



Interfaces between permanent education and interprofessional education in health

Interfaces entre a educação permanente e a educação interprofissional em saúde
Interfaces entre la educación permanente y la educación interprofesional en salud

How to cite this article:

Ogata MN, Silva JAM, Peduzzi M, Costa MV, Fortuna CM, Feliciano AB. Interfaces between permanent education and interprofessional education in health. *Rev Esc Enferm USP*. 2021;55:e03733. <https://doi.org/10.1590/S1980-220X2020018903733>

-  Márcia Niituma Ogata¹
-  Jaqueline Alcantara Marcelino da Silva¹
-  Marina Peduzzi²
-  Marcelo Viana Costa³
-  Cinira Magali Fortuna⁴
-  Adriana Barbieri Feliciano¹

¹ Universidade Federal de São Carlos, Departamento de Enfermagem, São Carlos, SP, Brazil.

² Universidade de São Paulo, Escola de Enfermagem, Departamento de Orientação Profissional, São Paulo, SP, Brazil.

³ Universidade Federal do Rio Grande do Norte, Escola Multicampi de Ciências Médicas, Caicó, RN, Brazil.

⁴ Universidade de São Paulo, Escola de Enfermagem de Ribeirão Preto, Departamento Materno-Infantil e Saúde Pública, Ribeirão Preto, SP, Brazil.

ABSTRACT

This was a reflective theoretical essay that was based on the national and international literature. The goal was to analyze the interfaces and historical-conceptual distinctions between permanent education in health and interprofessional education in health. In the international context, there have been educational movements aimed at health workers with an emphasis on the incentives of the Pan-American Health Organization. In Brazil, both proposals highlight a commitment to the quality of practice in the Unified Health System, focused on health needs, with approaches that have a lot in common. Permanent education in health is geared toward on-the-job training to transform work processes, with the objective of delivering comprehensive care. Interprofessional education in health involves shared interactive learning of collaborative skills for effective teamwork, guided by interprofessional collaboration. The purpose of both is to qualify health practices through the education of workers in groups; however it is essential to distinguish the theoretical, conceptual, and methodological frameworks that support them.

DESCRIPTORS

Health Education; Work Engagement; Interprofessional Relations; Interprofessional Education.

Corresponding author:

Márcia Niituma Ogata
Rua Lília Elisa Eberle Lupo, 151,
casa 91, Jardim Salto Grande
CEP 14803-886 – Araraquara, SP, Brazil
ogata@ufscar.br

Received: 05/06/2020
Approved: 11/21/2020

INTRODUCTION

The Unified Health System (*Sistema Único de Saúde* – SUS) requires professionals who are committed to the principles of comprehensiveness, equity and universality. The process of strengthening the SUS is marked by policies that reorient health education and work, and these policies have historically attempted to address bottlenecks that compromise the operationalization of the system according to its principles. In this historical movement, two major themes stand out: Permanent Education in Health (PEH); and Interprofessional Education in Health (IEH). The first is a SUS policy to educate workers in the sector⁽¹⁾. The second is an approach to education and professional training in health that emerged in the international scenario in the 1970s⁽²⁾ and grew in Brazil in the last decade.

Global movements to change the logic of health education and work have focused efforts on strengthening health systems, especially in terms of moving from the hegemonic model of care, which is centered on disease and/or professionals, toward a model focused on the needs of people, families, communities and territories. The PEH and the IEH models are recognized as important theoretical-conceptual and methodological frameworks⁽³⁻⁵⁾. They can help promote practices that support expected change toward implementation of comprehensive care, universal access, and quality of health care.

Despite the relevance of PEH in the process of constructing and strengthening the SUS, it is important to highlight its polysemy, since many practices call themselves PEH. Some are closer to being continuing education (CE).

The specificity of these terms is considered as a function of the broader aspect of PEH and CE⁽⁵⁾, in addition to the inclusion, for some authors, of one in the other as complementary practices⁽⁶⁾. Other terms are used as synonyms, including lifelong learning – a term most commonly used in the European community⁽³⁻⁶⁾. The national policy of PEH⁽⁷⁾, and research by some reference authors in the area⁽³⁻⁴⁾ establish a distinction between PEH and CE. This distinction is based on the differing educational assumptions that inform them: their main objectives (transformation of practices and meaningful learning, vs. a means of knowledge transmission); the audience toward which they are oriented (focus on interdisciplinarity and multiprofessionality, vs. focus on professional categories); the way they are organized (valuing work as a source of knowledge, vs. the technical and scientific knowledge of each area); and their pedagogical strategies (participatory teaching strategies that promote reflecting on practices, vs. an emphasis on specific courses and training)⁽⁵⁾.

In the historical movement toward ongoing reflection on the challenges related to training of health professionals, the debate about IEH has been gaining marked visibility, worldwide and in Brazil. This calls for more careful debate about its inaccuracies and conceptual mix-ups. The literature shows that IEH is an approach that seeks to promote coordination between health professionals based on collaboration⁽⁸⁾, which occurs when professionals from different areas work

together. Researchers acknowledge that this dynamic can produce better results in the health care offered to users, their families, and the communities in a given territory⁽⁵⁾. Despite the increasing interest in the theme of IEH in Brazil, there is still a need to obtain scientific evidence about the precursory developments of this discussion. The expansion of the debate about IEH in Brazil follows the global movement toward valuing interprofessionalism in training as a coping proposal to deal with the historical fragmentation of work and uniprofessional training in health.

Both PEH and IEH consist of movements that confront the challenges inherent in every process of (de)construction of the ways to construe training of the health professions in the Brazilian context. Depending on how they are executed, they can include a democratic perspective on knowledge construction, in contrast to the market logic applied to health, taking into account the alignment of both approaches with the democratic principles of the Brazilian health system and the engagement with maintaining social rights and the right of access to health by the population.

Authors have frequently pointed convergences in the development of the theoretical frameworks of PEH and IEH, in strategic settings of training and work in health, including the Teaching-Service Integration Commission, the PEH Center, the Educational Program for Work in Health (PET-Saúde/PET-Saúde Interprofissionalidade, as per their abbreviations in Portuguese), the Brazilian Program for Reorientation of Professional Training in Health (*Pró-Saúde*). This has also included multiprofessional residencies, professional master's courses, faculty development initiatives, health care services, practical teaching in different settings of the health system, and regional and national research projects.

In this context, the development of the present reflective theoretical essay was carried out by using the following questions as a guide: What are the interfaces and differences between theoretical-conceptual and methodological assumptions in PEH and IEH? How do they dialogue with the movement toward reorientation of training and work in health in the SUS context? By taking the contextualization provided by Brazilian and international literature and these questions as starting points, the present study had the objective of analyzing the historical-conceptual interfaces and differences between PEH and IEH.

CONTEXT OF THE ORIGIN AND IMPLEMENTATION OF THE CONCEPTS OF PEH AND IEH

The term permanent education (PE) originated in the field of education, and France is the country where it is applied more extensively (although it was not the first) from the perspective of addressing an increase in the number of mandatory school years and public education reform⁽²⁾. In the late 1960s, the United Nations Educational, Scientific and Cultural Organization incorporated the idea of training human capital, considering this to be one of the most important aspects of economic productivity and national development. In a neocapitalist context, the process of work automation, characterized by the replacement of people by machines, has had consequences for human work and

training⁽²⁾. Permanent education was initially related to the needs for specific knowledge in the accumulation process of late capitalism⁽²⁾. Thus, PE can be construed as an ideological tool of the state, imposing on workers the idea that there are new forms of work centered on the demands of economic and political modes of production⁽²⁾. The work *A educação contra a educação: o esquecimento da educação e a educação permanente*⁽²⁾ (loosely translated as *Education against education: the oblivion of education and permanent education*) was an extensive analytical study of the phenomenological, hermeneutic, and philosophical aspects of PE, offering important contributions to the field. Although this publication presented the idea that education must continue throughout life, it stated that such training was intended to face changes in the work world controlled by techniques and science. However, it ignored the issue of dealing with social inequalities, reinforcing them with a meritocratic perspective.

In the mid-1980s, the Pan American Health Organization (PAHO) borrowed the expression “permanent education.” The organization worked to revitalize the debate about educational actions oriented toward health workers, and to foster the understanding that training is the responsibility of health systems and has the objective of promoting changes in professionals’ practices⁽⁹⁾. A study analyzed PAHO data about the education of health professionals between 1975 and 2002. It led to the recognition of two conceptual matrixes. The first, present from 1975 to 1984, was called CE, and the second, widespread from 1984 to 2002, was called PE. Continuing education is based on the following components: transmission pedagogy; delimited educational moments; identification of needs and objectives by people outside the context; centralized establishment of priorities; and regulated participation of the set of health employees, with the last item defined as the sum of actions that can be carried out in isolation in the context of the knowledge and practices of each profession⁽⁹⁾.

Permanent education is made up of the following components: education at work, by work, and for work; problematization pedagogy; expanded participation; a strategic approach; and interprofessionality⁽⁹⁾. According to the authors, this conceptual matrix acknowledges work as having the power to serve an educational and knowledge role in the training and development of health workers⁽⁹⁾, getting closer to the goals provided for in the SUS legal framework. In Brazil, the phrase “in health” was added to PE, an indication that it was based on the bet that it could serve as a strategy to revise care, management, and training practices, as well as participation of society in the SUS. In the origin of PEH, it can be seen that it occupies a counter-hegemonic role of organizing work and care processes in a way that allows people to ponder about the challenges posed by the (de)construction of reified ways of learning, managing, and training in health.

To comply with the 1988 Brazilian Constitution, the Secretariat of Management of Work and Education in Health (*Secretaria de Gestão do Trabalho e da Educação na Saúde* – SGTES, as per its abbreviation in Portuguese) was created as part of the Ministry of Health, in 2003. Its function was to formulate policies to guide management,

training, education, and regulation of health workers. Initially, this secretariat consisted of the Department of Management of Health Work Regulation (*Departamento de Gestão da Regulação do Trabalho em Saúde* – DEGERTS, as per its acronym in Portuguese) and the Department of Management of Education in Health (*Departamento de Gestão da Educação na Saúde* – DEGES, as per its acronym in Portuguese), which was responsible for implementing the Brazilian National PEH Policy (*Política Nacional de Educação Permanente em Saúde* – PNEPS, as per its abbreviation in Portuguese), instituted in 2004⁽⁷⁾.

This is a strategic public policy to promote changes in the processes of training and development of health workers in the SUS, taking as its assumptions the problematization of the reality of work routines for collective reflection and proposal of solutions for problems, allowing the outlining of new concepts and paradigms, and the opportunity to bring about effective modifications in work processes⁽⁷⁾. Consequently, since 2004, PEH has been the guiding concept for a crosscutting policy of education and training of SUS workers. This policy is intended to meet the constitutional principle described in Article 200, item III⁽¹⁰⁾, which assigns to the SUS the constitutional responsibility for organizing the training of health workers and has, as its guiding principle, learning based on the work processes in health and integration with educational bodies.

A strategy implemented by Directive No. 198⁽⁷⁾ was the creation of councils in the form of PEH centers, whose objective was making the execution of the locoregional policy effective. These centers consisted of SUS devices to promote changes in care and health education practices, functioning as groups for debate and collective construction, called Circles for PEH, with the participation of representatives from the spheres of management, healthcare workers, educational institutions (professors and students), and users. This allowed different agents to come together and think about, discuss, and formulate changes in training in health.

From 2007 onwards, this policy has gone through alterations that took into account changes in the health management system, with the purpose of strengthening local management and social control⁽¹¹⁾. Institutional changes occurred in federal management after the implementation of a PEH policy that resulted in resignifying concepts and methodologies in the implementation of PEH. This led to changes such as the replacement of the centers by Teaching-Service Integration Commissions (*Comissões de Integração Ensino-Serviço* – CIES, as per its acronym in Portuguese) and the participation of Regional Management Councils in the management of PEH. This substitution caused a considerable alteration in the process that had been initiated by PEH centers, especially from the perspective of participation by various agents and the collective development of local PEH projects. A study on CIES in Brazil⁽¹²⁾ pointed out that they existed in several states and that there were difficulties related to ways to carry out and coordinate PEH actions in different territories.

The PNEPS focuses on work processes and development of professionals by means of ongoing coordination between

teaching and service^(7,10), focused not only on training, but also on qualification of management and work processes in health. Analysis of actions carried out by the Ministry of Health in 2017 and 2018 to resume the process of implementing the PNEPS, reported that, during workshops to discuss the subject, it was observed that managers showed a lack of understanding about PEH and the way CIES work, low levels of coordination in the quadrilateral, insufficient funding, and an insistence on maintaining the traditional training model, which is marked by reproduction of courses and reduced appropriation of PEH concepts⁽¹²⁾. What this study did not show, and which cannot be ignored, are changes in the Brazilian national political scenario that directly influenced the implementation of PNEPS, according to its founding premises. An example that stands out is the approval of Constitutional Amendment 95, which freezes public expenses for 20 years and worsens the scenario of defunding of the SUS. Another case concerns changes in the Brazilian National Primary Health Care Policy⁽¹³⁾, which confirmed lack of commitment to public policies oriented toward strengthening the SUS. Implementation of public policies occurs in the context of conflicts and disputes that are political rather than technical, affecting intentionality and attempts grounded in values and positions of agents that execute them in several spheres of action.

Similar to what happened with PE, the official origin of Interprofessional education in health (IEH) can be attributed to a group of experts at the World Health Organization (WHO). In 1973, they advocated for the incorporation of interprofessional training as a response to the demand for teamwork and for a comprehensive approach to the health needs of health system users⁽²⁾. Subsequently, during the 1978 Alma-Ata Conference, IEH was highlighted as a necessary strategy in the report entitled *Health for all by the year 2000*⁽¹⁴⁾.

In 1988, WHO published the report *Learning together to work together for health*⁽¹⁵⁾, in which it declared its commitment to a training model oriented toward the health needs of the population, with the development of interactive learning in association with other professional areas and skills for teamwork. However, at the time, the word “interprofessional” was still mentioned in the literature as a synonym for “multiprofessional,” with the latter defined by WHO as joint and interactive learning by students or workers, over an established period, to develop promotion, prevention, and recovery actions collaboratively⁽¹⁵⁾.

The encouragement given by WHO to IEH culminated in the publication of the *Framework for action on interprofessional education and collaborative practice* in 2010. In the same year, The Lancet Commission Health Professional for a New Century published an article that emphasized IEH as a response to the increase in the complexity of the health needs of health system users, taking into account population aging, increased incidence of chronic diseases, and increased incorporation of technology. The article supported integration between the educational and health systems so training and health could provide feedback to one other on their demands. The authors stressed that the hegemonic model of training in health developed by Flexner had to be overcome

by incorporating interprofessionality in the training process of the various health professions, active teaching-learning processes that support students’ protagonism, curricular reforms that favor IEH, and reinforcing a commitment to training oriented toward interprofessional teamwork⁽¹⁶⁻¹⁷⁾. The hegemony of the Flexnerian matrix, which is present in most Brazilian educational institutions, can be considered one of the critical obstructions in the process of implementing PEH and IEH. Subsequently, the report entitled *Global strategy on human resources for health: workforce 2030* reaffirmed the indication of IEH as a necessary model for responding health systems, preparing interprofessional teamwork, and establishing collaboration⁽¹⁸⁾.

The IEH movement in the United Kingdom began around 1966, and this country was followed by Canada and the United States, as well as other European nations, Australia, and, more recently, countries in Asia and Africa. Over more than four decades, efforts have been made to advance toward user-centered interprofessional collaboration, as it is increasingly acknowledged as a strategy to solve problems in health systems⁽¹⁹⁻²⁰⁾.

In 1969, Canada released its first publication on the IEH theme, produced by the University of British Columbia. It was only in 2003, by means of an agreement with health ministers, that a national expert committee was created for Interprofessional Education for Collaborative Patient-Centered Practice, which developed several studies and published the results. This initiative sought to bring training closer to health services. This coordination is indispensable to strengthening IEH and interprofessional collaboration, which are both acknowledged as necessary practices for the sustainability of health systems, and are disseminated by the Canadian Interprofessional Health Collaborative Consortium⁽¹⁹⁻²⁰⁾.

In the United Kingdom, the Centre for the Advancement of Interprofessional Education stands out. It was created in 1987 with the objective of promoting collaboration between professionals from different areas by means of IEH, oriented toward comprehensive care and effective attention to users’ health needs. The actions of the Centre were designed to coordinate IEH initiatives; promote dissemination of information, experiences, and studies; develop opportunities to share learning; and strengthen the interprofessional perspective in professional training⁽²¹⁾.

In Brazil, more well-known and long-standing trends related to reorienting training of health professionals have incorporated interdisciplinarity as one of their formative principles. This is especially true for initiatives for curricular reforms, which aim to design integrated curricula or curricula that are more directly grounded in the Brazilian national curricular guidelines for undergraduate courses in the health field. In this context, curricula based on skills, in which teamwork stands out, have been favored.

The main milestone of incorporation of IEH in Brazil was the creation, in 2006, of an interprofessional proposal to be implemented at the *Baixada Santista Campus* of the *Universidade Federal de São Paulo* (Unifesp, as per its acronym in Portuguese)⁽²²⁾. In the same year, the *Universidade Federal do Recôncavo da Bahia* was created, together with the proposal

of an interdisciplinary bachelor's degree in health (*Bacharelado Interdisciplinar em Saúde* – BIS, as per its abbreviation in Portuguese). This was also established at *Universidade Federal da Bahia* with the support of the Program for Restructuring and Expansion of Brazilian Federal Universities of the Ministry of Education⁽²³⁾. In 2008, the interdisciplinary project of the *Universidade de Brasília, Ceilândia Campus*, was initiated and, in 2013, the *Universidade Federal do Sul da Bahia*⁽²⁴⁾ adopted the BIS proposal, with emphasis on the new model of training in cycles. These universities experienced success regarding the incorporation of methodologies and theoretical-conceptual principles that are powerful in the process of training professionals who are more fit for effective teamwork, by means of the intentional and systematized development of collaborative skills⁽²²⁻²⁴⁾. It is important to stress that the integrated curriculum of undergraduate courses at the *Baixada Santista Campus* of the Unifesp is grounded in IEH, and the others are grounded in interdisciplinarity coordinated with IEH.

Interdisciplinarity pertains to the domain of scientific knowledge and subjects, whereas interprofessionality refers to the sphere of professional practices and professions. Inaccuracy in concepts and terms related to the two approaches, interprofessional and interdisciplinary, indicates the absence of a consensus on the keywords of each⁽⁵⁾. It is pertinent to emphasize the complementarity between interprofessionality and interdisciplinarity, given that students and workers have to deal with the challenge of taking ownership of both coordination between the knowledge specific to each subject and between the different professional practices found in health care. This debate is relevant, as increasing complexity in the health area is acknowledged. This characteristic demands that professionals face and overcome the reductionism and disjunction of modern scientific rationality, which that have led to fragmentation of knowledge into subjects and of health practices into professions.

Another historic milestone for the IEH movement in Brazil is the International Colloquiums on Interprofessional Education and Work in Health (*Colóquios Internacionais de Educação e Trabalho Interprofissional em Saúde* – Cietis, as per their acronym in Portuguese), proposed by a group of professors and researchers at public universities, which addressed interprofessional studies, teaching, and experiences. The first Cietis, organized by the *Universidade Federal do Rio Grande do Norte*, occurred in Natal in 2015. The second was at the *Baixada Santista Campus* of the Unifesp in 2016, during which the Brazilian Network of Education and Interprofessional Work in Health (ReBETIS, as per its abbreviation in Portuguese) was created. The third Cietis took place in Brasília in 2017 and was organized by the ReBETIS Executive Commission. The fourth colloquium occurred at the *Universidade de Brasília, Ceilândia Campus*, in 2018, with a restructuring of the commission⁽²⁴⁾. All the instances of the event were supported by PAHO and the Ministry of Health, by means of SGTES. CIETIS inspired professors, professionals, researchers, and students in the health area to carry out annual meetings aiming to share progress in and challenges to strengthening IEH and interprofessional collaboration, and

were markedly committed to the development of the SUS and the centrality of the health needs of users, their families, and communities, during both training and work.

The same social commitment to the SUS brought about the creation of ReBETIS, with the objective of disseminating experiences, knowledge, and practices that contribute to transforming training from the IEH perspective. The goal is to prepare professionals to develop their activities in interprofessional teams and for collaboration to be oriented toward care comprehensiveness in a high-quality health system that is fairer and more equitable.

Important Brazilian professional training reorientation experiences that were strengthened by the PEH Policy have included work as an educational principle in their design. Some that stand out are *Pró-Saúde*, *PET-Saúde*, multiprofessional residencies, and *Ver-SUS*. These initiatives adhere more closely to the principles and strategies that are also valued by the IEH movement: interprofessional communication; participation of users, families, and communities; integration between teaching, service, and community; teamwork; shared decision-making; and interprofessional collaboration. Therefore, IEH in Brazil has the potential to coordinate with this historical PEH movement.

Regarding Latin America and Caribbean, it is important to stress the work developed by PAHO in encouraging and supporting countries in their movement toward incorporation of IEH principles into policies designed to guide changes in training and work in health. The year 2016 was crucial in this respect, as PAHO organized and promoted the first Regional Meeting for Interprofessional Education in the Americas, in Bogotá, Colombia⁽²⁵⁾. During this event, the Regional Network for Interprofessional Education in the Americas was created, in order to develop a strategy for coordination and technical cooperation between educational institutions, professional organizations, ministries of health and of education⁽²⁵⁾. The countries that participated in the meeting were asked to formulate a Plan of Action to Strengthen IEH oriented toward their contexts.

Brazil participated in the meeting held in Bogotá, and carried out, in 2017, the Workshop on Conceptual Alignment of Interprofessional Education and Work, sponsored by the Ministry of Health, by means of DEGES/SGTES, and PAHO. The objective of the workshop was to establish a dialogue about IEH theoretical-conceptual and methodological frameworks by creating a partnership between researchers at higher education institutions and ReBETIS⁽²⁶⁾. During this workshop, the Plan of Action to Strengthen IEH in Brazil was presented and discussed, and the incorporation of this terminology was officially implemented in the Brazilian National PEH Policy in the SUS.

As part of the Plan of Action, in 2018 SGTES published the PET-Interprofessional Health public notice, aiming to promote the following: work as a formative principle; integration between teaching, service, and community; and prompting of changes in the training of health professionals by means of the deliberate and systematized incorporation of theoretical and methodological elements of IEH into pedagogical projects of selected courses.

The socio-historical nature of the PEH and IEH movements signals the search for the development of a health-school network, which demands efforts to change the hegemonic model, which is based on reproducing verticalized, hierarchized traditional education, with its protagonism centered on relationships of power and the uniprofessional perspective of training and work. This supports a logic of fragmentation of work and knowledge, with important implications for coping with complex and dynamic needs in health. Both educational movements value people's emancipation, autonomy, and collective construction, with inclusion of users in changes in educational practices and work processes in health.

THEORETICAL-CONCEPTUAL AND METHODOLOGICAL INTERFACES OF PEH AND IEH

Three domains of tension that can be strategic in reorienting education for the SUS⁽¹²⁾ in the process of development of this unified health system stand out: the health practices context, production of actions, and organizations.

Health practices, being a field involving disputes and development of care policies, are subject to distinct interests and abilities to carry out activities. Production of health actions involves a space of living work that allows employees to work according to the specificities of the context of each user, supported by soft technologies, and applying hard and soft technologies according to identified needs. In this living production, there is a certain level of uncertainty and a certain level of autonomy of the involved workers, which opens up possibilities for creation and innovation. Organizations are spaces for the intervention of different agents, with self-government capacity, that develop instituting practices and compete, in the routine of the work process, with established norms and rules, but which can be aligned with collective interests, especially those of users⁽²⁷⁾.

Adopting PEH and IEH as conceptual references for policies aimed at reorientation of education for the SUS is justified by the need to develop innovative care and management practices oriented toward SUS principles. Together with this issue, there was the criticism that the pedagogical format traditionally adopted in teaching in conventional courses and training programs, which are focused on transmitting knowledge of a strictly cognitive nature, without coordination between theory and the routine of the practices and between teaching and care, had little power when faced with the need for change. Permanent education in health assumes that education and training of health professionals occur in a reciprocal and dialectical relationship, with healthcare practices showing the ability to transform work processes, from the reflection on everyday routines being experienced in management, care, social control, problematization of these experiences, and collective development of new ways to carry out management and care as a starting point. To set up a process of change or incorporation of new practices, it is necessary to identify inconvenience, dissatisfaction, or insufficiency experienced and perceived as triggers for change.

The IEH movement also expresses commitment to the transformation of health practices in the SUS context by emphasizing its explicit purpose of promoting interprofessional collaboration and learning for effective teamwork⁽²⁸⁾. This emphasis can be seen as an important distinction between PEH and IEH. Historically, the idea of putting together students or professionals from different areas in the same space was already considered interprofessional, as if insertion into the dynamics of work in health – taking into account its eminently collective nature – was enough to encourage interprofessional collaboration.

Expression of intentionality arises from the choice to operationalize the theoretical-methodological frameworks of IEH. This requires a survey of educational needs, and definition and coordination of specific skills, both common and collaborative, based on educational theories that promote protagonism of students and active teaching-learning methodologies that encourage results that cannot be achieved with the uniprofessional perspective⁽²⁹⁾. Consequently, this intentionality requires that educational initiatives clearly express their contributions to the training of professionals more fit for collaboration and effective teamwork, in an ongoing process of reflective practice and learning. Therefore, it is possible to say that both the PEH and IEH movements include the perspective of a reciprocal relationship between education and work, and of a pedagogical approach grounded in active and problematizing learning methodologies.

Another aspect related to PEH refers to the “training quadrilateral,” which coordinates managers, workers, formative institutions, professors, students, users, and social movements involved in and committed to the construction of this teaching-learning network in the SUS, based on the interaction/care, management, teaching, and social control⁽³⁾. The background of this idea is that all agents exert control in everyday routines and experience conflict about the direction of actions in health, applying the resources available to them.

In the theoretical-conceptual configuration of PEH and IEH, there are common frameworks regarding the relationship between theory and practice, especially in the acknowledgement of the intrinsic relationship between health care and training of health professionals, which amounts to saying that the health and educational systems are interdependent and, therefore, impact not only practices, but also theories⁽¹⁵⁾. The reciprocal relationship between health care and professional training both reproduces models of prevailing practices and values and creates new, radical models and values that are oriented toward changing existing practices. The theoretical frameworks that expose the deep interconnections between health and training are found in several currents of thought, with critical pedagogy and constructivism standing out. However, the relationships involved in the “training quadrilateral”⁽³⁾ regarding management and social control of the SUS are not present in IEH formulations. This is true even when one takes into account the specificities of the health system of each country, the acknowledgement of users, families, and communities as participants of teams and collaborative interprofessional practices, and the social

participation tradition of some countries, such as France, the United Kingdom, and others.

Permanent education in health is grounded in concepts originated in historical, structural, and dialectical branches such as work, work processes in health, and concepts of health, disease, and care in the field of public health. In this context, health results from life conditions and, consequently, actions and practices in the health sector are intertwined with the capitalist mode of production, social inequalities, and economic interests. Health and education are taken as political practices, in the sense that they are practices filled with intentionalities. Permanent education in health proposes questioning the naturalization of the historical power difference between managers and workers, workers and workers, and workers and users. Other concepts have been originated by authors of the institutionalist movement, such as the notion of collectivities under analysis and questioning the knowledge of experts about people, which results in depreciation of these people's knowledge and hierarchization of relationships. This coordinates with trends in popular education in health and the Freirian problematization, so collectivities reflect on their issues and modes of operation, produce knowledge, and see themselves as producers of themselves and the world.

Interprofessional education in health advocates the motto "*learn together to work together*"⁽¹⁵⁾, and, with this purpose, experiences worldwide are guided by theoretical trends, moving from the culture of intuitive or pragmatic initiatives to an approach grounded in theoretical and conceptual assumptions capable of orienting the process and results of the initiatives. Adoption of IEH can be guided by a number of theories, but some appear more frequently in the literature, showing their contributions to the development of collaborative skills. The following stand out as some of the most cited: the theory of adult learning involving people adapted to interprofessional relationships described by Clark, Schon, Dewey, and Kolb; theories of education and psychology oriented toward the processes of learning and critical theories in sociology oriented toward analysis of the challenges to interprofessionality; social psychodynamics for analysis of the interactions and obstacles between people and groups; the contact hypothesis, which contributes to the understanding of professional stereotypes, from Carpenter's perspective; theories of social, professional, relational, and conflict-oriented identities, in which the field of sociology of professions stands out; Pierre Bourdieu's theory of practice; and learning based on the principle of community of practices, that is, shared learning practices⁽³⁰⁾.

FINAL CONSIDERATIONS

Appreciating different professional types of knowledge and participation of users are fundamental in both IEH and PEH, because the main goal of these movements is the

commitment with the attention to the health needs of users, their families, and their communities, from the perspective of comprehensive care in the SUS.

One aspect recognized in the theoretical-conceptual and methodological analysis shown as inherent in PEH and IEH stands out. Both approaches are triggers for processes of change in work and training of health professionals, since they do not reproduce the development of repressed individuals, as the hegemonic care and education model does. Instead, they are oriented toward training people who experience discomfort with ways to produce health and disease in everyday routines (whether as workers, students, managers, users, families, or communities), so participants open up to new paths and possibilities, putting themselves in a state of ongoing reflection and production.

It is fundamental that the concepts of PEH and IEH be understood in their conceptual nature so they do not lose their power and are able to strengthen the process of change in health practices in the SUS. Both PEH and IEH have, as a common guideline, the modification of education and training of professionals as a contribution to the development of a healthcare system that produces high-quality care and acknowledges the participation of the agents involved in the processes: workers, managers, users, families, and communities.

In Brazil, these two educational approaches have histories that interconnect, and they were created based on different theoretical-conceptual bases. Permanent education in health is based on the historical-structural and dialectical branch and on the institutionalist movement. Interdisciplinary education in health is grounded in theories originating in the fields of adult education, social psychodynamics, sociology of professions, and organizational sociology, among others. PEH proposes the development of activities with the quadrilateral involving people responsible for training, managers, workers, and social control, whereas IEH assumes the existence of interdependence between professional training and health care and encourages interactive and shared learning between students and workers from different areas to promote collaborative practices.

Implementing both approaches is a challenge, because it requires breaking with classic approaches to the organization and functioning of institutions that train health professionals, health services, and professional associations that represent professional categories.

It is important to emphasize that PEH and IEH are attempts to try to change health and educational practices that are deeply rooted, and that they are political attempts, whose implementation requires social mobilization of all involved agents and overcoming disputes in interplays of knowledge and power, by putting the development of an effective comprehensive and resolute health system at the center of these discussions.

RESUMO

Ensaio teórico de cunho reflexivo elaborado com base na literatura nacional e internacional, com o objetivo de analisar as interfaces e distinções histórico-conceituais entre Educação Permanente em Saúde e Educação Interprofissional em Saúde. No cenário internacional, ocorreram movimentos educacionais voltados para trabalhadores de saúde com destaque para os estímulos da Organização Pan-Americana de Saúde. No Brasil, ambas as propostas ressaltam o compromisso com a qualidade das práticas no Sistema Único de Saúde, centradas nas necessidades de saúde com enfoques que se aproximam. A Educação Permanente em Saúde, comprometida com

a formação no trabalho para a transformação do processo de trabalho, tem em vista o cuidado integral e a Educação Interprofissional em Saúde com o aprendizado interativo compartilhado de competências colaborativas para o efetivo trabalho em equipe, orientado pela colaboração interprofissional. Ambas visam à qualificação das práticas de saúde por meio da educação de trabalhadores em coletivos, mas é fundamental a distinção dos referenciais teórico-conceituais e metodológicos que as sustentam.

DESCRITORES

Educação em Saúde; Engajamento no Trabalho; Relações Interprofissionais; Educação Interprofissional.

RESUMEN

Ensayo teórico de corte reflexivo elaborado con base en la literatura nacional e internacional, objetivando analizar las interfaces y distinciones histórico-conceptuales entre Educación Permanente en Salud y Educación Interprofesional en Salud. En el ámbito internacional hubo movimientos educativos orientados a trabajadores de salud destacándose los estímulos de la Organización Panamericana de Salud. En Brasil, ambas propuestas subrayan el compromiso con la calidad de las prácticas del Sistema Único de Salud, centradas en necesidades sanitarias con enfoques cercanos. La Educación Permanente en Salud, comprometida con la formación laboral para transformar el proceso de trabajo considerando la atención integral, y la Educación Interprofesional en Salud con aprendizaje interactivo compartido de competencias colaborativas para un trabajo en equipo efectivo orientado por la colaboración interprofesional. Ambas apuntan a calificar las prácticas de salud educando al trabajador en colectivos, aunque resulta fundamental diferenciar los referenciales teóricos, conceptuales y metodológicos que las sustentan.

DESCRIPTORES

Educación en Salud; Compromiso Laboral; Relaciones Interprofesionales; Educación Interprofesional.

REFERENCES

1. Ferreira L, Barbosa JSA, Esposti CDD, Cruz MM. Permanent Health Education in primary care: an integrative review of literature. *Saúde Debate*. 2019;43(120):223-9. <https://doi.org/10.1590/0103-1104201912017>
2. Gadotti, M. A educação contra a educação: o esquecimento da educação e a educação Permanente. 5th ed. Rio de Janeiro: Paz e Terra; 1992.
3. Ceccim RB, Feuerwerker LM. A four-way approach to training in the health field: teaching, management, care, and social control. *Physis*. 2004;14(1):41-65. <https://doi.org/10.1590/S0103-73312004000100004>
4. Ceccim RB. [Permanent Education in the Healthcare field: an ambitious and necessary challenge]. *Interface (Botucatu)*. 2005;9(16):161-8. Portuguese. <https://doi.org/10.1590/S1414-32832005000100013>
5. Peduzzi M, Agreli HLF, Silva JAM, Souza HS. [Teamwork: revisiting the concept and its developments in inter-professional work]. *Trab Educ Saúde*. 2020;18(suppl 1):e0024678. Portuguese. <https://doi.org/10.1590/1981-7746-sol00246>
6. Ramos M. Trabalho, educação e correntes pedagógicas no Brasil: um estudo a partir da formação dos trabalhadores técnicos da saúde. Rio de Janeiro: EPSJV/UFRJ; 2010.
7. Brasil. Ministério da Saúde. Portaria nº 198/GM/MS, de 13 de fevereiro de 2004. Política Nacional de Educação Permanente em Saúde. Brasília, DF: Ministério da Saúde; 2004.
8. Reeves S, Fletcher S, Barr H, Birch I, Boet S, Davies N, et al. A BEME systematic review of the effects of interprofessional education: BEME Guide nº 39. *Med Teach*. 2016;38(7):656-68. <https://doi.org/10.3109/0142159X.2016.1173663>
9. Cavalcanti FOL, Guizardi FL. [Continued or permanent education in health? analysis of the production of the pan american health organization]. *Trab Educ Saúde*. 2018;16(1):99-122. Portuguese. <https://doi.org/10.1590/1981-7746-sol00119>
10. Brasil. Senado Federal. Constituição da República Federativa do Brasil. Brasília, DF: Senado; 1988.
11. Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Política Nacional de Educação Permanente em Saúde. Brasília, DF: Ministério da Saúde; 2009.
12. Gonçalves CB, Pinto ICM, França T, Teixeira CF. The resumption of the implementation process of the National Permanent Health Education Policy in Brazil. *Saúde Debate*. 2019;43(n spe 1):12-23. <https://doi.org/10.1590/0103-11042019s101>
13. Giovanella L, Franco CM, Almeida PF. National Primary Health Care Policy: where are we headed to?. *Cienc Saúde Coletiva*. 2020;25(4):1475-82. <https://doi.org/10.1590/1413-81232020254.01842020>
14. Declaração de Alma-Ata. Conferência Internacional sobre Cuidados Primários de Saúde; Alma-Ata, USSR, 6-12 de setembro de 1978. In: BRASIL. Ministério da Saúde. Secretaria de Políticas de Saúde. Projeto Promoção da Saúde. As cartas da promoção da saúde. Brasília, DF: Ministério da Saúde; 2002 [cited 2021 Apr 29]. p. 33-34 Available from: http://bvsm.sau.gov.br/bvs/publicacoes/cartas_promocao.pdf
15. World Health Organization. Learning together to work together for health. Report of a WHO Study Group on Multiprofessional Education for Health Personnel. Geneva: World Health Organization; 1988 [cited 2020 Sept 21]. (Technical Report Series, v. 769). Available from: https://apps.who.int/iris/bitstream/handle/10665/37411/WHO_TRS_769.pdf?sequence=1&isAllowed=y
16. Frenk J, Chen L, Bhutta ZA, Crisp N, Evans T, Fineberg H, et al. Health professionals for a new century: transforming education to strengthen health systems in independent world. *Lancet*. 2010;376(9721):1923-58. [https://doi.org/10.1016/S0140-6736\(10\)61854-5](https://doi.org/10.1016/S0140-6736(10)61854-5)
17. World Health Organization. Framework for action on interprofessional education & collaborative practice. Geneva: World Health Organization; 2010. [cited 2020 Sep 21]. Available from: https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf?sequence=1
18. World Health Organization. Global Strategy on human resources for health: workforce 2030. Geneva: World Health Organization; 2016 [cited 2020 Sept 19]. <https://doi.org/10.3109/13561829809014104>
19. Barr H. Competent to collaborate: towards a competency-based model for interprofessional education. *J Interprof Care*. 1998;12(2):181-7. <https://doi.org/10.3109/13561829809014104>

20. Canadian Interprofessional Health Collaborative. Interprofessional education & core competences: literature review [Internet]. Vancouver: University of British Columbia; 2007 [cited 2020 Sept 19]. Available from: <https://pdf4pro.com/view/interprofessional-education-amp-core-competencies-cihc-4c6330.html>
21. Horder J. A history of the Centre for the Advancement of Interprofessional Education (CAIPE) 1987 - 2003. London: CAIPE; 2003 [cited 2020 Sep 19]. Available from: <https://www.caipe.org/resources/publications/archived-publications/history-centre-advancement-interprofessional-education-caipe-1987-2003-john-horder-first-chairman>
22. Teixeira CFS, Ávila DCMT, Nunes DRM. [Interdisciplinary Bachelor's degree in Health: an innovative proposal in higher education in Health in Brazil]. *Cienc Saúde Coletiva*. 2013;18(6):1635-46. Portuguese. <https://doi.org/10.1590/S1413-81232013000600015>
23. Veras RM, Coelho MTAD, Teixeira CM, Traverso-Yeppez MA. [The cycle system training in the Interdisciplinary Bachelor of Health at the Universidade Federal da Bahia and the Interprofessional Education proposal]. *Avaliação (Campinas)*. 2018;23(2):294-311. Portuguese. <https://doi.org/10.1590/s1414-40772018000200002>
24. Câmara AMCS, Cyrino AP, Cyrino EG, Azevedo GD, Costa MV, Bellini MIB et al. [Interprofessional education in Brazil: building synergic networks of educational and healthcare processes]. *Interface (Botucatu)*. 2016;20(56):5-8. Portuguese. <https://doi.org/10.1590/1807-57622015.0700>
25. World Health Organization; Pan American Health Organization. Regional Network for Interprofessional Education in the Americas [Internet]. Geneva: PAHO; 2017 [cited 2020 Sept 20]. Available from: <https://www.educacioninterprofesional.org/en>
26. Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. Relatório final da oficina de alinhamento conceitual sobre educação e trabalho interprofissional em saúde [Internet]. Brasília, DF: Ministério da Saúde; 2017 [cited 2021 Apr 29]. Available from: https://www.educacioninterprofesional.org/sites/default/files/fulltext/2018/pub_relatoria_eip_bra_2017_po.pdf
27. Merhy EE, feuerwerker LCM, Ceccim RB. [Permanent education in health: a strategy for acting upon the micropolitics of the work in health]. *Salud Colectiva* [Internet]. 2006 [cited 2018 dez. 19]:2(2):147-160. Spanisch. Available from: http://www.scielo.org.ar/scielo.php?script=sci_arttext&pid=S1851-82652006000200004&lng=es
28. Costa MV, Freire Filho JR, Brandão C, Silva JAM. Education and interprofessional practice in line with the historical commitment to strengthen and consolidate the Brazilian National Health System (SUS). *Interface (Botucatu)*. 2018;22(suppl 2):1507-10. <https://doi.org/10.1590/1807-57622018.0636>
29. Shrader s, Jernigan S, Sick B. Developing interprofessional preceptors to promote intentional interprofessional education in practice settings: reflections from the preceptors in the Nexus Workshop. *JCIPE* [Internet]. 2020 [cited 2020 Sept 24];10(2):4. Available from: <https://jdc.jefferson.edu/jcipe/vol10/iss2/4>
30. Barr H. Toward a theoretical framework for interprofessional education. *J Interprof Care*. 2013;27(1):4-9. <https://doi.org/10.3109/13561820.2012.698328>

