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Social Work and Multiprofessional Residency in health: training professionals to work in Healthcare

Serviço Social e Residência Multiprofissional em saúde: formação de profissionais para atuar na saúde

Trabajo Social y Residencia Multiprofesional en la salud: formación de profesionales para trabajar en la salud

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This is a reflection carried out in September 2019, with the use of documents and resolutions, with the objective of unveiling the professional training of the Social Worker in the Multiprofessional Residency in Health, in relation to the dismantling in the Unified Health System. I study 15 references and was organized in three thematic areas, namely: *Counter-reform in health policy*, *Multiprofessional Residency in Health*, and *Social Work and Multiprofessional Residency in Health*. In the context of counter-reform of health that residencies in health are carried out in seeking to break with the logic of fragmentation between professions, focusing on the complementarity between practices, knowledge and the construction of shared competences. The formation of Social Work in the Multiprofessional Residency programs is articulated with the profession's ethical-political project, and must be aligned with the proposals and defense of public, state and socially referenced health, as well as working with other categories, with a view to questioning and resisting attacks on health that brings harm not only to professionals, but to the entire group of workers.
Descriptors: Right health; Social work; Profissional training; Unified Health System.

Esta é uma reflexão realizada em setembro de 2019, com o uso de documentos e resoluções, com o objetivo de desvelar a formação profissional do Assistente Social na Residência Multiprofissional em Saúde, na relação com os desmontes no Sistema Único de Saúde. Considerou-se no estudo 15 referências e, se organizou em três áreas temáticas, a saber: *A Contrarreforma na política de saúde, Residência Multiprofissional em Saúde,* e *Serviço Social e Residência Multiprofissional em Saúde*. No contexto da contrarreforma da saúde em que as residências em saúde se efetivam em busca de romper com a lógica da fragmentação entre as profissões, com foco na complementaridade entre práticas, saberes e construção de competências compartilhadas. A formação do Serviço Social nos programas de Residência Multiprofissional articula-se com o projeto ético-político da profissão, e deve alinhar-se com as propostas e defesa de uma saúde pública, estatal e socialmente referenciada, bem como trabalhar com outras categorias, com vistas a questionar e resistir aos ataques à saúde que traz prejuízos não apenas aos profissionais, mas para todo o conjunto de trabalhadores.
Descritores: Direito à saúde; Serviço social; Capacitação profissional; Sistema Único de Saúde.

Esta es una reflexión realizada en septiembre de 2019, mediante documentos y resoluciones, con el objetivo de desvelar la formación profesional del Trabajador Social en la Residencia Multiprofesional en Salud, en la relación con los desmantelamientos en el Sistema Único de Salud. El estudio consideró 15 referencias y se organizó en tres áreas temáticas, a saber: *La contrarreforma en la política de salud, Residencia Multiprofesional en Salud,* y *Trabajo Social y Residencia Multiprofesional en Salud.* En el contexto de la contrarreforma de la salud en el que las residencias en salud buscan romper con la lógica de fragmentación entre las profesiones, centrándose en la complementariedad entre prácticas, conocimientos y construcción de competencias compartidas. La formación del Trabajo Social en los programas de Residencia Multiprofesional se articula con el proyecto ético-político de la profesión, y debe estar alineada con las propuestas y la defensa de una salud pública, estatal y socialmente referenciada, así como trabajar con otras categorías, con el fin de cuestionar y resistir los ataques a la salud que traen perjuicios no sólo a los profesionales, sino a todo el conjunto de trabajadores.
Descriptores: Derecho a la salud; Servicio social; Capacitacion professional; Sistema Único de Salud.

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INTRODUCTION

The multiprofessional residency in health (MRH) is a professional training program for the Unified Health System (*Sistema Único de Saúde - SUS*), at the *Lato sensu* specialization level, created from the enactment of Law No. 11,129 of 2005[1,2]. This program is guided by SUS principles and guidelines, based on local and regional needs and realities. The MRH covers health professions according to Resolution No. 218 of 1997, which recognizes as health professionals: social workers; biologists; physical education professionals; nurses; pharmacists; physical therapists; speech therapists; doctors; veterinary doctors; nutritionists; dentists, psychologists and occupational therapists[2].

The MRH is oriented towards the expanded service to health needs and the qualification of care in the face of the health-disease process in its individual and collective dimensions. For this, the training takes place through the teaching-service-community axis and the permanent relationship between different nucleus of knowledge and practices of professions that are involved in the training.

However, in view of the dismantling of health policy - a process that tends to make SUS unviable as a right, it is possible to identify challenges and direct implications in the training of workers for the SUS, particularly in Health Residency programs with an impact on the various professional areas .

The current situation has heightened tensions and disputes in the face of the erosion of the pillars of Brazilian social security, the precariousness of SUS and public education. We are witnessing a set of offensives that has characterized a civilizing regression in Brazil, expropriation of the working class, specifically on rights and social policies.

The lack of investments in SUS and public education, and in this case, higher education, makes the defense and qualification of Health Residencies go far beyond the permanent training for health workers, in the search for the defense of targeted training and committed to the principles and guidelines of SUS, Health Reform and the radicalization of democracy. Thus, this study aims to reveal the professional training of the Social Worker in the Multiprofessional Residency in Health, in relation to the dismantling in the Unified Health System.

METHOD

This is a reflection carried out in September of 2019 with the use of documents and resolutions that support the insertion of social workers in the Multiprofessional Residency in Health. From these documents, the material was organized in thematic areas that were able to respond to the objectives of the study.

The theoretical-methodological foundation of this study is based on the critical social theory[3] that allows understanding the contradictions of the dynamics of reality beyond its appearances, but, as a dialectical and complex movement.

RESULTS

The study considered 15 references and was organized into three thematic areas, namely: *Counter-reform in health policy, Multiprofessional Residency in Health,* and *Social Work and Multiprofessional Residency in Health.*

DISCUSSION

Counter-reform in health policy

The Brazilian Federal Constitution (FC) of 1988[4] represents a historic achievement of Brazilian society, with regard to the expansion and guarantee of rights at the individual and collective levels, such as the social security system in its threefold - health, social security and

social assistance. In it, health was considered a universal right, integrating a network of regionalized and hierarchical services, which constituted SUS.

The consolidation of SUS represented a new organization of health care, establishing significant changes in: decentralization of services; openness to civil society participation; comprehensive care at national, regional and municipal levels; among others.

The design of SUS emerged, then, from the 1988 FC, and was ensured by article 196, in which health becomes "the right of all and the duty of the State"[4]. Its formatting begins with the establishment of Law 8,080 of 1990, which provides conditions of promotion, protection and recovery of health at various levels of government, and with Law 8,142 of the same year, which aims to ensure community participation in the management of SUS, through collective instruments of social control (such as management councils and conferences).

However, currently, SUS has faced clashes that prevent its progress, access and quality of services, in addition to putting into question the proposal of its management model, as well as its legitimacy. However, this health model was driven by the logic of neoliberal economic policy in the fragmentation of social policies, in inequality of access, which reflected, above all, in the direction of health policy.

With the Coup and the Temer government, the counter-reform of the Brazilian State and precisely of health policy enters a new phase of making the process explicit. Still in his opening statements, Health Minister Ricardo Barros openly stated to the press, the need to review the size of the SUS. This strategy revealed the direction of changes brought by Temer and, at the same time, the moment of the Brazilian State and its links with national and international capital[5,6].

Even though FC/1988[4] established a new health model and established the legal basis for the functioning of a single and universal system, with the legislative loopholes that allow the provision of services by the private sector, the conjuncture of SUS implementation was marked structural reforms that followed neoliberal ideology. Thus, with the logic of capital, causing the precariousness of state services, buying or transferring services to the private sector (profitable and or philanthropic), the health policy project advocated by the Health Reform movement is rendered unfeasible[5,6].

This process took place in the midst of the hegemony of neoliberal proposals, starting in the 1990s, which, under the guidance of multilateral agencies, triggered a series of counter-reforms in the National States considered "under development", among them Brazil and its health policy.

In health policy there are fundamentally two conflicting projects: the health reform project - hegemonic during the formulation of the FC that marks the conquest of SUS - and the privatist project, which was highlighted in the post-1964 military dictatorship, and which has a resumption of its hegemony in the 1990s, with interests linked to the private market and a perspective opposed to the rationality of the health reform project6.

Currently, the existence of another project is evident: the possible SUS. The defenders of this project aim to make health reform more flexible, but they call this process a "re-updating" and innovation of health policy. But, what the leaders do not recognize, is that this project brings the same rationality as the capital proposal, that is, the privatist[6].

This counter-reform idea finds fertile ground in the Brazilian State, in view of its historical particularities. The current trend of capitalism favors the privileges of neoliberal politics in several ways: it allocates the resources of the public fund to capital investment; transfers to old oligopolistic groups, through privatization, the old state mechanisms that end up protecting them (with incentives from the public fund) and turns social rights into profitable sources for the market[5,6].

Currently, this counter-reform in the sector directly affects professional health education and is expressed through different initiatives, among them: the expansion of new courses aimed at higher education that do not have the necessary infrastructure and quality

aimed at consolidating public health; public funding for students in private universities, the creation of management models through social organizations, private law entities that perform public activities, as proposed by the Brazilian Hospital Services Company (*Empresa Brasileira de Serviços Hospitalares - EBSERH*).

The counter-reform of health is as follows: precariousness of the SUS, in a restricted, fragmented and excluding expansion of the system, interfering in the model of care guided by the health reform and in its principles of universality, comprehensiveness, equity of SUS and participation of society in politics[5,6].

The precariousness of SUS is accentuated in the Bolsonaro government and beyond SUS, what occurs are health policies aimed at precarious living conditions and health of the population[7]. It is in this context of dispute and counter-reform in health policy that the Multiprofessional Residencies in health are.

Multiprofessional Residency in Health

Multiprofessional and uniprofessional residences appear to encourage changes in the training process, construction of knowledge and provision of services to the population, for a comprehensive approach to the health-disease process in the context of SUS. Its potential is based on an expanded service to the demands of the population, an apprehension of the individual and collective dimensions, in addition to the possibility of connecting teaching, service and community[8].

In the opposite trend of the reality still prevailing in undergraduate courses and in health work itself, the Multiprofessional Residency seeks to break with the logic of fragmentation between professions, seeking the necessary complementarity between different practices and knowledge, in addition to seeking the construction of skills shared. Residency programs also seek to overcome the dissociation between teaching and service, placing the SUS network as a locus of learning and care innovation. Thus, this training modality proposed the enhancement of changes in the context of public health, in order to overcome the curative and punctual performance by a total and integral approach to the health-disease process[8,9].

The experiences of the MRH come to signal the debate about the existing gaps in professional training, the limits of the quality of work in SUS, which necessarily requires continuous training, participation in the spaces for discussion, as well as the production of knowledge in graduate studies.

Interministerial Ordinance 1.077, of November 12, 2009 provides for the Multiprofessional Residency in Health and defines its guiding axes and, among them, the integrality of care and the performance in an interdisciplinary team, as fundamental guidelines for the teaching/work process in residences, which need to be connected to critical and consistent pedagogical projects[10].

It is necessary that MRH have a dialogue and contribute to the affirmation of comprehensiveness and this implies a total approach to health needs and care, which unfolds in the analysis and intervention on: the relationship between demands, health needs and provision of services; the reorganization of the teams' work processes, the professional/user relationship and accessibility to different levels of care in an articulated way, aiming to expand the possibilities of meeting individual and collective needs[8,9].

Among its challenges, the following stand out: the search for permanent education that aims to qualify health care with the political dimension of work in this area, that is, professionals to work in health and SUS. In addition, to promote a critical debate about its regulation, given that it is the representation and participation of the residence that will outline the formulation of the guidelines and the directions that the training will take within the framework of health education policies.

There have been advances in public health policy, but there are several conflicts that need to be problematized and stressed. A romantic view of public health policy would in no

way strengthen the struggle for a SUS that effectively meets the real demands of the population. The MRH can be understood as a strategy against hegemony of the current model, which provides for the structuring of a multidisciplinary and interdisciplinary work.

For this, health policies and actions must be articulated with social forces in defense of SUS itself and in line with the social direction of the professional project of Social Work.

Consolidating and expanding this social direction is a persistent challenge in terms of training and the professional work of the social worker, this because Social Work is one of the professions inserted in the context of training in multiprofessional residency programs.

Social Work and Multiprofessional Residency in Health

The specific training of workers for the SUS must contemplate the integration of several areas of knowledge without allowing the particularity of the professions to be lost in the midst of the multidisciplinary discourse. With regard to Social Work, it is emphasized that it should contribute to the strengthening of a multidisciplinary and interdisciplinary work project that meets the profession's political ethical project, in order to overcome the pathological character of the expressions of the social question, which are the forms of inequalities in capitalist society.

In order to train health workers to work in an interdisciplinary team, the Ministries of Education and the Ministry of Health proposed that the resident act in the three levels of health care: primary, secondary, medium and high complexity, with a view to to learning focused on the integrality of the actions and services provided, through reference and against reference in public health.

There are several initiatives before consolidating the MRH and, among them, the following stand out: the Reforms project of the Ministry of Health (MH). In 2002, 19 multiprofessional residences in Family Health were created, with funding from the Ministry of Health, with different formats, but with the perspective of working with all health professions in an integrated manner[11].

In 2003, with the creation of the Secretariat for Management of Work and Health Education (*Secretaria de Gestão no Trabalho e Educação na Saúde - SGTES*) within the structure of the Ministry of Health, the National Policy for Permanent Education in Health was established, expressed in Ordinance No. 198, of February 13, 2004. Such actions made it possible to strengthen Multiprofessional Healthcare residencies[11].

The document Parameters for the Performance of Social Assistants in Health, shows that in the neoliberal logic, professionals are directed by the privatist project to work “the socioeconomic selection of users, psychosocial performance through counseling, supervisory action to users of health plans, assistance with the ideology of favor and predominance of individual practices, and in contrast, the Health Reform project presents as main demands of Social Work in health issues such as: “democratization of access to health units and services; strategies for bringing health units closer to reality; emphasis on group approaches; democratic access to information and encouraging popular participation ”[12].

Social Work at MRH seeks to contribute to a broader view of the subject, and enhances other social aspects such as: education, housing, work, which leads the social worker to act in the broader understanding of health.

For Social Work, the training provided by residency programs, while continuing education is provided for in the Curriculum Guidelines of 1996, and in the Social Worker Code of Ethics of 1993 when establishing “commitment to the quality of services provided to the population and to intellectual improvement, from the perspective of professional competence[13]”.

Several challenges are posed to the resident social worker, one of which is to overcome bureaucratic procedures and develop a professional, creative and purposeful performance. It is important the participation of the social worker in the daily life of health, in guaranteeing full citizenship, through guidance on civil and social rights and responsibilities in carrying out

various orientations about health rights and access to the necessary information. social demands, health promotion and disease prevention, through political actions and universal and egalitarian measures. It is necessary to recognize the social issue as an object of professional intervention, as established in the Curricular Guidelines of the Brazilian Association for Teaching and Research in Social Work (*Associação Brasileira de Ensino e Pesquisa em Serviço Social - ABEPSS*), which requires professional performance, in a totalizing perspective, based on the identification of social determinations, economic and cultural aspects of social inequalities[13].

Another challenge that presents itself to Social Work is related to that: "[...] *the ethical-political performance of social workers will only be strengthened if the professional body articulates with the segments of another professional category that share similar proposals* [...]"[14]. Thus, it is necessary to break with the internal endogenous view of the profession, and seek an exogenous view, expanded and related to other professions, which have different professional projects, but similar ideologies. In other words, joining efforts with the other health professions in search of interdisciplinary work and in the implementation of the Health Reform project.

It is demanding to overcome such challenges so that the Multiprofessional Residency Programs in Health are effective, while a permanent education course that qualifies professionals in the area of Social Work for the materialization of the principles of SUS and the Health Reform Project.

The role of the Social Worker in the Integrated Multiprofessional Residency in Health must follow the direction of the commitment to the strengthening of health as a social right and duty of the State, and therefore, from the theoretical-practical relationship proposed by the multiprofessional residency programs, the resident in Social Work also assumes the commitment to seek the protagonism of health users.

It is imperative that the professional training of social workers in the residency programs has: an expanded conception of health; critical reading of the situation; ability to identify material living conditions; recognition and strengthening of spaces for the struggle and organization of workers in defense of their rights; construction of political and technical strategies for workers to change reality and formulate ways of pressure on the State, focusing on the financial, material, technical and human resources necessary to guarantee and expand rights.

Social work in health has made it possible to discuss the general formation of the profession, which is not exclusive to an area, pointing out that:

> [...] *Social Work is not exclusive to health, but it qualifies the professional to act with competence in the different dimensions of the social issue within the scope of social policies, including health;* [...] *health actions must take place in an interdisciplinary perspective, in order to guarantee attention to all the needs of the user population in the mediation between their interests and the provision of services;* [...] *the consolidation of the principles and objectives of the Unified Health System, it is essential to carry out social control and the social worker, based on his ethical-political commitment, has focused his activities on a technical-political action that contributes to enabling popular participation, the democratization of institutions , the strengthening of Health Councils and the expansion of social rights*[15]*.*

The training provided by the MRH is relevant to the continuing education and intellectual improvement of the social worker in the dimensions: practical and theoretical, a space that favors complementarity between the various types of knowledge, with emphasis on mutual relations between professions, which enhances the performance of collective work in Health.

The need for a Social Work work project must pay attention to the particularities of the profession and the contribution of directing daily professional work. And yet, to ensure the

inherent practices of the profession, which tend to be obscured by the questionable history of professional performance in health, since "[...] it is necessary to escape improvisations, it is imperative to plan the work, to give it a teleological meaning"[15].

The relations and working conditions of social workers must be considered in order to draw a panorama of social reality and thereby direct the work of these from the MRH. The relevance of the construction of the work project of the social worker as of the other professionals of the multiprofessional team is highlighted as an instrument of counter-hegemonic struggle in the face of the neoliberal offensive of health policy.

Social Work is one of the professions that defends a society different from the capitalist order, that is, in favor of the working class. If this critical stance in favor of the Sanitary Reform movement is not taken seriously, there is a risk of reproducing and reaffirming the sociability of the neoliberal project.

Thus, some questions take the scene of debates: *How to discuss, debate and propose questions regarding the Health Reform Project in times of barbarism? How to articulate forums for discussions, conferences, symposia, advice and reflections with health professionals, when the construction of the Privatist project expands more and more? How to share values, norms and political and ideological references together with civil society that uses health services?* Such questions are challenging, but they deserve to be reflected upon, debated and articulated in the category and, with other distinct professionals.

CONCLUSION

It is evident that there is a minimization of the State in Brazil to meet the interests of big capital, called overcapitalization, that is, social services are transformed into spaces of profitability and commercialization linked to private logic and rationality, previously occupied by public policies.

Private rationality seeks to break with the principle of universality, integrality, conditioning policy to technification, which results in focused, fragmented and precarious assistance; beyond privatization. On the other hand, there is the anti-hegemonic rationality that, based on the principles and guidelines of the movement for health reform, defend not only the democratization of health, but also the democratization of the State and society. Thus, health policy consists of a field of dispute for rationalities linked to different political projects.

The formation of Social Work in Multiprofessional Residency programs must be linked to the ethical-political project of the profession, in addition to being aligned with the proposals and defense of public, state and socially referenced health. The Social Service professional in the context of multiprofessional residency must join forces with the other categories in order to question and resist the attacks on health that brings harm not only to professionals, but to the whole group of workers.

The effort is for interdisciplinary work that, based on an exchange of knowledge and views of reality, is able to guide proposals and strategies in training, promotion and health education. However, it is essential that the discussions between working groups be strengthened in a critical and systematic reflection of the demands that emerge in the professional routine, which is often hampered by correlations of different forces and institutional limits.

For that, it is necessary that Health Residencies, as a space that involves different areas of knowledge, act in order to break with the perspective of a hegemonic model in health, which places on the agenda a fragmented and individualistic view, without taking into account the context of singularities and particularities of collective subjects.

The collective work in health becomes a challenge, however, fundamental to break with conservative and vertical practices provided by the neoliberal project and disseminated in the local reality of the residences. Social Work, therefore, must articulate its theoretical,

methodological, ethical and political references in order to enhance its training process, anchored to the principles that guide SUS and democratic initiatives in health.

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CONTRIBUTIONS
Josiani Julião Alves de Oliveira collaborated in the revision. **Nathália Moreira Albino** participated in the conception, collection and analysis of data and writing. **Marta Regina Farinelli**, **Priscila Maitara Avelino Ribeiro** and **Rosane Aparecida de Sousa Martins** contributed to the writing and review.

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