

The challenge of organizing a universal and efficient National Health System in the Brazilian federal pact

O desafio da organização do Sistema Único de Saúde universal e resolutivo no pacto federativo brasileiro

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Abstract

Since the establishment of the Brazilian National Health System (SUS), important challenges remain to guarantee the right to health in the country. This theoretical reflection on the organization of SUS was based on interviews with social and health policy actors in the country, analysis of indicators related to municipalities, population, healthcare network and financing of the health system and from a critical yet not systematic foundation, guided by the conceptual framework of universalization, public oversight, financing of needs and decentralization of SUS. Universal health systems are considered as the most responsive to the population's needs. However, underfinancing challenges their consolidation, with a nearly unchanged percentage of federal spending as a portion of gross domestic product (GDP), despite the actual growth of the total expenditure on health between 2000 and 2012, which reflects economic growth. A stability that does not respond to the growing needs of the health system. In Brazil, the federative pact and the organization of SUS based on the municipality, mostly with less than 30 thousand inhabitants, hinder the organization of health networks, compromising the system's resolution, an understanding that reinforces the need for conformation of population-based territories. These are challenges that need to be addressed and that demand the recovery of the ideals of the Brazilian Sanitary Movement. The moment requires a resistance action, in defense of SUS, to ensure universality, unquestionably the greatest social achievement of the Brazilian population.

Keywords: Brazilian National Health System; Regional Health Planning; Government Financing.

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Resumo

Desde a implantação do Sistema Único de Saúde (SUS), persistem importantes desafios para garantia do direito à saúde no país. Esta reflexão teórica acerca da organização do SUS foi elaborada a partir da realização de entrevistas com atores da política social e de saúde do país, da análise de indicadores referentes aos municípios, população, rede assistencial e financiamento do sistema de saúde e de uma fundamentação teórica crítica, porém não sistemática, orientada pelo marco conceitual da universalização, do controle social, do financiamento das necessidades e da descentralização do SUS. Os sistemas de saúde universais são considerados os que melhor respondem às necessidades da população. Entretanto, o subfinanciamento desafia sua consolidação, com um percentual quase inalterado dos gastos federais como proporção do produto interno bruto (PIB), apesar do crescimento real dos gastos totais com o setor da saúde entre 2000 e 2012, reflexo do crescimento econômico. Trata-se de uma estabilidade que não responde às necessidades crescentes do sistema de saúde. No Brasil, o pacto federativo e a organização do SUS com base no município, na sua maioria com menos de 30 mil habitantes, dificulta a organização das redes de saúde e compromete a resolutividade do sistema, entendimento que reforça a necessidade de conformação de territórios de base populacional. Esses são desafios que precisam ser enfrentados e que exigem o resgate dos ideais do Movimento Sanitário Brasileiro. O momento exige uma ação de resistência, em defesa do SUS, para assegurar a garantia da universalidade, indiscutivelmente a maior conquista social da população brasileira. **Palavras-chave:** Sistema Único de Saúde; Regionalização; Financiamento Governamental.

Introduction

Issues related to state reform and social security were not part of the country's left-wing debates until the 1970s, when the struggle for redemocratization and citizens' rights became the center of political debates. In this context, efforts were directed towards strengthening social public policies and building a welfare state (Fleury, 2009).

For the advocates of the Brazilian Sanitary Movement, the health system in force at the time privileged medicalization, privatization and physician-centered action, which neglected public health and social issues, deepened inequalities and strengthened the health system fragmentation (Pêgo; Almeida, 2002).

As a result of this movement, the Brazilian National Health System (SUS) was established as a federative system with the participation of the three government spheres, with universal and free services throughout the national territory, including decentralization as a basic guideline and with the constitutional mechanism of public control, by means of public oversight (Mendes, 2002).

With its establishment, Brazil has become the only Latin American country with a universal health system, approaching the experience of countries such as "United Kingdom, Sweden, Spain, Italy, Germany, France, Canada and Australia" (Marques; Mendes, 2012, p. 346). It was the greatest policy of social inclusion in history, which severed an unjust division and transformed health into a right to every citizen and a duty of the State (Mendes, 2013).

However, given its complexity and the difficulty in building a universal health system in a heterogeneous country such as Brazil, persistent challenges constantly emerge related to issues, such as organization and fragmentation of policies, insufficient funding, the complex relations between the public sphere and the market, weaknesses in regulatory processes and health inequalities that remain and mark Brazilian society (Machado; Baptista; Nogueira, 2011).

Therefore, the challenge lies in the guarantee of a social right that must be ensured by the State and, with the iniquities that characterize the country, it must be managed under the responsibility of

municipalities, states and the Union, autonomous spheres of governing (Viegas; Penna, 2013).

This study proposes to analyze the organization of SUS in the Brazilian federative pact, pointing to possible ways to ensure the principles and guidelines that guide it.

Traversed path

The need to reflect on the organization of the health system in the country arose from a study conducted during a PhD dissertation, which aimed to analyze the relationship between public health-care and demographic, epidemiological and social changes in Brazil from 1995 to 2010.

In order to subsidize the theoretical reflection on the main challenges for the consolidation of SUS, eight actors were interviewed who occupied important functions in the Brazilian health management (the former Minister of Health, the former Secretaries of the Ministry of Health, the former State and Municipal Secretaries of Health) and in the legislative power, as well as health intellectuals and planners.

The analysis of the interviews was conducted with the analysis method of meaning condensation, proposed by Kvale (1996), which guides the definition of central themes and, finally, the performance of a synthesis, through an essential description that includes the themes identified in the interview and related to the objectives researched.

The essential description of the perceptions presented by the participants made it possible to systematize this essay, contributing to the reflection on the federative pact and the organization of the health system.

Based on a critical but non-systematic theoretical basis guided by the conceptual framework of universalization, public oversight, financing of SUS needs and decentralization, the essay aimed at understanding the complexity of the Brazilian health system.

Thus, in order to contextualize the discussions, indicators related to the municipalities, the population, the healthcare network and the financing of the country's health system were analyzed.

Therefore, recognizing the incompleteness and uncertainty of reality, as well as the multiple con-

nections between its components (Tôrres, 2009), the combination of different points of view was conducted, which resulted in a data triangulation – a phenomenon that amplifies the perception of the movements, structures, subjects' actions, indicators and relationships between micro and macro realities (Minayo, 2005).

This essay did not intend to exhaust the reflection regarding the complex organization of SUS, even though it debated fundamental questions for the consolidation of the health system. Therefore, due to the topic's depth, it is not conclusive, although it contributes to the understanding of the country's health policy.

The essay aims to strengthen the debate on the challenges that surround SUS and to strengthen the need to restore health as a political priority, reorienting the planning and directing specific policies aimed at improving the quality of healthcare offered to the population.

The organization of SUS in the Brazilian federative pact

Solidarity, universality and equity are principles that are closely related to equal access to health actions and services (Sojo, 2011). SUS was established in the Federal Constitution of 1988, an accomplishment of the Brazilian Sanitary Movement, ensuring health as a citizen's right and a duty of the State, with the healthcare based on the principles of universality, equity and integrality (Paim et al., 2011; Teixeira, 2011).

Over the years, in response to current growing needs and to technological and scientific development, universal health systems have been considered to be the most responsive to the needs of the population as well as the ones that most contribute to the economic development of a country.

In the Brazilian history, the guarantee of universality addressed a social gap and represented the beginning of the implementation of the health sector reform. The duty of the State was first ensured in a Constitution, and represented by the responsibility of the organization of a single, national, public and universal health system. However, after nearly 30 years, the system and its advocates face major challenges.

These are issues that have existed since the implementation of the system and that aggravate the threats imposed for its operation in times of political and economic crisis.

The triple organization, with the autonomy of the government spheres, complexified the development of the health system, since municipalities, states and Union do not possess hierarchic relationships between one another (Almeida-Filho, 2009; Dourado; Elias, 2011).

Municipalities, formerly agents, became key actors in the system. And this organization, having the municipality as its main sphere, hinders the offer of actions and health services in a resolute and timely manner. The only country in the world with this level of decentralization, the non-differentiation between federative entities is a complicating element in the organization of health networks in Brazil.

According to Campos (2014), among countries with universal health systems, only Brazil has an organization with the autonomy of the three federative entities. In other countries, health system planning and management are regional, with no decentralization at the municipal level. In Spain, for example, it reaches the state level, and in Italy, the regional level.

It is a country with a continental size and that is composed of municipalities of small size in its majority, almost 80% of the Brazilian cities have less than 30 thousand inhabitants. In addition to municipalities with up to 100 thousand inhabitants, they represented less than 45% of the Brazilian population in 2015 (IBGE, 2016).

Together, these municipalities concentrated only 25% of physicians with ties to SUS. The largest proportion (35.2%) was located in municipalities with more than one million inhabitants, only 17 cities in the country, which had a ratio between the numbers of physicians and inhabitants three times higher than those with less than 30 thousand inhabitants (Brazil, 2016).

According to Rodrigues (2014), during the decentralization, this diversity of Brazilian municipalities was not considered. Many cities did not have enough inhabitants to implement a proper health system, with different levels of its complexity.

Most of the small municipalities depend on federal government transfers to support their health structure. Nearly all of them have already reached or exceeded the constitutional limit of spending defined by the 29th Constitutional Amendment. In 2015, municipalities spent an average of 22%¹ of their own budget, which is above the amount defined by the Constitutional Amendment.

In adjusted amounts according to the Extended Consumer Price Index (IPCA) on December 31, 2012, total public health expenditure per capita presented a growing trend, with mean annual increase of R\$ 40.76, from R\$ 438.00 in 2000 to R\$ 903.52 in 2012. The lowest proportional variation was obtained in the federal expenditure per capita, which increased 61.2% in the period studied, when municipal per capita expenditure increased by more than 180%.²

There was an increase of 106.5% in total health expenditures in updated values between 2000 and 2012, with a greater participation of the states and municipalities in their financing. The figures surpassed the period's cumulative inflation, due to the country's high economic growth, identified by the real GDP increase of 74.4%.²

However, despite being the largest financing source of the system, the proportion of federal health expenditures from the percentage of GDP has remained constant, standing at 1.82% in 2012.²

It is a stability that does not respond to the growing needs of the health system. The difficulties related to financing have been present since the implementation of SUS, a period when the country faced an economic crisis that, combined with the liberal position of the State, reduced the state's performance in public policies.

States and municipalities reaching or exceeding the constitutional limit of health spending (Saiani;

1 BRASIL. Ministério da Saúde. Secretaria Executiva. Departamento de Economia da Saúde e Desenvolvimento. *Sistema de Informações Sobre Orçamentos Públicos*. 2016. Disponível em: <<https://goo.gl/kYkQZ4>>. Acesso em: 4 jul. 2016.

2 BRASIL. Departamento de Informática do Sistema Único de Saúde. Indicadores e Dados Básicos: Brasil: 2012. 2014. Disponível em: <<http://bit.ly/2sjN1iS>>. Acesso em: 4 jul. 2016.

Galvão, 2011) reinforces the challenge of financing the public health system, due to the complexity of the services provided to the current and future health demands of the population and the decentralization of responsibilities.

Since the beginning of the SUS, therefore, financing has been a major challenge for the health system in order to ensure universal, integral and equitable access to actions and healthcare services.

Since 1988, Constitution did not clarify the financing rules, since 1993 Proposals for Constitutional Amendments have conferred responsibilities and resources for health. However, it was only in 2011 that 29th Constitutional Amendment was effective (Fortes, 2012), and to date the federal participation in health financing has not been defined, with an average of 1.70% of GDP between 2000 and 2012.

According to Soares and Santos (2014), countries such as Spain, Canada, France and the United Kingdom, which also have a universal health system, spend between 7% and 8% of their GDP on public health actions and services. In Brazil, this expenditure reached 3.99% of the country's GDP in 2012, a lower percentage if compared to the investment made by other countries with universal health systems.²

In addition to the insufficiency, new threats are added, such as the approval of the tax budget, which consolidates the under-financing of the system, the authorization of foreign capital investment in healthcare (Bahia, 2015) and the approval of the 55th Constitutional Amendment, which freezes the public spending for 20 years and jeopardizes the achievements in the period. This represents a setback for the consolidation of the health system itself and disregards the need for public investment to respond to the difficulties originated from Brazilian demographic and epidemiological transitions - a window of opportunity (Miranda; Mendes; Silva, 2016), which, if used with the rightful and necessary investments, may potentialize demographic opportunities and contribute to the reduction of severe inequalities.

More up-to-date than ever, the answer to this question is sought after: "How much is society willing to pay for SUS?" The system's security calls for the politicization of the population and the defense of universality (Menicucci, 2009, p.1625).

To this set of challenges, the difficulties of making the space correspond to the territory and to the population are added, as well as the political-administrative organization of a municipality being equivalent to a regionalized and service-oriented network (Acirole, 2012).

In this context, the formation of population-based territories and the strengthening of health networks, in the face of consolidation of pacts and the mediation of political conflicts between government spheres, become essential actions for the organization of the system and for the health demands.

This understanding reinforces the importance of health networks in order to organize, in an integrated way and under the coordination of primary healthcare, the points of care, support systems, logistical systems and the governance system (Mendes, 2013).

The limit imposed by this fragmentation has been acknowledged since 2002 by the public management, which has proposed pacts to surmount the fragility in the political organization of SUS, however, these plans have not been enough to address the problem. The disparity between the municipalities' capability of governance has negatively affected the organization of the health system.

In the last decades, the Ministry of Health has adopted mechanisms to surmount the tensions imposed by this fragmentation, through pacts signed between the government spheres. These are changes that represent advances in SUS's policy of pacts, but exclusively those do not guarantee the achievement of the expected results (Guerreiro; Branco, 2011; Lima et al., 2012).

It is necessary, therefore, to create instruments that enable the organization of a resolute, integral, and equitable health system, as well as spaces that stimulate debate and promote the reformulation of sanitary responsibilities, redesigning the healthcare model and consolidating permanent spaces for dialogue and health system development, aiming at, according to Acirole (2012), the expansion of the regionalization and the search of equity, through the organization of functional health system at all care levels, not necessarily exclusively for municipal territories.

The scenario points to an urgent need for a reform and the development of policies that surpass

the current organizational model based on the municipality to a regional model, by conformation of the health networks

Santos and Campos (2015) point to the urgent need to debate the institutionalization of the country's health system. Proposing changes in the organization of SUS, the authors center the discussion on the conformation of robust health regions, capable of responding to at least 95% of the health needs of the regional territory and to ensure sanitary autonomy.

Final Remarks

It is necessary to create spaces for the discussion of the main aspects that hinder the consolidation of SUS, studying sanitary responsibilities and the role of the government spheres. Almost 30 years later, it is concluded that the debates must point to the necessary paths for the planning of policies that surmount current and future challenges, but that guarantee the citizen's social right of universal access to health.

In addition, it is fundamental to surmount the formal character of the norms and guidelines instituted since the implementation of SUS, promoting the articulation between the three government spheres to act in as a collective group capable of consolidating the health networks and reducing the inequalities that mark the Brazilian society.

Facing the challenge of the health system's underfunding, in a scenario of political and financial crisis, demands the recovery of the ideals that legitimized the Brazilian Sanitary Movement. The moment demands an action of resistance, in defense of SUS, to ensure the guarantee of universality, indisputably the greatest social achievement of the Brazilian population.

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Authors' contribution

Miranda and Mendes participated in the project design and writing of the article. All authors contributed to the data analysis, interpretation and critical review of the article.

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