

The Unified Health System in the Federal District, Brazil (1960 to 2018): revisiting history to plan the future

Leila Bernarda Donato Göttems (<https://orcid.org/0000-0002-2675-8085>)¹

Marilza Oliveira de Almeida (<https://orcid.org/0000-0001-7277-4900>)¹

Armando Martinho Badou Raggio (<https://orcid.org/0000-0002-8398-8928>)¹

Roberto José Bittencourt (<https://orcid.org/0000-0002-6482-5840>)¹

Abstract *The analysis of health policy trajectories contributes to disclose the endogenous and exogenous elements that influence the management of health systems. This article aims to describe the trajectory of the Unified Health System of the Federal District (SUS-DF) from 1960 to 2018 and identify the challenges to expand the capacity for protection and health promotion of the population of the Federal District. A documentary analysis of plans, reports, and articles published from 1959 to 2018 and the collection of secondary data were carried out in databases of DATASUS and the Government of the Federal District. Results: The SUS-DF trajectory was delineated through care organization actions, health system management and health care personnel training and development. Health indicators such as infant mortality and life expectancy at birth have shown a positive development. There was an increase in health care services supply, with an increase in the number of beds, basic health units and professionals, although insufficient, given the population increase. Conclusion: the actions indicate the growing complexity of health system management, with challenges related to the adaptation of the capacity to respond to the population's health needs and reveal internal potentials in the field of health training.*

Key words *Unified health system, Health policy, Health management*

¹ Escola Superior de Ciências da Saúde, Fundação de Ensino e Pesquisa em Ciências da Saúde. Setor Médico Hospitalar Norte Conjunto A Bl. 01/Edifício Fepecs, Asa Norte. 70710-907 Brasília DF Brasil.
leila.gotttems@gmail.com

Introduction

The current context of the Federal District (DF) health system requires, to be understood, to resume the motivations to change the country's capital. Brasília, which turned 58 in 2018, is a young municipality, with challenges accumulated throughout its existence. Incidentally, its construction constituted the meta-synthesis n. 31, as an addition to the Plan of Goals of Brazilian president Juscelino Kubitschek and took less than four years to be completed^{1,2}. This record time was only possible because all there was of knowledge, materials and workforce necessary for the project of the new capital would be gathered here, in the badlands of the Central Plateau.

The new DF was officially inaugurated on April 21, 1960, where Brasília is located, which has peculiar characteristics to a city constructed to be the Capital of the Country, quite different from Rio de Janeiro, the cultural and political metropolis that preceded it by more than 150 years³. In that context, the health system of the Federal District was a pioneer in meeting the health needs of the resident population, without any official discrimination from 1960 until the institution of the Unified Decentralized Health System (SUDS) in 1988, succeeded by the Unified Health System (SUS), when universality of care was established throughout the national territory and for the entire population resident in Brazil, through the 1988 Federal Constitution⁴ and Laws n. 8,080⁵ and 8,142⁶ of 1990.

Although DF's health system was created together with the city inauguration, its current formation occurred through a particular process and under the direct influence of the SUS development. Therefore, this article aims to describe the trajectory of the health system of the Federal Capital in the period between its foundation and the last administrative year, between 1960 and 2018, and identify the challenges to expand the capacity of health care protection and promotion of the DF population. Although more descriptive than analytical, this work is based on studies of public policy analysis, defined as the evaluation of governments in action or the study of the set of actions that governments carry out⁷.

The analysis sought to identify the main mechanisms that guided the course of the political actions without, however, extending the explanation of the difficulties related to the changes and the complexity that the local health policy acquired over time⁸. The rescue of this historical process can disclose the endogenous and exog-

enous elements that favor or not the change or inertia of health policies⁹, especially those present in the creation of the Unified Health System of the Federal District (SUS-DF).

Method

A documentary research and non-exhaustive literature review were carried out. The documentary analysis consists of the technique of analyzing original documents, which have not yet received analytical treatment by any author¹⁰. The following were included in the research: management reports, District Health Plans, ordinances and internal regulations of the State Health Secretariat of the Federal District (SHS-DF) that regulated programs, actions and services, publications on the local health policy. The search for the documents was carried out in the physical and digital collection in the SHS-DF library network and the articles, in the Virtual Health Library and Scientific Electronic Library Online.

The historical periods were defined according to the government terms, and in each of these periods the factual information on actions and interventions were collected according to the following categories: health care organization, depicted in Figure 1; training and development of health personnel, shown in Figure 2; and health system management, which can be seen in Figure 3.

Secondary data were also collected from the official information systems on indicators that showed the evolution of the living conditions of the Federal District population – Life expectancy at birth and Infant Mortality, as well as indicators of service provision and population growth (Tables 1 and 2).

Results

Period from 1960 to 1994: service planning and infrastructure

In the period between 1960 and 1994, the DF was administered by mayors and/or governors appointed by the President of the Republic, the so-called “bionic” governments. With the Federal Constitution of 1988, the DF became politically autonomous and elected its first governor in 1990⁴. From the first foundations to raise the city, its fancy constructions and housing and service blocks, health care here would have to be destined to all who needed care, universal care as it

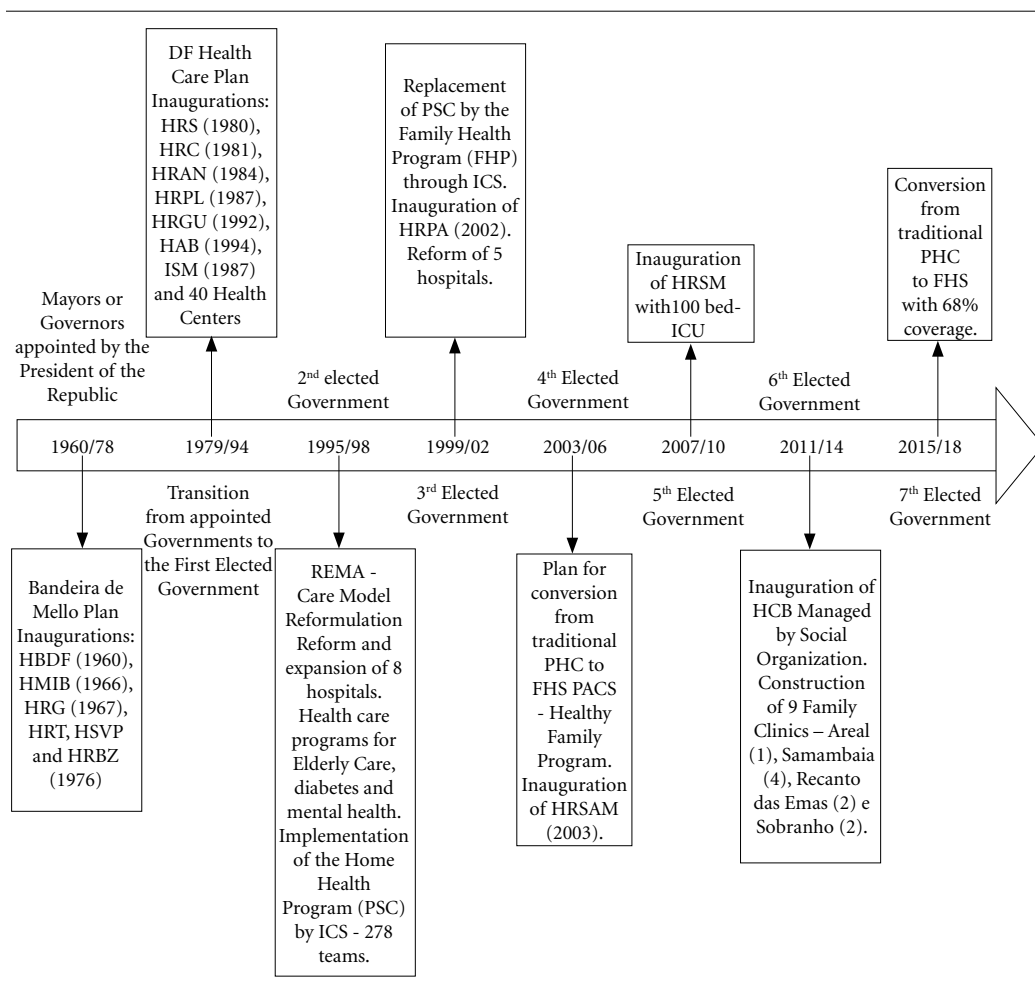


Figure 1. Chronology of the main organization actions of the DF health care system – 1960-2018.

Legends: HBDF – Hospital de Base do Distrito Federal; HMIB – Hospital Materno Infantil de Brasília; HRG – Hospital Regional do Gama; HRT - Hospital Regional de Taguatinga; HRBZ - Hospital Regional de Brazlândia; HRS - Hospital Regional de Sobradinho; HRC - Hospital Regional de Ceilândia; HRAN - Hospital Regional da Asa Norte; HRPL - Hospital Regional de Planaltina; HRGU - Hospital Regional do Guarã; HAB - Hospital de Apoio de Brasília; HRPA - Hospital Regional do Paranoá; HRSM - Hospital Regional de Santa Maria; ICS – Instituto Candango de Solidariedade; ESF – Estratégia Saúde da Família; APS – Atenção Primária a Saúde; PCS – Programa Saúde em Casa; PACS – Programa de Agentes Comunitários de Saúde; UTI – Unidade de Terapia Intensiva.

is today, since there was no other provider rather than the entrepreneurial government of the largest construction site in the country. Although this was the case, starting with Hospital Presidente Juscelino Kubitschek, currently the Candanga Memory Museum, the practice of universality faced several difficulties, including corporate ones, characterized as units for the treatment of workers, such as the Presidente Médiçi Hospital, currently Hospital Universitário de Brasília^{2,11}.

At the inception of the Federal District Health System (Figures 1 and 2), two plans were important in defining what we still have nowadays: the

General Plan of the Hospital-Medical Network of Brasilia, known as Bandeira de Mello Health Plan of 1960 and the Health Care Plan of 1979¹¹⁻¹⁴. The Bandeira de Mello Health Plan¹² proposed the organization of a health system with the following configuration: a) elimination of the multiplicity of health care organs; b) distribution of health centers and hospitals per population groups; c) cost reduction and increased efficiency of services resulting from the merging of services; d) convenience for the population, avoiding displacements; e) user's free will in choosing the physician who would treat their health; f) physicians would

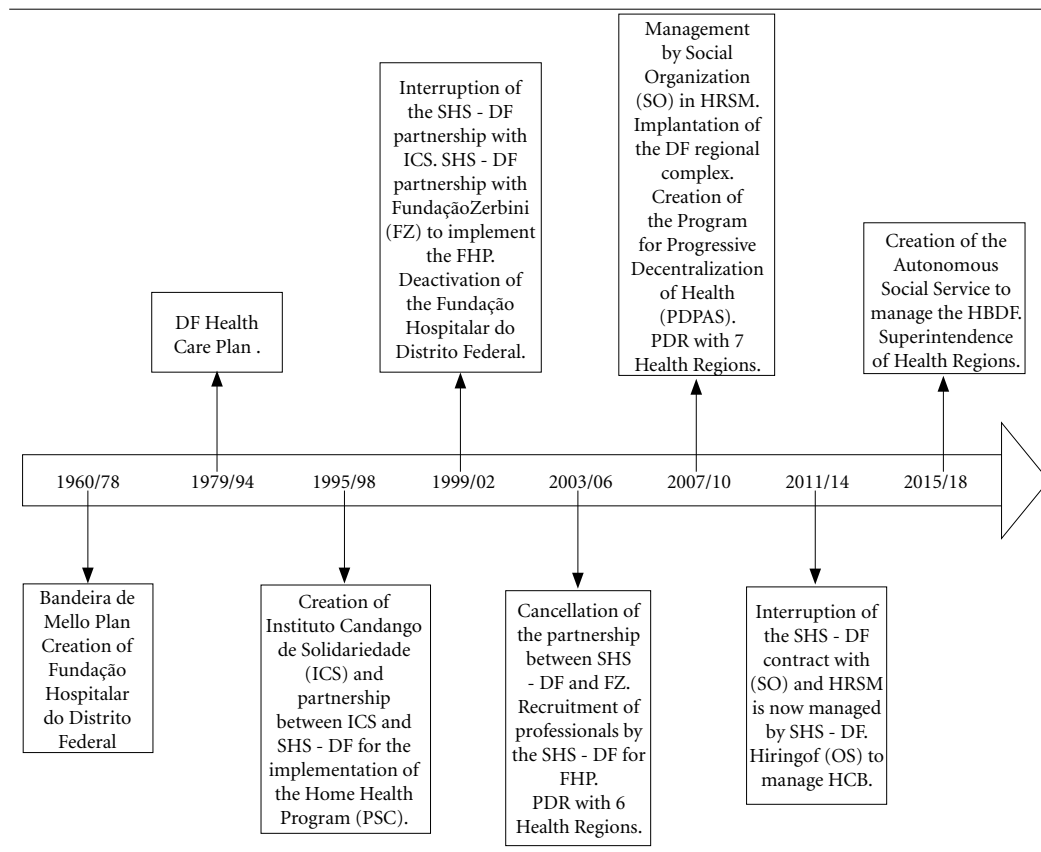


Figure 2. Chronology of the main changes in the DF health system management of the – 1960-2018.

Legends: HCB – Hospital da Criança da Criança; PDR – Plano Diretor de Regionalização; FZ – Fundação Zerbini; PFS – Programa Família Saudável; ICS – Instituto Candango de Solidariedade.

be paid by productivity; g) full-time employment regime; h) possibility of medical care for private patients; i) participation of the population in problem-solving through the Community Health Councils; k) convalescent home care services, avoiding lengthy hospital stays.

The Bandeira de Mello Plan had as its principles, the structuring of health services with a clear separation between the areas of executive and normative organ actions, obtained through the creation in 1960 of the *Fundação Hospitalar do Distrito Federal* (FHDF) as a central administration organ. After 1981 onward, with the creation of the State Health Secretariat of the Federal District (SHS-DF), both entities managed the health system until 1999, with the first being responsible for executive and operational activities; and the second, for the creation of health policies. The planning included the construction of a “high-complexity” hospital (currently Hospital de Base do DF), eleven general hospitals and six rural hospitals, surrounded by satellite units

capable of providing assistance to a population of 500,000 inhabitants¹¹⁻¹⁷. The guidelines aimed at treating the people in several clinical specialties, stimulating patient turnover and reducing hospital length of stay^{12,14}.

The plan proposed by Jofran Frejat in 1979¹³, inspired by the UK National Health System (NHS) and the Alma Ata ideals, proposed Primary Health Care (PHC) as a strategy for expanding coverage and population access to health services, with the provision of primary health care units in rural (rural units) and urban areas (health centers). However, due to the scarcity of physicians with generalist training following the example of the General Practitioners of that country, PHC was organized through doctors with specialized training in Gynecology, Pediatrics, Internal Medicine, plus epidemiologists and sanitarians to work in Health Centers for each 30,000 inhabitants¹³. This characteristic would represent the resistance of the medical corporation to the idea of PHC, considering that it changed the or-

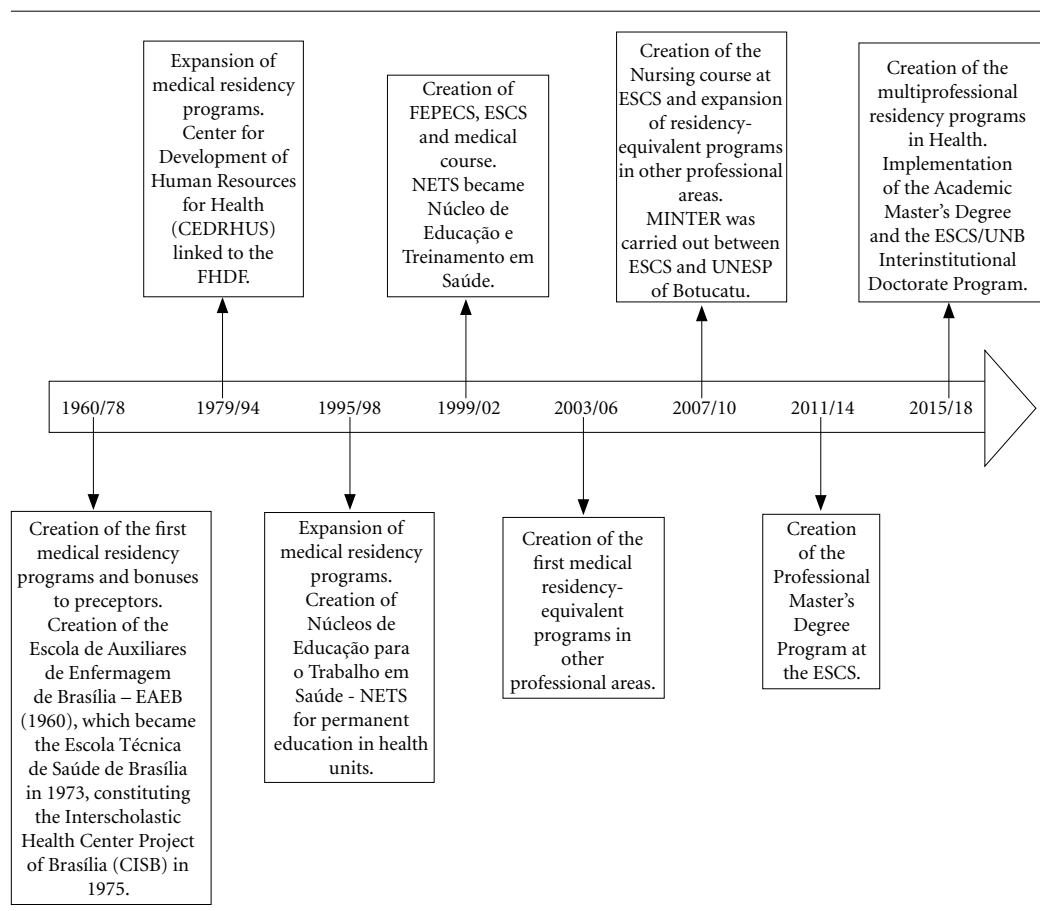


Figure 3. Chronology of the main health personnel training and development actions of the ESCS/FEPECS/SHS-DF – 1960-2018.

Legends: FEPECS – Fundação de Ensino e Pesquisa em Ciências da Saúde; ESCS – Escola de Ciências da Saúde; NETS – Núcleo de Educação para o Trabalho em Saúde; EAEB – Escola de Auxiliares de Enfermagem de Brasília; CISB – Centro Interescolar de Saúde de Brasília; CEDRHUS – Centro de Desenvolvimento de Recursos Humanos para a Saúde; UNESP – Universidade Estadual de São Paulo.

Table 1. Supply of health services, infant mortality, maternal mortality and life expectancy at birth in the DF. Brasília-DF, 2019.

Year	1993	2000	2010	2018
Population	1,657,841	2,043,169	2,570,160	2,972,209
N. of public hospitals	11	13	15	16
Operational beds	2,727	2,706	4,338	4,327
N. beds/1000 inhab/year	1.6	1.3	1.7	1.4
N. of physicians		2,570	4,683	5,466
Mean/1,000 inhab		1	2	2
N. of Nurses		1,070	2,216	3,547
N. of Nurses/1000 inhab		0.5	0.9	1.1
Child Mortality Rate **	25.43	15.27	12.16	
Life Expectancy Rate	68.60	73.20	76.00	
N. of maternal deaths / 100,000 LB		35.42	45.2	

N. = Number; inhab. = inhabitants; LB = living births

Notes: (*) In the period 2017/2018, all Health Centers started to operate as BHUs with Family Health Strategy Teams or Polyclinics, with the exception of 2 units, which continued as support. (**) Source: RIPSAs, 2012 (1990-2011) and SHS-DF (2012-017). Data from 2017 are partial.

Table 2. Evolution of the supply of PHC health services and population coverage from 1998 to 2018. Brasília-DF, 2018.

Year	N.HC	NºU/R HU	Total of BHUs	N.FHTs***	% coverage by FHTs***
1998	58	27	85	277	50.91
1999	59	24	83	121	22.59
2000	63	29	92	60	10.51
2001	61	30	91	60	9.87
2002	61	30	91	40	6.58
2003	61	31	92	0	0
2004	61	33	94	38	5.99
2005	61	37	98	40	6.3
2006	56	42	98	24	3.55
2007	62	41	103	33	4.77
2008	61	31	92	39	5.64
2009	61	31	92	92	12.41
2010	68	25	93	120	15.87
2011	68	39	107	110	14.77
2012	66	41	107	133	17.58
2013	66	41	107	154	20.06
2014	60	38	98	242	31.52
2015	66	49	115	246	32.04
2016	66	2	68	247	32.17
2017	66	2	68	259	33.74
2018	(*)	2	176	326	68(**)

Source: Data extracted from: http://dab.saude.gov.br/historico_cobertura_sf/historico_cobertura_sf_relatorio.php

Legend: HC – Health Centers; U/R HU – Urban and Rural Health Units; FHT – Family Health Teams

Notes: (*) In the period 2017/2018, all Health Centers started to operate as BHUs with Family Health Strategy Teams or Polyclinics, with the exception of 2 units, which continued as support. (**) A change was made in the DF, regarding the indicator that measures the population coverage by FHTs, which increased the amount of population per team, which is why there is a divergence between the data extracted from the MoH and the SHS-DF reports.

ganization of the profession up to that moment, creating different technical and social valuations among the specialties¹⁷. It also predicted the construction of regional hospitals in each “satellite city” and preserved the high-complexity hospital of the previous Plan. Its principles comprised the hierarchy of care, referral and counter-referral, as well as the regionalization of services. At its implementation, the hiring of health professionals was significantly increased, as well as service provision, especially in PHC, with a consequent improvement in indicators, particularly those related to infant and maternal mortality^{13,14}.

During this period, 12 general hospitals and at least 60 Basic Health Units (BHUs) were created, named Health Centers, Rural Health Units and Urban Health Units, which were differentiated by the staff profile and services provided, with Health Centers having a more comprehensive staff¹²⁻¹⁴. Public entities were also created and implemented for the management and supply of basic health system services, such as the Central Laboratory, created in 1978 (formerly the DF Health Institute) and the Hemocentro Foundation, created in 1991¹⁸.

For the training of health personnel, the creation of the School of Nursing Aides of Brasília (EAEB) in 1960, transformed in 1973 into the Technical School of Health of Brasília (ETESB) was the highlight. The first specialized medical training initiatives also took place, through courses for the technical improvement of these professionals, in the Hospital Distrital de Brasília (HDB) in 1960, with the objective of attracting recently graduated medical professionals and six-year undergraduate medical students to the city^{14,19}. In 1964, the creation of the Medical Residency and Internship system was officially established through Resolution N. 37/64 of May 11 of that same year. In that year, the first professionals, who would comprise the first official medical residency class in 1966, started their studies^{14,19}.

Period from 1995 to 2002 – the changes in DF Primary Care and the training of the health personnel

The period from 1995 to 2002 comprised two terms of elected governors for the DF. In the field of health, this period was highlighted by proposals of changes in PHC organization aiming at increasing the population’s coverage and changing the care model. The period from 1995 to 1998 are highlighted, with the implementation of the Home Health Program (PSC), which would be equivalent to the former Family Health Program, later called the Family Health Strategy.

In 1995, the Instituto Candango de Solidariedade (ICS) was created to develop social projects associated to government sectors, with the First Lady of the Federal District as its president¹⁷. This entity was responsible for supporting the implementation of the PSC in the period 1996-1999. This way of implementing PHC in the DF differs regarding two respects: it changed the model of primary care developed until that moment and created a nongovernmental entity responsible for

the physical infrastructure, installation of teams and hiring of health professionals¹⁷.

The management of DF's health system was also subject to remodeling in this period, through the public administration reforms supported by the Federal Government, which culminated in the process of the FHDF deactivation in 2000. With that, the executive, control and evaluation functions became the responsibility of the SHS-DF.

Another important milestone in the Federal District health management was the creation, in 2000, of the Federal District Constitutional Fund (FCDF), through Law N. 10,633, dated of December 27, 2002²⁰. The FCDF consists of government budget resources, which are intended for the entire funding of public security and partially of public health and education in the Federal District.

Regarding In the training and development of health personnel (Figure 3), the creation of Fundação de Ensino e Pesquisa em Ciências da Saúde (FEPECS²¹), the Escola Superior de Ciências da Saúde (ESCS) and the Medical Course in 2001 are highlighted. This Foundation became responsible for the maintenance of the ETESB and the ESCS, both responsible for the training of professionals at technical, undergraduate, postgraduate and extension and permanent education levels in health. The schools, in turn, stand out for the development of educational activities, integrated to the services and the community, having the SHS/DF units themselves as actual teaching scenarios and, consequently involving the health professionals working there²². Still in the field of training, in 1997, under Instruction N. 16, dated of 08/05/1997, within the scope of the FHDF, we highlight the creation of the Professional Education programs, analogous to the Residency Program for physicians, for Nursing, Nutrition, Dentistry, Mental Health and Physical Therapy professionals²³.

Period of 2003 to 2010 – the changes in the health system management

During the period of 2003 to 2010, there were two terms of elected governments in the Federal District, and the 2007-2010 period was interrupted in 2009, due to signs of corruption. The elected governor was initially replaced by the Speaker of the Legislative Chamber in 2009 and another Governor was elected by indirect elections in 2010.

In the health system management field, the first experience of managing public health services was implemented through the Social Health Organization (OSS). It consists of the Hospital Regional de Santa Maria, which was managed by the Real Sociedade Espanhola de Beneficência (RSEB), the object of the Management Contract n. 1/2009 - SHS-DF, which lasted until 2010. Incidentally, this experience was analyzed and did not prove to be advantageous from the point of view of cost reduction, with great difficulties related to the process of contract performance monitoring, being interrupted rather abruptly at the end of 2010²⁴.

Another important initiative of the SHS-DF, which has been under development since 2010, is the Program for Progressive Decentralization of Health Actions (PDPAS), created through Decree n. 31.625/2010²⁵, with the objective of assigning greater responsibility and managerial autonomy to the managers of Health Regions and Health Units.

The operation is carried out through the transfer of funds for the purpose of acquiring consumer material and medications, permanent materials and equipment, repairs to physical facilities, the hiring of services of legal entities and individuals, in accordance with legal regulations.

The use of these resources is prohibited for the payment of personnel expenses, taxes, bonuses, parties and receptions, travel and accommodation expenses, infrastructure works, except for minor repairs of structure, acquisition of vehicles, rental of computer equipment and advertising. The program limits the acquisitions by the amount of the expenses, as defined in Law N. 8.666/93²⁵.

In the field of personnel training, the creation of the Nursing course at the ESCS, which carried out the first National College Entrance Exam in 2009, was outstanding in this period. Similar to the medical course, the pedagogical project and the curriculum are guided by active teaching-learning methodologies and teaching-service integration, with teachers being selected among health professionals, especially nurses, with an employment relationship with SHS-DF.

Period of 2011 to 2018 - new changes in the management of hospitals and primary health care

In the period of 2011 to 2018, the sixth (2011 to 2014) and seventh (2015 to 2018) elected governments took office. In the health field, the most

significant changes occurred in the implementation of new management models in two hospitals and a new change in the PHC organization.

Significant changes also occurred in the Health Regions of the Federal District with the creation of Superintendencies responsible for the management of health networks in each of these territories and the establishment of goals and results between the Superintendencies of Health Regions and the Central Administration of the SHS-DF¹⁵ (Figure 2).

In 2011, the implementation of Hospital da Criança de Brasília José Alencar (HCB) was started, through a management agreement signed between SHS-DF and the Institute of Childhood Cancer and Specialized Pediatrics (ICIPE), a Social Organization created by the Brazilian Association of Assistance to Families of Children with Cancer and Hemopathy (ABRACE), especially for the purpose of managing HCB²⁶.

In 2017, the HBDF was transformed into an Autonomous Social Service and became known as the Instituto Hospital de Base (IHBDF), according to Law N. 5,899 of 2017²⁷.

The creation of this entity was motivated by the need to grant autonomy to the management of resources, in the acquisitions and hiring of personnel necessary for its operation, maintaining the public characteristic of all its actions.

In the period from 2015 to 2018 actions were taken to reorganize the PHC, with the aim of changing the configuration that had existed since the mid-1990s, of the coexistence of two models of PHC: BHUs with services organized through medical specialties and scheduled agenda that prevailed in the Pilot Plan and some Administrative Regions; and the FHS, organized according to principles of clientele assignment, family approach, linkage and longitudinality, among other principles, present in most Administrative Regions with greater social vulnerability^{17,28,29}.

As milestones of these initiatives, one can cite SHS-DF Ordinance N. 77³⁰, which establishes the norms and guidelines of the Primary Health Care Policy of the Federal District, and SHS-DF Ordinance N. 78³¹, which regulates Article 51 of Ordinance N. 77, by defining the conversion process from the PHC to the FHS model. The reorganization actions included the remodeling of the work process, the hiring and qualification of professionals, the extension of days and hours of BHU operation, among other changes.

This proposal was formulated in 2016 and 2017, as a complement to the “Brasília Saudável Project”³², presented in 2016, which proposed

a set of actions to strengthen the PHC and the Emergency Care Units (UPAS), through the hiring of OSS, similar to experiences of other Brazilian municipalities.

This proposal, however, was not fully approved by the DF Health Council (CSDF), especially the expansion of OSS participation in the management of health units. As a result, the CSDF created a Reform Committee for the Care Model / Management of Primary Health Care of the Federal District through CSDF Resolution N. 464 of 07/12/2016³³, which proposes guidelines that were summarized in CSDF Resolution N. 465 / 2016 of 10/24/2016³⁴. In Article 7 of this resolution, the CSDF limits the participation of public and private entities in the management of UPAS, providing that the actual need is justified. To identify and recognize the complementary characteristic of the Emergency Care Units (UPAs) in the health network of the Federal District, through an individual analysis of the characteristics of care in each service, in order to justify the adoption of alternative management models within the existing legal framework, with the possibility of establishing partnerships through a management contract with specialized entities, public or private, including educational institutions³⁵.

Regarding the training and development of health personnel, there was a significant expansion of medical residency programs and the creation of the first multiprofessional health and network residency-equivalent programs in the SHS-DF, under the coordination of ESCS/FEPECS. In addition, *stricto sensu* graduate programs were created at ESCS, in addition to the Professional Master’s Degree Program in Health Sciences in 2012 and the Academic Masters’ Degree in Health Sciences in 2016, as well as the Interinstitutional Doctorate Program in 2016, between ESCS and Faculdade de Ciências da Saúde of Universidade de Brasília. Previously, ESCS had been responsible for the Interinstitutional Master’s Degree program with UNESP of Botucatu, which promoted institutional learning and favored the creation of their own programs³⁴.

In 2014, the *Escola de Aperfeiçoamento para o SUS* (EAPSUS), was created, responsible for organizing courses corresponding to the needs pointed out by SHS-DF managers. This school has a strong role in the qualification of the clinical practice of professionals through the organization of permanent education activities, in which experienced professionals, with recognized experience in service provision and willing to share their knowledge, work as instructors in

theoretical-practical activities that continuously increase, constituting learning communities³⁴.

Evolution of the population's health conditions and the provision of services

In 2017, the Federal District had a population size estimated by Instituto Brasileiro de Geografia e Estatística (Brazilian Institute of Geography and Statistics - IBGE) of approximately three (3) million inhabitants, plus approximately two (2) million residents in the municipalities of the Integrated Development Region of the Federal District and Surrounding Areas (RIDE) (Complementary Law n. 94 of 1998)²⁸. SUS-DF has a network of its own, offering comprehensive care and services of different technological densities.

In 2018, there are 7962 available beds, of which 4482 (56.2%) are SUS-DF beds, belonging to 16 hospitals. PHC is developed in 168 BHUs, with 540 FHS teams, of which coverage reaches more than 2 (two) million inhabitants (68% of the resident population). There are 06 (six) UPAS and 14 (fourteen) regional laboratories, among several points of care, in addition to the associated units, such as: Hemocentro Foundation, Central Laboratory, FEPECS and CSDF²⁸.

The management of the public health system of the Federal District has the SHS-DF as its main entity, supporting and carrying out the different management activities, such as funding, planning, procurement and hiring of professionals. The funding is mostly provided by the local government's own resources, plus the transfer of resources from the Ministry of Health (MoH) and FCDF^{22,34}.

Over time, the health conditions of the DF population favorably changed, according to infant mortality and life expectancy at birth indicators (Table 1). Infant mortality decreased from 28.88 to 11.2 deaths per 1,000 live births from 1990 to 2017. On the other hand, life expectancy at birth increased from 68 years in 1993 to 77 years in 2013. These data indicate improvement of living conditions in the country's capital city.

When evaluating the data that characterize the public supply of health services in the Federal District (Tables 1 and 2), one can observe a significant population growth, but not an equal measure of growth in the supply of services when measured by beds per 1,000 inhabitants, which was constant throughout the period, despite the increase in the absolute number of hospitals and beds³⁴.

Regarding PHC, Table 2 shows that 277 FS teams were implemented in 1998, reaching

50.91% of population coverage. In the following year it decreased to 22.6%, followed by 10.5% in 2000, reaching 0% coverage in 2003. The recommencement of FHS implementation occurred in 2004, but only in 2108 the 1998 levels of coverage were reached once again (544 teams and 68% of population coverage). The ratio of doctors per 1,000 inhabitants, considering only those hired as public servants, increased in the period, as well as that of nurses.

Discussion

In this retrospective of the 58 years of the creation of the Public Health System in the Federal District, the characteristics of path dependence^{8,9} can be identified, going from moments in which the original idea reinforcement mechanisms overlap, and moments in which proposals for changes in the policy trajectory to overcome limitations are presented in its ability to promote, prevent, assist and restore the health of the population^{15,17,29}.

The implementation of the first plans for the organization of the Federal District health system resulted in the creation of most of the physical infrastructure of health services that are currently available in the Federal District. Emphasis is placed on the construction of large hospitals that have been maintained for at least 20 years, adding to these units all other strategies, such as the training of professionals, the incorporation of technologies, the way the system is managed and how health care is thought of. Since the 1980s, under the influence of new concepts and national and international guidelines, the emphasis has been placed on plans to strengthen PHC, to expand the population's access to services, and to promote innovative changes in the care model^{17,29,36,37}.

The PHC inclusion in the health policy agenda of the DF took place in the background and has undergone consecutive initiatives to change its organization during the subsequent government terms since 1994, when the Ministry of Health adopted the Family Health Strategy as the main model of PHC reorganization. Local political efforts then started to seek strategies to incorporate into the work's routine actions and services based on the recognition of the population's needs, apprehended from the establishment of relations between service users and health professionals, in permanent contact in the territory³⁶, characteristic of the FHS model.

It is noteworthy that in the last four years one dared to promote the restructuring of PHC

through the existing structures, without the inclusion of intermediary entities for the hiring of professionals, a recurrent practice in previous moments and in other Units of the Federation¹⁷. Moreover, the debates and expositions of this measure promoted by the local press and by the instances representing health discussion arenas, particularly the CSDF, have attracted the attention from important sectors of the population, which might (re)politicize the demonstrations in favor of SUS -DF.

Regarding the health system management, attention was drawn to the deactivation of the FHDF, which promoted the accumulation of operational and policy-making functions by the SHS-DF. The effects, although scarcely evaluated, include the difficulty of coordination, fragmentation and slowness in the acquisition operation, with the decision-making centralization in relation to budgetary-financial and human resources management. This predominant characteristic in the DF health system is in constant conflict with the strong decentralization in the provision of services in the Health Regions and Units, which are at risk, consume the supplies and that solve the health problems of the population¹⁷.

The SHS-DF administrative centralization has been credited with the main difficulties in supplying inputs, hiring of personnel in a timely manner and overall maintenance. This characteristic has also justified many projects that either go to public-private partnerships, or focus on administrative decentralization/deconcentration, such as the PDPAS²⁵ and the Regionalized Health Management Program¹⁵. There is not, however, a more in-depth analysis of other exogenous factors that imply difficulties in public health management, such as the likely budget deficit, the already known excesses by the control bodies, and the exhaustion of the Brazilian Bidding Law.

This scenario raises an important question: how to solve the contradiction between the accumulated centrality of health policy formulation and operationalization and the decentralization of services, given the current subdivision of the DF in Administrative Regions, according to its Organic Law. It is important to evaluate the decentralization processes that have already been carried out in the Federal District and in other Federal Units to build evidence that can contribute to future decisions.

The experiences of health personnel training and development in the Federal District represent a powerful innovation vector in health and education. Although their origin is characterized by the

dichotomy between technical training and intense medical specialization, the initiatives that unfolded since the 2000s, especially since the creation of the ESCS and the medical and multiprofessional residency programs, demonstrate the viability of the professional formation guided by the deep teaching-service-community integration, which are capable of contributing to the consolidation of SUS, since they associate the understanding of the objective and subjective aspects of human health to the daily practices and health services²².

This experience is also fruitful regarding the production of new knowledge and new public policies and has been an inspiration for other sectors, such as education and public security^{8,9}.

The quick assessment of the infant mortality and life expectancy at birth indicators shows there were improvements in the general living conditions of the population over the period of 1990 to 2017. On the other hand, the service provision indicators show the existence of assistance gaps related to hospital care and the instability in the population coverage by PHC, which has been well documented in the literature^{17,29}.

Thus, what can be observed in the SUS-DF trajectory is that a health system has been created here, one that considers the peculiarities of the DF as the country's capital, influenced by contingent (exogenous) factors, such as the demographic, nutritional, epidemiological transition and technological innovations³⁷, but showing the slow velocity of this system in adapting to these changes through internal reforms (organizational culture, organizational arrangements, assistance models, funding models, incentive systems and leadership)³⁷.

Conclusions

The DF health system has a complex organization, with different legal entities, purposes and health service deliveries to the population, including those that develop assistance activities of different complexities to the ones that deal with education, research and scientific development, which constitutes its strength. Moreover, the rapid examination of the SUS-DF trajectory shows that the structures and experiences of health personnel training and development with multi- and interdisciplinary characteristics and integrated health management and services, when well-coordinated, can provide feedback and drive the local public health system towards a new cycle focused on the population and their needs.

Collaborations

LBD Göttems and AMB Raggio – worked on the study's concept, design, data collection, analysis and interpretation, writing the manuscript and its critical review; MO Almeida – worked on the study's concept, design, data collection, analysis and interpretation; RJ Bittencourt – worked on the manuscript's critical review and approval of the version to be published.

References

- Oliveira LL. *A construção de Brasília*. [acessado 2018 Jun 14]. Disponível em: <http://cpdoc.fgv.br/producao/dossies/JK/artigos/Brasilia/Construcao>.
- Lassance A, Lopes CNS, Farias DD, Silva DC, Pereira MM. *Brasília: Capital do Brasil*. Brasília: Instituto Histórico e Geográfico do Distrito Federal, Pórfiro; 2003.
- Campos CEA, Cohn A, Brandão AL. Trajetória histórica da organização sanitária da Cidade do Rio de Janeiro: 1916-2015. Cem anos de inovações e conquistas. *Cien Saude Colet* 2016; 21(5):1351-1364.
- Brasil. *Constituição da República Federativa do Brasil*. Brasília: Centro Gráfico do Senado Federal; 1988.
- Brasil. Lei Federal nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 19 set.
- Brasil. Lei Federal nº 8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. *Diário Oficial da União* 1990; 28 dez.
- Souza C. “Estado do campo” da pesquisa em políticas públicas no Brasil. *Rev. Bras. Ci. Soc.* 2003; 18:15-20.
- Kay A. A critique of the use of path dependency in policy studies. *Public Administration* 2005; 83(3):553-571.
- Kwamie A, Dijk HV, Ansah EK, Agyepong IA. The path dependence of district manager decision-space in Ghana. *Health Policy and Planning* 2016; 31(3):356-366.
- Sá-Silva JR, Almeida CD, Guindani JF. Pesquisa documental: pistas teóricas e metodológicas. *Revista Brasileira de História & Ciências Sociais* 2009; 1(1):1-15.
- Kaniak CEA. Plano Geral da Rede Médico-Hospitalar para o Distrito Federal de Henrique Bandeira de Mello. *Rev Saúde Dist Fed* 1999; 10:52-53.
- Melo HB. Plano Geral da Rede Médico-Hospitalar de Brasília. *Revista do Serviço de Saúde Pública* 1959; XI(1).
- Frejat J. Sistema de saúde do DF: modelo para o país. *Rev Saúde Dist Fed* 1999; 10:53-59.
- Silva E. *A saga da Fundação Hospitalar no Distrito Federal: e a medicina da poeira e da lama*. Brasília: Copacabana; 2000.
- Göttems LBD, Raggio AMB, Oliveira A, Roque MV, Bittencourt RJ. A regionalização da Gestão da Saúde no DF: o caminho para a “ponta” virar centro. *Brasília em Debate* 2017; 17:22-27.
- Scartezini M. Hospital Juscelino Kubitschek de Oliveira (Ex-hospital do IAPI). *Rev Saúde Dist Fed* 1999; 10:66-70.
- Göttems LBD. *Análise da política de atenção primária a saúde desenvolvida no Distrito Federal: a articulação entre o contexto político, os problemas, as alternativas e os atores na formação da política de saúde (1979 a 2009)* [tese]. Brasília: Universidade de Brasília; 2010.
- Câmara Legislativa do Distrito Federal. Lei nº 206, de 13 de dezembro de 1991. Autoriza o Governo do Distrito Federal a criar a Fundação Hemocentro de Brasília e o Sistema De Sangue, Componentes e Hemoderivados (SSCH) e dá outras providências. *Diário Oficial do Distrito Federal* 1991; 16 dez.

19. Campos VDG. Residência Médica: Desafios e Perspectivas. *Com. Ciências Saúde* 2015; 26(1/2):7-8.
20. Brasil. Lei nº 10.633, de 27 de dezembro de 2002. Institui o Fundo Constitucional do Distrito Federal – FCDF, para atender o disposto no inciso XIV do art. 21 da Constituição Federal. *Diário Oficial da União* 2002; 30 dez.
21. Câmara Legislativa do Distrito Federal. Lei nº 2.676, de 12 de janeiro de 2001. Cria a Fundação de Ensino e Pesquisa em Ciências da Saúde e dá outras providências. *Diário Oficial do Distrito Federal* 2001; 15 jan.
22. Silva VO, Santana PMMA. Conteúdos curriculares e o Sistema Único de Saúde (SUS): categorias analíticas, lacunas e desafios. *Interface (Botucatu)* 2015; 19(52):121-132.
23. Mineto RC. Residência em enfermagem do Hospital de Base do Distrito Federal: avaliação dos ex-residentes. *Com. Ciências Saúde* 2008; 19(2):155-162.
24. Nascimento ICR. *A experiência do contrato de gestão no DF: o caso do Hospital Regional de Santa Maria* [monografia]. Brasília: Universidade de Brasília; 2011. [acessado 2018 Jun 14]. Disponível em: http://bdm.unb.br/bitstream/10483/2837/6/2011_Isabel_CristinaRigottidoNascimento.pdf
25. Governo do Distrito Federal. Decreto nº 31.625, de 29 de abril de 2010. Institui o Programa de Descentralização Progressiva de Ações de Saúde (PDPAS) para as Diretorias Regionais de Saúde e as Unidades de Referência Distrital da Rede Pública de Saúde do Distrito Federal. *Diário Oficial do Distrito Federal* 2010; 30 abr.
26. Governo do Distrito Federal. Secretaria de Estado da Saúde do Distrito Federal. *Plano Distrital de Saúde 2016-2019*. Brasília; 2016 [acessado 2018 Jun 14]. Disponível em: http://www.saude.df.gov.br/wp-content/uploads/2017/11/PDS_2016-2019_OFICIAL_Parte_I-1.pdf
27. Câmara Legislativa do Distrito Federal. Lei nº 5.899, de 03 de julho de 2017. Autoriza o Poder Executivo a instituir o Instituto Hospital de Base do Distrito Federal – IHBDF e dá outras providências. *Diário Oficial do Distrito Federal* 2017; 4 jul.
28. Distrito Federal. Secretaria de Estado da Saúde do Distrito Federal. *Relatório Anual de Gestão*. Brasília; 2017. [acessado 2018 Jun 14]. Disponível em: <http://www.saude.df.gov.br/wp-content/uploads/2017/11/RAG-2016-Parte-I.pdf>
29. Göttems LBD, Evangelista MSN, Pires MRGM, Silva AFM, Silva PA. A trajetória da política de atenção básica à saúde no Distrito Federal. *Cad Saude Publica* 2009; 25(6):1409-1419.
30. Distrito Federal. Secretaria de Estado da Saúde. Portaria nº 77, de 14 de fevereiro de 2017b. Estabelece a Política de Atenção Primária à Saúde do Distrito Federal. *Diário Oficial do Distrito Federal* 2017; 15 fev.
31. Distrito Federal. Secretaria de Estado da Saúde. Portaria nº 78, de 14 de fevereiro de 2017. Regulamenta o art. 51 da Portaria nº 77, de 2017, para disciplinar o processo de conversão da Atenção Primária à Saúde do Distrito Federal ao modelo da Estratégia Saúde da Família. *Diário Oficial do Distrito Federal* 2017; 15 fev.
32. Distrito Federal. *Projeto Brasília Saudável: fortalecimento da Atenção Primária à Saúde no Distrito Federal*. [acessado 2018 Jun 14]. Disponível em: http://www.coren-df.gov.br/site/wp-content/uploads/2016/06/BRASILIA_SAUDAVEL_DOCUMENTO_REFERENCIAL.pdf
33. Distrito Federal. Conselho de Saúde do Distrito Federal. Resolução CSDF nº 464, de 12 de julho de 2016. *Diário Oficial do Distrito Federal* 2016; 29 jul.
34. Distrito Federal. Secretaria de Estado da Saúde do Distrito Federal. *Relatório Anual de Gestão*. Brasília; 2017. [acessado 2018 Jun 14]. Disponível em: <http://www.saude.df.gov.br/wp-content/uploads/2017/11/RAG-2016-Parte-I.pdf>
35. Distrito Federal. Conselho de Saúde do Distrito Federal. Resolução CSDF nº 465, de 04 de outubro de 2016. *Diário Oficial do Distrito Federal* 2016; 24 out.
36. Oliveira MAC, Pereira IC. Atributos essenciais da Atenção Primária e a Estratégia Saúde da Família. *Rev Bras Enferm* 2013; 66(esp):158-164.
37. Mendes EV. 25 anos do Sistema Único de Saúde: resultados e desafios. *Estud. Av.* 2013; 27(78):27-34.

Article submitted 15/06/2018

Approved 06/02/2019

Final version submitted 27/03/2019