG1).

> [...] we draw attention to the fact that "there is no planning", that's clear to us, what we have to manage are demands, reports, requests by the Public Prosecution, which always wants a report or an investigation [...] (NE3, FG1).

> We do have some monthly planning, but the demands are huge, like I said in the beginning. We work much more for the Public Prosecutor's Office than for anyone else. We have a monthly schedule with priorities, but sometimes we simply can't do it, we can't stick to the plan because there are urgent and emergency demands, so we need to change our schedule (NE3, FG2).

> This is very disruptive. At the end of the year, there are countless unmet demands and we have to meet them somehow, but in practice we end up working to fulfill the requests of the Public Prosecution and of the managers. So the whole plan is disrupted. And I'm at the state level, we don't have much articulation with the municipalities. We do our job at the state level and then the municipalities do their independent planning (NE4, FG3).

> [...] we don't really work with planned actions, we fulfill the demands of the Public Prosecution, routine demands. As an inspector, I receive my routine, I have a command of

Chart 2. Thematic categories and subcategories of the main challenges to the work of health surveillance in health services.

Thematic categories	Subcategories
Service Management and Organization	Action planning
	Work organization
	Coordination and integration of actions
	Management turnover
	Standardization of procedures
Working Conditions	Reduction in the number of workers
	Precariousness of employment relationships, salary situation
	Unavailability of technological resources

Source: Prepared by the authors, 2021.

> scales [...] of course we manage to work in an organized way, although we are obviously understaffed to meet all the demands of the Public Prosecution [...] (N1, GF3).

> [...] we carry out control actions, we also investigate complaints both from the Public Prosecution and those that arrive via ombudsman or via the Council, they account for much of the work we do, especially the Public Prosecution [...] (SE1, GF2).

Planning and evaluation in health surveillance have not yet been incorporated, nor has the use of indicators—necessary for the diagnosis and evaluation of the area—that could enable the analysis of the health situation and insight into the determining and conditioning factors[17,18,19], especially those related to the specific field of health surveillance. A study by Maia and Guilhem[20] reported the lack of indicators and tools for evaluating health surveillance actions as one of the five main challenges to health regulation in Brazil. In the present work, the analysis of what FG participants said about planning reveals that it is all about programming activities and not exactly about planning actions.

A study on state health surveillance cases[21] found that the services studied did not plan health surveillance actions in health services, not even regarding the reuse of single-use medical products. Moreover, they do not apply any reuse assessment method or carry out specific training for their professionals.

The National Forum Report[22] that closed the regional forums of the Cycle of Debates on Health Surveillance, which had the broad participation of workers and managers in the area, academics and other guests, listed the 12 main challenges discussed at the events and established priorities and proposals for dealing with them. These challenges include the lack of planning and the establishment of predetermined instruments in the decentralization process. This process is considered precarious and fragile because it does not take into account local reality and particularities, which hinders agreements between the components of the SNVS.

Regarding the decentralization process, FG participants discussed the difficulty in coming to agreements and the high turnover of managers. According to the participants, this high turnover rate harms the consolidation of the SNVS in its state arm, as illustrated by the excerpts below:

> [...] I think it's worse now, because those who already had it... 207 [RDC n. 207, of January 3, 2018 — Anvisa] says that you have to come to an agreement, so it wasn't about acting, you simply had to decentralize services. Then, since 207 said that low risk was for them to deal with, if they came across any high [risk] they would return it to the state. You have to agree, like, they don't want to be held accountable. In fact, municipalities struggle more because there is a high turnover, there is always someone new coming in, and since it is not their obligation, it is not written there that they have to deal with high [risk], they just leave it up to the state (NE4, GF3).

> I see the dismantling of the surveillance system as a whole and in the state [...] understaffing harshly impacts this risk control and this is extremely worrying (NE1, FG1).

The classification of establishments as low, medium and high risk was a strategy used to determine competences in the decentralization process and to rationalize the work processes in health surveillance services. However, according to the debates that took place in the forums, state health surveillance bodies have taken on medium and high risk inspections, especially because there are still major gaps in municipal services that prevent them from operating in areas considered to be of medium risk[22]. The following excerpts address that:

> [...] we cannot fulfill the entire demand. So, we cannot inspect 100% of the things we should inspect. We do not have enough personnel to meet this demand. So we have to prioritize and categorize risks [...] (SE1, FG2).

> [...] more basic settings, let's say, medical offices or dental offices, although they may be classified as high risk, could be inspected by the municipality with a minimal team. But we don't do this. Only municipalities with more than 100,000 inhabitants that have the structure to inspect Primary Care, that is, very few in the state (NE4, FG3).

> We recently held a workshop involving municipal and regional health surveillance bodies thinking about starting the process of decentralization. First we will train our people, make partnerships, not with complex hospitals, but at least with low and medium complexity hospitals, so that they can be our partners, because alone we can't do it, it's too much (NE3, FG2).

A key concept in health surveillance, risk is a construct that is still poorly addressed. It is subject to the whims of a slow process of theoretical, conceptual and doctrinal construction in the area. According to the National Forum Report[22], another challenge considered a priority for the SVNS and for the population is the lack of harmonization and understanding of risk.

However, our FG participants did not mention any problem in this sense. The use of the risk category was always associated with the existing definitions in the regulations and, specifically with regard to the classification of establishments under health surveillance, as low, medium and high risk. We also observed that, in view of the challenges arising from the shortage of workers, material and technological resources, professionals declare that they focus on what is defined as high-risk activities.

> [...] work on risk, it indicates whether it is low or high risk, so it is also Anvisa's priority goal and we followed this path, high, medium and high risk establishments take priority [...]. But we are not able to deal with this because we lack human resources, it's an extremely serious problem in our state, and I don't know how the state will solve it in the short, medium or long term. The situation is so critical that we just can't do planning anymore, we can't set any goals anymore (NE1, FG1).

> [...] so, the state deals with medium and high complexity, as we call it, which involves inpatient services, with even greater complexity, right? (NE3, FG2).

> [...] because the state already has to deal with high complexity, which cannot be decentralized, it is a huge challenge. I don't know about your states, but in mine, talking about health services makes municipal bodies shudder, they find it impossible to inspect health services [...]. So we have this challenge (NE4, FG3).

In addition to recurrent management problems, organizational fragility and lack of institutional structures to solve them, the participants raised conflicts of interest in the execution of inspections in some municipalities:

> [...] when you put the municipal inspector to inspect a health unit, people will ask him how things work, there will be demands that may cause conflicting situations, right? Inspectors are civil servants, their specific role is that of inspectors, they cannot work with care, so they are not supposed to inspect themselves at other times. Actually, sometimes they even do, but that's not supposed to happen, is it? And they have colleagues in healthcare, so how can they conduct the inspection process if they have a fundamental interest in it? [...] (NE1, FG1).

We emphasize that issues related to work in the SUS have not yet received the priority that they deserve. In health surveillance, the situation is even worse due to the nature of the work and the limitations and conflicts of interest that may arise. As agents of the State in regulatory positions, they cannot have concomitant employment contracts with regulated segments. Health surveillance actions are the exclusive competence of the State and, as a public service, health surveillance is subject to limitations in the exercise of individual rights for the benefit of the public interest. Therefore, its workers cannot exercise, at the same time, a function in public or private organizations in the same areas of activity[23].

Another topic raised by the FG participants, related to the management and organization of health surveillance, was described as the difficulty in coordinating and integrating actions between different management instances. This was especially noticed when the participants dealt with patient safety issues in Primary Health Care and actions that changed the competence of the states in the decentralization process. The following excerpts illustrate the point:

> [...] the Patient Safety policy is regulated by an ordinance from the Ministry of Health and an RDC [joint board resolution] from Anvisa. They may seem like separate things, but actually they walk together. But the federal, state and municipal representation should be the same. Like people say, too many cooks spoil the broth. There should be only one person to conduct these strategies, one person of contact, otherwise, every time there is an event, we have to fend for ourselves, everything is scattered (NE4, FG3).

> We struggled a lot [to coordinate the actions between different instances of management] when decentralization began. We realized that the state was very involved with some services and did not want to let go, you know? That's what we noticed then, but now, after a few years, we don't notice it anymore. [...] At the beginning, we had this issue of too many cooks spoiling the broth, because the people from the state health surveillance body thought they were the owners of everything, but over time we showed them that we are their partners, so today we work in partnership (N1, FG3).

Distance, lack of articulation and systematic dialogue and disharmony between the SNVS entities pose yet another challenge, considered a priority in the National Forum Report[22] as a challenge that affects the performance and the results of health surveillance initiatives. The lack of integration of health surveillance actions in health policies in general also stands out. According to a study by Maia and Guilhem[20], the lack of knowledge about the role of health surveillance in healthcare is one of the main challenges to health regulation in Brazil.

Although formalized by Law n. 9.782, of January 26, 1999, the SNVS still has many gaps in terms of setup and organization. It is often regarded as a fragmented system. Only the federal component was structurally redesigned, and the result is that the system has a very fragile structure in terms of bonds of cooperation and responsibilities, in addition to having questionable efficacy[11,24].

The fact that many attributions are shared between the three levels of government highlights the interdependence between the components of the SNVS and the complementarity of their work. In order to fulfill certain competences, like marketing authorizations and business operation permits, for example, Anvisa requires a health permit from establishments, and granting these permits is the responsibility of states or municipalities. In the case of health services, a health permit is the first requirement for hospitals to participate in accreditation processes, among others. Interdependence in legally established attributions, as indicated by Patrício et al.[25], interferes with the quality of the work done by health surveillance bodies.

The effective qualification of health surveillance actions strengthens the processes of collective construction, since it is associated with the definition of responsibilities, based on technical criteria of competence and uniformity in the execution of their actions, with an impact on the protection of the population's health[26].

Another topic addressed by the FG participants was the turnover of managers. Dissatisfaction with the frequent changes of managers emerges because it is something that hinders the work of health surveillance, as it often implies discontinuity of initiatives: "[...] we also suffered with four changes in management in a short time, and every time it changed, we returned to square one" (NE1, FG1).

For the respondents, the turnover of managers also results in work overload for the state health surveillance, since there is no

understanding, on the part of new municipal managers, about the agreements of what establishments are classified as high risk, according to the Anvisa's RDC n. 207/2018, as noted in the following excerpt:

> [...] municipalities struggle more because there is a high turnover [of managers], there is always someone new coming in, and since it is not their obligation, it is not written there that they have to deal with high [risk], they just leave it up to the state (NE4, GF3).

In addition to discontinuity, the participants say that this high turnover makes managers feel like they don't belong in the work group, which can result in lack of accountability and engagement with the ongoing processes.

> [...] because we understand that if they don't feel part of the process, things won't happen. Maybe it's different in your areas, but in my area we struggle with that. As it is now, it is not working for us (NE1, FG1).

Problems related to the lack of professional management, as highlighted by some authors[27,28], can compromise the quality of SUS services, both due to the lack of qualified professionals to perform specific and complex activities, as well as the interference caused by political indications for management positions and roles at all levels of the public health system. Particularly in the municipalities, health surveillance faces a number of challenges related to political interference and the lack of political support, which add to the society's lack of engagement and awareness[29].

> There in XXX [state capital], we only inspect primary care units if there's a demand from public prosecutors [...], but they are linked to the municipal administration, and this is a problem [...], then we may inspect the same unit countless times, make countless reports, but the irregularities remain. I talked to my manager about that recently. The other day I requested that a primary care unit be shut down because it was completely unable to function due to lack of hygiene, poor management [...], So I requested the shutdown [...], When I went back there two months later, they had fired the director, but things had gotten even worse [...] Without a director, it was a total mess, but my manager said that they were linked to the state health department and there was only so much we could do (N1, FG3).

> [...] we make the reports, deliver them to the manager and it is up to the manager to determine what to do, but most of the times, the reports are just filed and no improvements are made (S1, FG3).

The alignment of procedures was another issue addressed in the FGs. In the participants' opinion, alignment and standardization of procedures are an important strategy to enable better management and organization, since clear-cut procedures help ensure that managers have a sense of unity and belonging to the process. That is, this helps make them feel part of the group and, with that, problems can be better addressed.

According to the participants, regional offices and health districts need to work in synergy with their bases, but also in a standardized way as a whole, without devaluing or failing to meet regional/local needs:

> [...] we reviewed these SOPs [standardized operating procedures] based on that to reach everyone. And actually we've been achieving some results; it is also a way for us to standardize our actions; we are working toward the same objective (NE1, FG1).

> [...] we have regional offices that cover 60 municipalities and regional offices that cover 20 municipalities. These regional offices have surveillance teams composed of several professional categories that could deal with these services that are the responsibility of the state (S2, FG1).

Standardizing procedures and raising the bar in health surveillance is not a simple, easy task. In addition to the uncertain and subjective nature of some regulation and risk management activities, there are also questions like training, qualification, number of professionals, roles, infrastructure and institutional organization, availability of technological resources or adequate and sufficient working conditions. In short, these things require public policies that prioritize health protection in the scope of health surveillance.

When discussing a question presented by the Central dos Hospitais de Minas Gerais about the lack of standardization of health surveillance initiatives, Oliveira and Ianni[30] argued that

> 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[30].

Working Conditions

The Working Conditions category grouped together a set of intertwined challenges to the work of health surveillance: understaffing, precarious employment relationships, low salaries, unavailability of technological resources. Although these topics are related, we decided to organize the reports separately to identify the developments, the workers' movement and the results that these working conditions produce on health surveillance.

Professionals expressed great concern about the reduction in the number of workers that has been occurring over time in health surveillance services. In general, this fact is due to retirements, relocation of civil servants to other areas, changes in the

administrative structure of the states, unattractive compensation. However, despite this reduction, there are no public tenders aimed at hiring new civil servants to recompose the staff. In addition, severe economic crises in the states have contributed to delays in the payment of civil servants and cuts in their benefits and rights.

> [...] I'm not even going to talk about our situation because it's dismal. First, the salary situation, 47 months with our salaries being paid in installments. We will receive the October salary in December, then they will pay the second or third installment of the next month, I don't even know, I lost count, it's just so sad... (S2, GF1).

> [...] when the new administration took office, they extinguished 31 regional directorates and transformed them into nine regional health centers. This weakened the whole organization [...] our capillarity, our performance in the regional offices, the loss of additional payment for work in unhealthy conditions too, these administrative reforms, [...] this new retirement project [...]. Over the years, I have noticed this huge dismantling of the organization, which compromises all our plans (NE1, FG1).

> About 50% of the state team retired, including in the regional offices, so that group that was mentioned here, older staff and everything, we don't have that anymore [...] we try to handle everything, but we can't, we can barely do the basic work, we can barely inspect blood and blood products because our team is very small (S1, GF1).

> In state XXX there is a division of health services [...]. It is a multidisciplinary team, but it's very small. Very few have passed qualification exams. We also have contracts, but it is very difficult, the demand is very high [...] (NE3, FG2).

The current landscape of uncertainty, cuts and loss of rights of public servants has caused an increase in people requesting their retirement, pensions, and this makes organizations even more understaffed. The situation is worse than ever, according to the participants, because of the lack of new admissions. There is an inevitable damage to the quality of inspections, especially in those that must be carried out by professionals with particular areas of expertise, like professionals who inspect hemotherapy services:

> [...] in the regional office where I work, we were responsible for that, but today that office is responsible for 72 municipalities, so the same multidisciplinary team does everything, both medium and high complexity. We faced a major challenge when our blood work group was completely dissolved; it was a group [...] formed in 2012, for you to have an idea, [...] it had 26 members to inspect hemotherapy [...] (NE1, FG1).

> Another major challenge for the coordination of health services was the flight of qualified servers, many professionals left health surveillance. I believe it's no different from other states, but we received a lot of people from care services. We don't expect to hire new people before 2023, because of the tax recovery regime in the state, so there is no prospect of renewing the staff. Of course these new people who came from other areas were very welcome, we need all the help we can get. But they didn't have the health surveillance mindset, they were not familiar with the culture of patient safety, and that was a challenge [...] (SE1, FG2).

Inadequate infrastructure for health surveillance operations, shortage of professionals, work overload were some of the topics discussed in the Debate Cycle and recognized as challenges to be prioritized[22].

Hiring new professionals with different backgrounds, training, qualification and awareness of their responsibility, combined with a human resources policy that includes professional growth, continuing education and stability, are fundamental conditions to strengthen health surveillance in Brazilian municipalities[29] and states. Silva et al.[11] highlighted the importance of career plans for health surveillance workers in states and municipalities, in addition to the need to increase the number and strengthen the qualification of workers with a focus on acting on health risks in different territories[11].

Implementing a policy capable of meeting the demands of health work is also challenging. The challenge becomes even more significant when we consider the lack of government attention and capacity to invest in infrastructure to improve working conditions in the SUS. Melo et al.[31] drew attention to the fact that the position of organizations influences the behavior of their workers; when this position is affirmative, it may encourage workers to feel part of it and satisfied with the work they do, it may encourage them to stay in their jobs. The authors conclude that health surveillance managers should consider the importance of their workers in the implementation of health policies and prioritize actions that result in a stronger commitment from these professionals.

In the FGs of this study, another topic stood out in relation to working conditions: the (un)availability of technological resources and integrated information systems. This was also listed among the priority challenges discussed in the Cycle of Debates[22].

Integrated information systems were highlighted as important tools to manage actions and ensure better working conditions. Only states in the South and Southeast regions reported working with updated versions of information systems that really provided support and information for the planning and execution of activities.

> We already have a series of systems, right? Today the process of issuing permits is already fully digital, it is all computerized, it is the so-called online protocol [...] from there we have actions of control and regulation. And there are also some systems that provide us internal support,

> but they are for the management of infraction notices, to follow up on administrative processes, and I would say that this is basically our structure (SE1, FG2).

> [...] we also have a system [...] not all municipalities have joined it [...] because some municipalities have had their own for many years [...] but it is a system where municipalities can ask for support, and we, as regional offices, can see what inspections were made, what support is needed, it is like an information hub [...] (S1, FG1).

> We also have a system that helps us with the planning part [...] it is a surveillance system for issuing permits, information data, registration, control, and in my state there is a decree ruling that municipalities must join that system; about 70% of our municipalities have already adopted this state system, it enables us to monitor things better [...] (S2, FG1).

Overall, participants from the Northeast said that these information systems are still in early stages or are underused, which demonstrates inequality in the infrastructure of services to the detriment of working conditions for health surveillance workers.

> [...] I think that this documentary part is still very incipient there. We don't have a computerized system, we can barely print our checklists and inspection guides there [...] We have an inspection system [...] that we feed all the information into, but it just arrived and we still need more training on how to use it, especially because some people left the agency, others arrived, so we still need training. [...] and maybe some retraining, you know? And then it will be put into practice. It is a system that we feed with information from the inspections, how they were done, if the hospital is able to receive the permit or not, you know? It's actually a very interesting system (NE3, FG2).

The absence of an information system at the national level is a structural problem of the SNVS. It contributes to the lack or precariousness of relative and updated information on the regulated sectors, inspection actions and administrative processes. It also hinders the monitoring of services and the identification of adverse events[29]. It slows down decision-making processes and compromises the formulation of policies that are consistent with local reality[25]. Therefore, a specific information system for health surveillance, with technical and scientific indicators that match the work done in this area, could enable these bodies to use reliable information to support and improve their work. Another challenge is designing an information system that matches the purpose of health surveillance actions[17]. The absence of an information system, identified as one of the main challenges to health regulation in Brazil[20], remains, even after more than 20 years of the creation of Anvisa, which is responsible for coordinating the SNVS.

Reflection on health surveillance, whose actions are essentially of a preventive nature, underscores its relevance to health and the need for its technical and political strengthening. Lucchese[32] highlighted this component of the SUS as a privileged space for State intervention. Functions and instruments that are inherent in health surveillance enable us to improve the quality of health-related products and services and also to adapt the respective productive segments and environments to the needs of the health system and the social demands in health.

CONCLUSIONS

The study revealed a series of challenges to health control actions in the operating spaces of the SNVS and elicited important topics that deserve further investigation, like the persistence of problems related to the organization and management of services, incipient action planning practices, lack of systematic articulation and dialogue, disharmony between SNVS entities, organizational fragility and insufficient infrastructure and personnel, among other issues. The difficulties faced in the organization of health surveillance services and in working conditions are certainly reflected in the control of health services and, consequently, in the quality of these services and in the health security of users.

Some regional differences were observed in the use of information systems for health surveillance operations, with positive highlights to states in the Southeast and South regions and unmet needs mentioned by workers from states in the North and Northeast regions. The concept of risk, the founding construct of health surveillance actions, continues to be a process of slow theoretical-conceptual construction and, consequently, difficult to operationalize in the control of health services.

We also observed that topics related to poor working conditions were frequently mentioned by the workers participating in the FGs. The current political and economic landscape in Brazil has led to the underfunding of the SUS and the exacerbation of chronic structural problems in the organization and operation of health surveillance bodies in Brazil. Health surveillance workers are dissatisfied with their salaries and working conditions and there is also great concern with the loss of rights caused by social security reforms in some states and also by the absence of public tenders to recompose the staff.

In view of the difficulties and challenges pointed out by health surveillance workers, we suggest reflecting on how these weaknesses can affect the quality and safety of the health services provided to the population. Reaffirming the strategic importance of these services for the protection of public health is therefore mandatory.

There is a plethora of challenges. To improve health policies in general and the quality of the service provided to the population, we must fill some gaps in technical and scientific training, strengthen the ties between professionals and health surveillance bodies, standardize the infrastructure and technical capacities of subnational levels, reduce paperwork, and standardize some procedures.

As for the limitations of the study, although the FG technique was conducted by an experienced team, with a moderator to encourage the participants to interact, their statements are the only evidence of the challenges to health surveillance in health services and they may not reflect the totality of the participants' opinions. We also emphasize that the intentional and convenience-based composition of the groups may reflect on their transferability capacity, that is, the possibility that the conclusions be applied to other contexts or other groups.

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Authors' Contribution

Lima YOR, Costa EA, Costa EAM, Araújo OS, Paz BMS, Souza MKB, Souza GS – Conception, planning (study design), analysis, data interpretation and writing of the manuscript. All authors approved the final draft of the manuscript.

Disclosures

The authors report that there is no potential conflict of interest with peers and institutions, nor political or financial conflicts in this study.

Conflict of Interest

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