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CHAPTER 5

NURSE MANAGEMENT IN THE BED REGULATION PROCESSES OF THE UNIFIED HEALTH SYSTEM

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ABSTRACT

The requirement of the Ministry of Health for the implementation of Internal Regulatory Centers in hospitals has brought Nurses into the picture, as they are healthcare professionals with extensive managerial knowledge. This center, which has technical-administrative functions, is responsible for establishing flows and protocols for access to services, interfacing with regulatory centers, managing beds, among others. This research aims to analyze nurse management in the SUS bed regulation processes and corroborate the fact that this practice of promotion should be practiced and implemented in the management routine. This study is an integrative literature review. Twelve articles were selected for the integrative literature review. Since this is a research without an approach to human beings and without co-

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participating institutions, this study did not require submission of the project to the Ethics Committee, nor approval from institutions and/or individuals for its implementation. The regulation of access to health care has become a fundamental instrument in the organization of health care services, ensuring greater equity and efficiency in the distribution of available resources. The regulatory model implemented over the last few decades has enabled significant advances in the management of the SUS, expanding access to specialized services and reducing the barriers imposed by the fragmentation of services.

Keywords: Access to health services; Nurse manager; Health management; Health regulation.

INTRODUCTION

The historical development of Brazil's public health policies and the construction of the Unified Health System (SUS) highlighted the need for new alternatives to reduce the fragmentation of public management. In this context, the Ministry of Health (MS) established the National Regulation Policy (PNR) through Ordinance GM/MS 1559/2008. The concept of regulation is based on ensuring the allocation of resources for the implementation of regulatory complexes in healthcare and the development of instruments that operationalize regulatory functions (Souza et al., 2024).

The necessity for regulatory intervention in healthcare is justified both by the specific nature of health itself and by the particular context of each country. Generally, healthcare exhibits significant information asymmetries: the patient is unaware of the unpredictable nature of health risks, only identifies symptoms, and it is the healthcare professional (typically the physician) who informs and guides them through the complex network of choices (Melo et al., 2021).

"Regulation" is a polysemic term, redefined according to the contexts and sectors in which it is applied, especially in Public Administration, Social Sciences, and Economics. In Brazil, its connotation is primarily associated with public interest services operating under state concession (Oliveira, 2022).

Since the creation of SUS, the role of health provider has become a public responsibility, with the objective of guaranteeing the right to health by offering quality services and meeting the population's needs (Rocha, 2021).

In summary, health regulation assumes various forms depending on the perspective adopted in each country. Health has followed other economic sectors, where regulation emerges alongside the withdrawal or retreat of the State, yet still requiring the maintenance of consumer rights regarding services of general interest. Contemporary challenges demand the planning and provision of quality healthcare that aims to satisfy the population and provide a positive experience in the hospital environment (Souza et al., 2024).

The Ministry of Health's requirement for the hospital implementation of Internal Regulatory Centers (NIR) has brought nurses into this scenario, as they are care professionals with substantial managerial knowledge. This center, with its technical-administrative functions, is responsible for establishing service access flows and protocols, interfacing with regulatory centers, and managing beds, among other duties (Lisbôa, 2022).

The organization of services, emphasized in this study, aims to discuss the presence of the nurse professional in all regulatory contexts and environments where regulation may be exercised. Furthermore, bed management services must have their processes systematized and regulated through manuals and standard operating procedures, in an effort to make patient and population care more equitable, universal, safe, and of high quality (Borsato & Carvalho, 2022).

The decentralization of actions within SUS has enabled the inclusion of new social actors. Nursing participates in these actions through leadership and coordination roles and stands out as one of the main agents strengthening the National Regulation Policy, equipped with technical skills and political power. Nurses are involved in the main regulatory activities, from organization to implementation and execution (Melo et al., 2021).

Regarding health indicators, the nurse's role is prominent in terms of access to healthcare, particularly in risk classification, demand and bed regulation, which may be associated with a greater presence of indicators related to care flows and continuity. Additionally, indicators related to team management and resource utilization are also noted, given the increased delegation of managerial roles to nurses. Moreover, addressing determinants, equity, and resolvability are also highlighted (Recco et al., 2022).

Despite the importance of bed management, it is scarcely discussed in the literature. Making access to this scarce resource a transparent, effective, and quality process plausibly contributes to the improvement of local health. Nursing must also be included and valued in this field, as its care, scientific, and managerial knowledge ensures that this service is provided continuously and effectively, guaranteeing the resolution of clinical referrals for hospitalized patients or those requiring surgical intervention (Feijó, 2022).

Therefore, this research aims to analyze nurse management in the SUS bed regulation processes and support the notion that this upward practice should be routinely implemented in management.

LITERATURE REVIEW

THE HEALTH SYSTEM IN BRAZIL AND THE HISTORICAL ADVANCEMENT OF REGULATION

In Brazil, with the promulgation of the 1988 Federal Constitution and the creation of the Unified Health System (SUS), the State expanded its responsibilities to ensure access to health services, establishing a public, universal, and comprehensive system funded by taxes. The decentralization of health actions to states and municipalities led to the establishment of shared responsibilities among different levels of government (Borsato & Carvalho, 2022).

In the 1990s, the Basic Operational Norms (NOB) of SUS served as guiding instruments for health actions and services. These norms strengthened the municipalization and decentralization of the health system, and NOB 96 detailed guidelines for organizing the programming processes of health care activities in an ascending and integrated manner (PPI – Agreed and Integrated Programming), among government spheres and control, evaluation, and auditing actions, especially concerning contracted and accredited services (Melo et al., 2021).

As the municipalization process and the strengthening of Primary Health Care (PHC) in SUS progressed, the challenges of ensuring equitable and comprehensive access to health actions and services highlighted the need to reinforce regionalization processes. This was necessary due to the unequal distribution of specialized and hospital care services and the characteristics of Brazil's federative system, which includes many small municipalities. In 2001 and 2002, the Operational Norm for Health Care (NOAS-SUS) aimed to define the basic responsibilities of each federative entity in Brazil, particularly regarding care programming, control, monitoring, and evaluation of health services, access assurance, and care regulation within the scope of regionalized care, in response to the highly autonomous municipalization established by the NOBs (Rocha, 2021).

Thus, regionalization has been viewed as a fundamental process for the advancement of SUS. The progress of regulatory processes has occurred from a regional perspective, focusing on their organization and sufficiency. A major challenge lies in the absence of a regional federative entity, which renders governance processes highly complex and hinders the advancement of regulatory processes, especially considering the lack of autonomous instances in this regard (Recco et al., 2022).

Health regulation in Brazil has been progressively developed with the aim of improving service delivery, ensuring access and quality of care for the population. Accordingly, a set of governmental actions has been established for the regulation, control, and oversight of the private sector to safeguard public interest, considering that the public health system is largely provided or managed by services from the social sector (Melo et al., 2021).

HEALTH REGULATION IN THE CONTEXT OF SUS

In the period preceding the creation of the Unified Health System (SUS), medical care was guaranteed to contributors of the National Institute of Medical Assistance of Social Security (INAMPS), established in 1978 through Law No. 6,439/1977. Within the social security context, INAMPS prioritized profitable procedures and clients with formal employment ties and their dependents. Information was stored in data systems for accounting purposes, which formed the basis of the regulatory logic. At that time, the care model was highly centralized and verticalized (Farias et al., 2022).

Between 1976 and 1983, the Hospital Admission Guide (GIH) was implemented, which reimbursed service providers for performed actions and their costs, as part of the National System for Hospital Billing Control and Payments (SNCPCH). In 1981, the Hospital Admission Authorization (AIH) was introduced, which also financed health services through a system of bundled procedure packages, aiming to establish mechanisms to combat fraud. The AIH fed into the Social Security Medical-Hospital Assistance System (SAMHPS) until the implementation of the Hospital Information System (SIH) in 1991, developed by the SUS Informatics Department (Freire et al., 2021).

From 1978 to 1987, the emphasis remained on financial-accounting aspects, with control and evaluation occurring after hospital and outpatient admissions (Konder, 2021). In 1982, Ordinance No. 3,042 established service provision control due to a financial crisis. Consequently, tools for control, evaluation, and auditing were developed, laying the legal groundwork for what would later become SUS, which was only formally established in 1990 through the enactment of Law No. 8,080/1990 (Freire et al., 2021). Initially, SUS regulation was governed by the Basic Operational Norms (NOB) Nos. 1/91, 1/92, 1/93, and 1/96, and the Operational Norms for Health Care (NOAS) Nos. 1/2001 and 1/2002, issued by the Federal Government.

In 2003, the Department of Regulation, Evaluation, and Control of Systems (DRAC), under the Secretariat of Health Care, became responsible for coordinating and enhancing the Health Care Regulation component of the National Regulation Policy (PNR), as well as for issues related to resource control and the development of SUS control and evaluation guidelines. During the organization of DRAC, the term "regulation" was used in conjunction with the already established concepts of "control" and "evaluation," expanding its dissemination in NOAS 1/2002 as regulation of access to care (Konder, 2021).

In 2006, the Health Pact was launched, opening new opportunities for political discussion of inter-federative relations, emphasizing regionalization and aiming at financing, decentralization, and regulation. The Management Pact, established by Ministry of Health Ordinance No. 399, defined the health responsibilities of managers and provided guidelines for managing the Health System (Farias et al., 2022).

According to Ordinance No. 1,559/2008, Regulatory Complexes may have state, regional, or municipal scope and structures. These complexes must be composed of operational units known as regulation centers, with a minimum subdivision into a Regulation Center for Consultations and Exams, a Regulation Center for Hospital Admissions, and a Regulation Center for Emergencies. The Regulatory Complex is also expected to integrate with the State Center for High-Complexity Regulation (Konder, 2021).

CHALLENGES IN ACCESS REGULATION AND IMPROVEMENT PROPOSALS

Access regulation faces structural and operational challenges, such as unequal distribution of services, delays in regulatory systems, lack of integration among information systems, and inefficiencies in managing medical transportation. Less developed regions suffer from a shortage of specialized services, which compromises equity. The centralized regulatory model hinders agile responses, while fragmentation between municipal and state systems undermines efficient management. To address these challenges, it is necessary to strengthen the structure of Regional Polyclinics, modernize regulatory

systems, promote greater autonomy for local Regulatory Complexes, and enhance regulatory processes, making management more transparent and objective (Bastos et al., 2020).The regulation of access within SUS faces numerous challenges that impact the efficiency and effectiveness of the services provided. The shortage of hospital beds is another critical barrier, exacerbating system overload and extending wait times for admissions and treatments. Simultaneously, the high demand for health services strains regulatory centers, which often operate under inadequate conditions to efficiently manage available resources. This scenario is further complicated by systemic issues within the Regulation System (SISREG), whose structural limitations affect care coordination, compromising the quality of care and predictability of service access (Melo et al., 2021).

Another significant limiting factor is the absence of well-defined protocols for prioritizing access, which can lead to distortions in resource allocation and in meeting users' needs. The fragility of human resources also emerges as a structural challenge, reflecting both the shortage of qualified professionals to operate the regulation system and the precariousness of working conditions (Bastos et al., 2020).

Given this context, it becomes evident that investments in structural improvements are necessary to strengthen regulatory governance and ensure greater equity in access to health services. The implementation of clear and standardized criteria, modernization of information systems, and training of professionals involved in regulation are essential strategies for overcoming these challenges and building a more responsive system (Melo et al., 2021).

METHODOLOGY

This study is an integrative literature review. It is a research tool that allows for the search, critical evaluation, and synthesis of available evidence on the investigated topic. The final product is the state of knowledge, the implementation of effective interventions in care delivery, and cost reduction. Additionally, it enables the identification of gaps that may lead to the development of future research (Mendes et al., 2021).

The elaboration of this work followed the six stages of the integrative literature review process:

1. Identification of the theme and selection of the hypothesis or research question for the integrative review.
2. Search for the best evidence.
3. Critical evaluation of the evidence.
4. Integration of the evidence.
5. Discussion of the results.
6. Presentation of the synthesis of the produced knowledge (Mendes et al., 2021).

For this study, the guiding research question was: What are the impacts of nurse management in the SUS bed regulation processes, and how does this support the notion that such an ascending practice should be routinely implemented in management?

Inclusion criteria were defined as: primary articles, published in full, in Portuguese, English, or Spanish, whose general objectives relate to the theme, and published between 2021 and 2024. The articles had to include the following keywords: Access to health services; Nurse manager; Health management; Health regulation.

Exclusion criteria included: articles not referring to the Brazilian context and the proposed subject, theoretical review studies, editorials, dissertations, theses, and review articles.

The search strategy involved combining descriptors using Boolean operators “And”; “Or” e “Not” • AND – finds documents containing both subjects. • OR – finds documents containing either subject. • AND NOT – finds documents containing one subject while excluding another undesired subject.

Articles were selected from scientific journals available in the Virtual Health Library (BVS), accessed through the Scientific Electronic Library Online (SciELO) and Latin American and Caribbean Literature in Health Sciences (LILACS) platforms.

The data search was conducted online in May 2025. Of the 219 articles found, 135 were excluded for being outside the database journals (84 after title and abstract analysis, 51 for not meeting the criteria). Of the remaining 33 articles, full-text reading led to the exclusion of 22 duplicates. Thus, 12 articles were selected for the integrative literature review.

Data collection was carried out using a validated URSI form to gather scientific articles. The form included the following topics: article title, journal, type of approach, methodology, methodological characteristics of the study, and conclusion. The objective was to identify the impacts of nurse management in SUS bed regulation processes and support the notion that this ascending practice should be routinely implemented in management.

The results were analyzed using Bardin’s content analysis methodology, which involves three stages:Pre-analysis – systematization of the material; Material exploration – categorization and coding system definition; Treatment of results – presentation of findings obtained through the bibliographic survey (Bardin, 2024).

This study respected the copyright of the consulted authors, using the Brazilian Association of Technical Standards (ABNT) guidelines for citations and references. Although the study posed minimal risks, it is important to highlight the potential risks of misanalysis, result misrepresentation, and plagiarism. However, the researcher committed to conducting a faithful analysis of the selected texts and adhering to NBR 10520:2024 and NBR 6023:2025 standards, as well as Law No. 9.610/98 (Copyright Law), to ensure a reliable outcome for the scientific health community.

As this research did not involve human subjects or co-participating institutions, submission to an Ethics Committee or institutional approval was not required.

RESULTS AND DISCUSSION

Bed management is a resource aimed at optimizing the use of hospital beds, promoting greater turnover based on technical criteria. Its objective is to reduce the duration of unnecessary hospitalizations and make beds available to meet suppressed demand. The implementation of Internal Regulatory Centers (NIR) within SUS seeks to improve hospital management, especially in urgent and emergency situations, enhancing bed occupancy and the flow of admissions. The NIR, with the essential participation of nurses, monitors discharges and admissions using technical criteria to reduce hospital stay durations (Melo et al., 2021).

Nursing contributes significantly in this regulatory context, being one of the main professional groups qualified to propose and draft legislation and ordinances aimed at improving the quality of Brazilian healthcare. These professionals are naturally well-versed in care delivery, population demands, and local health needs, and therefore should be protagonists in the regulation of health systems (Bastos et al., 2020).

The role of the internal regulatory center in nursing practice has proven essential in improving the availability of hospital beds and patient flow, ensuring that all stages of hospital discharge and follow-up are completed. An increase in patient satisfaction was also observed (Tavares, 2021).

Health system regulation encompasses macro-regulation, represented by regulatory agencies and SUS norms, but also includes the regulation of healthcare delivery, such as the regulation of services provided by public and private entities operating within SUS. It also involves defining strategies and guidelines for regulating access to healthcare, as well as contracting, monitoring, evaluating, auditing, and overseeing health services within SUS to ensure quality and continuity of care (Rocha, 2021).

It is important to highlight the challenges associated with the various regulatory models that have emerged within SUS, which reveal several dichotomies—such as public versus private sectors, professionals versus technologies, access versus quality (the latter being heavily regulated by health surveillance), and varying degrees of autonomy and decentralization of regulatory authorities. The adopted regulatory model depends on what is being regulated, the concept of regulation, and the context (Souza et al., 2024).

User access to the healthcare network requires an organizational rationality, meaning it must consider the complexity or severity of the diagnosis, the characteristics of the user, and the profile of the network. Therefore, it must be guided by principles, guidelines, and protocols to ensure equity, which is materialized through care regulation. Additionally, it involves not only governmental regulation but also

the care pathways created by users and the uniqueness of processes that consider need as a social construct (Freire et al., 2021).

Understanding how the regulation process unfolds in the daily operations of local health systems allows for the identification of strengths, weaknesses, and barriers that affect users' access to health services. Regulation reduces conflict and legal disputes by establishing operational criteria and responses in advance, bringing contracts with health services and their remuneration and oversight models to the forefront of regulatory responses in health systems (Borsato & Carvalho, 2022).

Care regulation processes, within the context of regionalization and health care networks, include contracting, control, evaluation, and auditing activities involving both public and private providers. However, these processes often unfold in a context of conflict due to the interests of these providers. Additionally, intergovernmental disputes between municipalities and between municipalities and state governments hinder the effective development of a network of regulatory actions tailored to the health problems identified in each territory (Lopes et al., 2024).

Regionalization processes are essential for addressing territorial inequalities and disparities in service availability in Brazil. However, initiatives have been sporadic and still face many challenges in building integrated care networks and systems, as seen in other countries. Territorial equity remains the greatest challenge to achieving the principle of comprehensiveness in SUS (De Carvalho et al., 2022).

Furthermore, contracting processes require the training of managers and regulators to move beyond the traditional logic of service providers, who, despite their quality, rarely achieve comprehensiveness. This situation is often worsened by the managerial logic of management contracts, which can reinforce care fragmentation and precarious work processes (Souza et al., 2024).

The challenge lies in ensuring that regulatory mechanisms align with the regionalization proposal built into regional health networks. These mechanisms should aim to rationalize resources through access regulation, despite having limited capacity to reverse the current fragmented, highly specialized, costly, and often ineffective care model. This must be done while considering the diversity of territories and the various points of care within the network, which must be interconnected to form an integrated health service system (Machado et al., 2021).

While the municipalization and decentralization of health actions and services have advanced SUS, several issues remain, such as the maintenance of health services that fail to meet population needs—e.g., small hospitals—and the introduction of new SUS management models, such as Social Health Organizations and State Foundations under private law. These developments have led to the early onset of privatization in the Brazilian health system and a public-private mix in healthcare (Sousa, 2022).

In this context, the importance of strengthening regional regulatory complexes is increasingly emphasized. This should be done in a broad and coordinated manner through agreements among the three

levels of SUS management, aiming to ensure the organization of flows and processes, as well as a network of health service references. This network should be designed to meet the health demands and needs of each region through control, monitoring, evaluation, and auditing, thereby implementing a normative regulation capable of achieving effective health outcomes and access coverage (Recco et al., 2022).

FINAL CONSIDERATIONS

The regulation of access to healthcare has been consolidated as a fundamental instrument in organizing health care services, ensuring greater equity and efficiency in the distribution of available resources. The regulatory model implemented over recent decades has enabled significant advances in the management of the Unified Health System (SUS), expanding access to specialized services and reducing the barriers imposed by service fragmentation.

Health regulation, understood as a promoter of equity in access and quality of health services, must organize its regulatory processes in alignment with the characteristics and premises of the health systems in which it is embedded. It must ensure the public interest of the population, which benefits from better predictability of service availability, fewer legal disputes, and more appropriate responses to health needs.

However, persistent challenges remain, such as the need for greater integration among information systems, optimization of regulatory flows, and improved coordination across different levels of care. The decentralization of services through regional polyclinics and inter-federative consortia represents progress in structuring the healthcare network, promoting greater problem-solving capacity and efficiency in the provision of specialized services.

Nonetheless, overcoming regional inequalities still requires continuous improvement policies, including investments in professional training, strengthening technological infrastructure, and enhancing medical transportation mechanisms. Furthermore, the micro-regulation of care must be constantly evaluated to ensure that the established guidelines truly meet users' needs.

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