

National Policy for Hospital Care: con(di)vergences among the Federal Executive's rules, Conferences and strategies

Política Nacional de Atenção Hospitalar: con(di)vergências entre normas, Conferências e estratégias do Executivo Federal

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ABSTRACT This paper is aimed at analyzing the National Policy for Hospital Care and its convergences and divergences regarding National Health Conferences and National Health Plans in the 1988 Brazilian Federal Constitution. Documents were collected from January to June 2016, then processed and analyzed until December 2016. Results on policy making were subdivided into pre-decision and decision periods. In the first one, the normative character pointing to the formalization of contracts and the decentralization of hospital management at the state level can be highlighted. During the decision period, the indirect management model was strengthened, thus enhancing tensions involving decisions made in Conferences.

KEYWORDS Public health policy. Policy making. Public hospitals.

RESUMO *Objetivou-se analisar a formulação da Política Nacional de Atenção Hospitalar e suas convergências e divergências com as Conferências Nacionais de Saúde e aos Planos Nacionais de Saúde no pós Constituição Federal de 1988. Os documentos foram coletados entre janeiro e junho de 2016 e tratados e analisados até dezembro de 2016. Os resultados quanto à formulação da política foram subdivididos nos períodos de pré-decisão, de 1988 a 2002, e decisão, de 2003 a 2013. No primeiro, foi marcante o caráter normativo voltado para a contratualização e descentralização da gestão hospitalar em nível estadual. Na decisão, houve crescimento da gestão indireta, aprofundando o tensionamento frente às deliberações das Conferências.*

PALAVRAS-CHAVE *Políticas públicas de saúde. Formulação de políticas. Hospitais públicos.*

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Introdução

Hospital care is an important theme in the analysis of health public policies and the target of persistent concern on the part of managers, due to the complexity and challenges that characterize this area. It has been fostered since colonial times and, during the republican and dictatorial governments in the centuries that followed, has strengthened the liberal welfare model centered on physicians and hospitals.

Hospital organization has changed over the centuries. From the original religious concept as an institution addressed to the dying, hospitals became tools for therapeutic-healing medical practices and research, which led to the emergence of clinics and the modern concept of the 19th century, when the disciplinary model based on power relationships was developed (FOUCAULT, 2015). In the second half of the 20th century, in the postwar period, the hospital structure and number of available beds were enlarged, and this became a central concern of national health systems (BRAGA NETO ET AL., 2012).

Adjustments in the hospitals' profile in order to fulfill new functions were required to face challenges that involved financial sustainability and social relevance, and considering that Brazilian State is deemed accountable for the right to health (RIBEIRO; DACAL, 2012). This socio-historical phenomenon, linked to the re-adjustment of Brazilian hospital organization, took place in the process of creation and implantation of the Unified Health System (Sistema Único de Saúde – SUS) (BRAGA NETO ET AL., 2012).

Since the last decade of the 20th century, this level of care was hegemonic, financially very costly, adopting the superposition of varied technologies and requiring the training of specialized personnel (SOLLA; CHIORO, 2012). As to the management, directors had little technical-administrative autonomy, and there were bureaucratic obstacles related to fiscal accountability, auction requirements and the process of outsourcing personnel (NOGUEIRA, 2011).

By the end of the first decade of the 21st century, hospitalizations were concentrated in

the Southeast and Northeast regions; as public hospital beds were not enough, complementary units were provided under contract, in order to improve the number of beds *per* inhabitants; and new, mainly smaller hospitals (Hospitais de Pequeno Porte – HPP) were created, based on management decentralization (PAIM ET AL., 2011).

It must be stressed that the private sector is now maintaining and innovating its relationship with the public sector (PAIM ET AL., 2011), which places the public-private relation among the analytical dimensions of SUS implantation and the State's role in this process (HEIMANN ET AL., 2011). It is relevant, therefore, to understand the process that led to the formulation of the 2013 National Policy for Hospital Care (Política Nacional de Atenção Hospitalar – PNHOSP).

Once 1988 Brazilian Federal Constitution (CFB/1988) included regulations for the hospital care provided by SUS, legal documents from the Federal Executive Power were created over 25 years – from 1988 to 2013 – and were used in the process to formulate the ruling basis of SUS Hospital Care. Therefore, as the phenomenon of formulation of Hospital Care policies in Brazil in the period following the Constitution's promulgation is made clear, and considering the gap identified in the scientific production, this paper aimed at analyzing the formulation of PNHOSP, besides its convergences and divergences regarding the National Health Conferences (Conferências Nacionais de Saúde – CNS) and the National Health Plans (Planos Nacionais de Saúde – PNS) that followed the 1988 Federal Constitution.

Methods

This is a qualitative and exploratory documental analysis (MINAYO, 2012) and public policies analysis (PINTO; VIEIRA-DA-SILVA; BAPTISTA, 2014), adopting the theoretical conception of Public Policy Cycle, particularly as to the phase of policy formulation as an analytical referential (HOWLETT; RAMESH; PERL, 2013).

The time interval considered was the

25-year period between the CFB/1988 and the PNHOSP/2013. The documental research was electronically performed from January to June 2016, by means of a public site including 39 documents – three laws, two decrees, 24 administrative rules, seven reports of National Conferences and three National Health Plans. The documents were thoroughly read in order to identify aspects inherent to the management of hospital care and the chronological organization of the documental contents, which were associated with the respective periods of the federal government: from president Sarney government to president Dilma government (first term), up to December 2016. The critical

perspective was based on the triangulation of those findings with CNS recommendations from 1988 to 2013 and with strategies defined in both 2004 and 2005 PNS, and convergences with PNHOSP. *Chart 1* presents a synthesis of reflections on political-administrative periods, normative-legal landmarks and dis-alignments in governmental strategies.

This study is linked to the project Analysis of Policies and Health in Brazil (2003-2017), which is part of the research named 'Alternative Management Models in Hospital Care by SUS Bahia', and was approved by the Ethics Committee in Research (CAAE 41872715.2.0000.5030).

Chart 1. Con(di)vergences among norms, Conferences and strategies by the Federal Executive in PNHOSP formulation, per government period

Periods	First normative period of formulation					Second normative period of formulation		
Governs	Sarney	Collor	Itamar	FHC 1	FHC 2	Lula 1	Lula 2	Dilma 1
Dimensions	1985-89	1990-92	1992-94	1995-2002		2003-10		2011-14
Political-administrative	<p>Along the democratization process, this period became the legitimating perspective as CFB and LOS were sanctioned. In this period, SUS was created as a social welfare element, with directives that involved decentralization, integrality and social control. SUS was launched along with NOB and Noas, Five different federal governments were elected over this period, characterized as: development-driven, with neoliberal agenda, inflationary control, specific tributes destined to the health area, normative procedures aimed at purchases and contracts, and contracts by the public power and administrative modernization. New managerial procedures were implemented as neo-developmental practices took place with privatization plans, reduction of public civil service, selectivity of social policies and social welfare reform.</p> <p>Administrative landmarks:</p> <ul style="list-style-type: none"> - CFB/1988: exposing the principles of the public administration (legality, impersonality, morality and publicity) and its configuration as either direct or indirect character (by means of autarchies and foundations); - Law #8666/1993: established norms for bids and contracts by the public administration; - EC #01/1994: created the Social Emergency Fund (FSE); - Mare/1995: a ministry was created to be responsible for the Directive Plan for Reforming the State Operational Structure (PDRAE); - EC #19/1998: includes the principle of efficiency in public administration; - Law #9637/1998: created OS along with the National Publicizing Program; - Law #9790/1999: created the Civil Society Organizations of Public Interest (Oscip) and the Partnership Agreement; - Law #101/2000: established public norms for fiscal management responsibility; - EC #27/2000: renaming the Emergency Social Fund (FSE) to Disentailing of the Union's resources (DRU). 					<p>Started during the fifth post-Constituent government elected, it was characterized by continuity known as neo-developmental, socio-liberal character. Consequently, the agenda was built on inclusion, social policies and incentives for income re-distribution.</p> <p>Concerning administrative procedures, transparency and State control were improved and public management strategies aimed at partnerships and concessions were widened. Remarkable normative remodeling of health care procedures, specifically as to hospital care, stressing inter-sector procedures and relation between the different care levels.</p> <p>Administrative landmarks:</p> <ul style="list-style-type: none"> - Law #1.1079/2004: established general norms for PPP bid-dings and contracts in the public administration sphere; - Administrative Act #161/2010: established cooperation among public entities; - Administrative Act #1.034/2010: rules for complementary participation of either private or non-profit institutions; - Complementary Act #141/2012: rules for minimum values to be paid for health services in the government spheres; - Law #12.550/2011: creates the EBSERH; - Law #13.019/2014: creates the Organization of Civil Society (OSC); - EC #42/2003, EC #56/2007, EC #68/2011: DRU renewals. 		

Chart 1. (cont.)

Legal normative landmarks of the Health Policy	<p>1986: VIII CNS; 1988: Created the new CFB, where health is considered a social right and a State duty, services are linked to SUS and may be either public or private, rendered as straightly public, complementary and supplementary;</p> <p>1990: LOS #8080 and #8142; 1991: NOB 91; 1993: NOB 93; 1996: NOB 96;</p> <p>2000: EC #29, altering articles and assuring, under the Constitution, minimum resources for financing public health actions and services;</p> <p>2001: Noas 01; 2002: Noas 02;</p>	<p>2003: PNAU; 2004: RAHB, PNH, PN-HPP; 2006: Health Pact; PPI-Assistance; 2008: PN-Regulation; 2009: Beneficent Entities Regulation;</p> <p>2010: RAS/SUS; Cooperation Agreement between Public Entities; Complementary Participation of either private or non-profit institutions; 2011: RAU/SUS; Ruling LOS; Conitec; Stork Network; Psycho-social; RDC Best Functioning Practices; Readequa PNAU, RAU, PNAB and Certification of Beneficent Entities; 2012: Attention Network for Disabled Persons; National List of Health Actions and Services; 2013: Redefine Home Care; Care Network for Chronic Diseases; Creates the PNHOSP, procedures for celebrating contracts with hospitals/SUS.</p>
Strategic Convergences and/or Divergences	<p>Deliberations made between VIII CNS and XI CNS displayed important (dis)alignments regarding the PNHOSP formulation. Among alignments, stand out: organic participation of the society in SUS, decentralization from the municipalization perspective. As dis-alignments: health priority in the context of political and economic crises, changes in the hegemonic care and tripartite financing, complementarity of services characterized as public right or covenant, improvement in quality and assistance coverage, opposition to multiple forms of privatization and alternative management models, greater autonomy, inadequate follow-up tools, evaluation and regulation.</p>	<p>National Health Conferences (CNS) from XII to XIV were realized. There was alignment with Brazilian Sanitary Movement, de-bureaucratization, decentralization towards regionalization, reinforcement of social welfare, pacts and tripartite financing flows, improved RHS management, wider coverage and strengthening of HPP. (Dis)alignments: tributary reform and adjustment of social responsibility, private initiative concerning financing and regulation, health as a marketable item, regulatory function and no more privatization, no more DRU and managerial procedures.</p>

Source: Conass (1986, 1992, 1998, 2001, 2004, 2008, 2012); Brasil (2005, 2010, 2011).

Results and discussion

It is important to present the findings of the present research, starting with the comprehension of PNHOSP and its two periods of normative formulation. In a later stage, it was possible to apprehend and analyze convergences and divergences regarding CNS deliberations and strategies by the Federal Executive presented in the PNS.

On the National Policy for Hospital Care

For the PNHOSP, hospitals are complex organizations aimed at the provision of care according to the epidemiological and demographic profile of the regional Health Care Network (Rede de Atenção à Saúde – RAS). Its directives are committed with: (1) the principles of universality, equity, integrality and social control; (2) regionalization and continuity of care by means of regulated

articulation with other services; (3) a model of care centered on humanized and interdisciplinary attention; (4) tripartite financing according to a pact; and (5) monitoring, evaluation, transparency and efficiency in resources destination (BRASIL, 2013).

Three structuring axes of the policies stand out: hospital management, which includes assistance quality, attainment of goals under outsourced contracts, efficiency and transparency, participative planning, role in the RAS, regulatory flows and monitoring and evaluation criteria; tripartite financing and formal tools for outsourcing contracts to regulate the relationship between the manager and the public and private hospitals, by means of regional, budgetary, monitoring and attainment of goals criteria, assistance improvement and effective social control and transparency; and accountability of management sectors, which specifies competences of State Health Secretariats as to goals and priorities for hospital care,

co-financing, outsourcing and monitoring or evaluation.

As to outsourcing contracts procedures, it is established that the outsourced entity will regulate actions, services and accountability of the contracted regarding assistance, teaching and research, accomplishment of commitments, goals and services under outsourced contracts, and monitoring, evaluation and audits.

Normative periods of PNHOSP formulation

The retrospective research and the chronological organization allowed for a deeper exam of relevant dimensions for the analysis of basis supporting the Policy. In this sense, legal and regimental reference possibilities of hospital care were divided into two analytical periods.

FIRST NORMATIVE PERIOD OF THE FORMULATION

This period was committed with the legitimation, by means of the Organic Health Laws (Leis Orgânicas da Saúde – LOS), and the start-out of SUS implantation under the Basic Operational and Health Care Norms (Normas Operacionais Básicas – NOB/ Normas de Assistência de Saúde – Noas). The time limits were the period from 1988 to 2002, involving the governments of presidents Sarney, Collor, Itamar and Fernando Henrique Cardoso 1 and 2 (FHC1 and FHC 2).

Sarney government (1985-1989) was marked by the pre-constitutional movement that led to 1988 Brazilian Federal Constitution (DAVID, 2011), known as the Citizen Constitution, since it has led to the re-democratization of the country, the strengthening of the society's participation and the successful movement on behalf of direct presidential elections, known as 'Direct (elections) Now' (PAIM, 2013). SUS was created in the Constitution as part of the

Social Security item; hospitals were defined as units of the system's hierarchical and regionalized network, which has launched the new character of the Brazilian State, which since then was oriented towards social welfare, enabling the social security to be legitimized, thus ensuring the right to health (FLEURY; OUVÉNEY, 2012).

In the first post-constitution direct election, Fernando Collor de Melo was chosen president and remained in charge for about two years (1990 to 1992). He kept the pace of the developmental process, adopting a liberal government agenda, in line with the program of lesser participation of the State (Programa de Desestatização do Estado – PDE) (DAVID, 2011). Collor was impeached in 1992, replaced by Itamar Franco (1992 to 1994), whose government focused on inflation control by means of the Real Plan (Plano Real) and of the creation of norms for purchases and contracts in the Public Sector, based on the Auctions Law #8.666/1993. As to the health sector, those governments were responsible for passing other laws – LOS, NOB1991 and NOB1993 –, starting off the implantation of SUS and creating the Provisional Contribution on Financial Movements (Contribuição Provisória sobre Movimentação Financeira – CPMF) – the first tax to be destined to the health system.

During both FHC governments (1995 to 2002), the Ministry of Federal Administration and State Reform (Ministério da Administração Federal e Reforma do Estado – Mare), whose mission was to modernize the administration and to vigorously implant a reforming agenda for the managerial public administration. The neo-developmental agenda succeeded at the expense of infrastructure privatizations, reduction in the number of public servants, selectivity of public policies and social welfare reform (COSTA; LAMARCA, 2013). Among legal instruments, stands out the Constitutional Amendment #19/1998, which included the principle of public administration efficiency,

and two other laws: Fiscal Accountability and PDE readjustment.

An important normative mark of hospital care at that time is the continuity of the process of SUS implantation, management being decentralized, distributed among several governmental spheres by means of NOB and Noas. These were important documents, as they did launch the reform of the health system and represent a vertically oriented perspective (ANDRADE, 2001) of the Federal Executive Power for implanting health policies in the first period of this analysis. Documents allow for grouping these government periods according to the regulation of the health and hospital care system in the SUS.

NOB 1991 was not a rupture with the regulatory logic established by the National Institute of Medical Assistance and Social Welfare (Instituto Nacional de Assistência Médica e Previdência Social – Inamps). It led to making public and private servers equal as to the budget transfer to hospital care and adjusted the Hospital Information System (Sistema de Informação Hospitalar – SIH), by means of the Hospital Internment Authorization (Autorização de Internação Hospitalar – AIH). Under NOB 1993, mechanisms of decentralization of management and regulatory capacity were created for states and municipalities, budgets included through transfers to their respective Health Funds. A historical mark that year is the extinction of Inamps and the creation of the National Audit System, besides the National Health Agencies (2000) and Sanitary Vigilance (1999), reinforcing the conception of a regulatory role of the State in the Health sector. (SANTOS; MERRY, 2006).

It is worth remarking that NOB 1996 was the means used to re-adjust the budget to the new perspective based on demographic density and historical series; and it must be stressed the coincident relationship between the instrumentation of dependent decentralization processes, either supervised or attached, and trend towards a transversal reform of the public administration over that

period, which created Social Organizations as one of the alternative models of indirect management – a governmental via used for publicizing activities.

Under Noas 2001, the responsibility for the regulation of both public and private hospital networks at the state level was assigned to SUS management. This recommendation was guided by the regionalization process, and its functioning was enabled by Noas 2002, through pacts between all three management levels (SANTOS; MERRY, 2006).

Between 1988 and 2002, juridical-normative documents aimed at the implantation of SUS were sanctioned. Among these documents, only LOS were considered in the PNHOSP, establishing that the states should be responsible for managing the hospital system; and that budgets should be composed by the National Health Fund (Fundo Nacional de Saúde – FNS), which indicates that the lack of inclusion of operational norms occurs as a possible rupture between the first and the second periods focused in this analysis.

Nevertheless, a retrospective exam reveals that, in the first period, a sort of ‘normative patrimony’ was maintained, according to which the governmental agenda included accountability of state and municipal agents, linked to outsourced contracts by means of commitment agreements; integrated planning, with pacts between sub-regional care networks with available hospital beds; financing submitted to a set of criteria, such as evaluation by audit procedures on SUS, notification in the information system and payment to service providers; and strengthened social control.

SECOND NORMATIVE PERIOD OF THE FORMULATION

This period started in 2003, in the transition to the first Lula government, and lasted until the first Dilma government in 2013, when a decision process by PNHOSP took place.

The two consecutive Lula governments (2003 to 2010) were liberal, adjusted to the social dimension, thus combining continuity and changes (COSTA; LAMARCA, 2013).

As the first mandate started, in 2003, a governmental meeting coordinated by the Health Care secretariat of the Health Ministry (Secretaria de Atenção à Saúde do Ministério da Saúde – SAS/MS) developed the plan named Brazilian Health Care Reform (Reforma da Atenção Hospitalar Brasileira – RAHB), published in 2004, aimed at the indication of directives of governmental efforts towards the re-management of hospital care. RAHB was a historical landmark in policies formulation, since it proposed the re-adjustment of the health care model and the establishment of norms for public policies on hospital care in Brazil. It was extensively discussed at the Tripartite Managerial Commission (Comissão Intergestora Tripartite – CIT) and was later unanimously approved by the National Health Council (Conselho Nacional de Saúde – CNS) (REIS; CECICLIO, 2009).

The plan included promotion, inter-sector activities and interrelation with care provision levels in the process of reorientation of hospital care, by means of the National Humanization Policy (Política Nacional de Humanização – PNH) as of 2003 – a remarkable document, as it offered directives that should be respected in future pre-decisional ruling norms. All together, they have launched the second period of PNHOSP, looking after formulating the policy with social dimension, solidary action networks and subjects as protagonists, directives for the re-structuration and strategies for the adequacy of hospital services under SUS.

It is worth pointing out that health was the main sector undergoing a decentralization process in that period (COSTA; LAMARCA, 2013), and that outsourcing was the strategy that was chosen and included in RAHB (REIS; CECICLIO, 2009). Other normative documents related to innovations in the hospital

care model under SUS and as RAHB was launched were sanctioned during both Lula governments: National Policies for Urgencies Assistance (Políticas Nacionais de Atenção às Urgências – PNAU); National Policies for Small Hospitals (Políticas Nacionais para Hospitais de Pequeno Porte – PNHPP); and for SUS regulation, Pact for Health and Management, Integrated Pact Programming (Programação Pactuada Integrada – PPI) and Health Care Networks (Redes de Atenção à Saúde – RAS).

Other tools for the regulation of relationship between public and non-public spheres were the Cooperation Commitment involving Public Entities, Social Security Beneficence Certificate, and the re-establishment of the complementary participation of private institutions – documents meant to keep continuous decentralization of State functions, which marked the 1990's and persisted along the 2000's (COHN, 2011).

Having succeeded in subsequent elections, the Federal Executive kept pace under Dilma Rousseff first government (2011-2014), characterized by continuity of the inclusion agenda, with social policies and income redistribution incentives, improvement of transparency and State control, besides enlarged strategies of public management, by means of partnerships and concessions (PESSOA, 2015).

During this governmental period, eighteen documents analyzed in the present study were sanctioned, starting with Urgencies Care Networks (Redes de Atenção às Urgências – RAU), Stork and Psycho-social Care (Cegonha e Atenção Psicossocial), regulation of LOS #8.080, composition, competences and functioning of SUS National Commission for the Incorporation of Technologies (Comissão Nacional de Incorporação de Tecnologias – Conitec), adequate functioning practices in services, re-adjustment of National Policies for Urgencies Care (PNAU) and for Basic Care (PNAB), and of Beneficent Entities

Certification. These strategies were highly relevant in the period analyzed here.

In PNAU and RAU, once can notice the protagonism of the federal government regarding financing, regionalization, formative processes and implantation of regional committees, as well as challenges faced for adopting incorporation flows, for divulging technologies evaluations at SUS, and for strengthening SUS institutionalization by making managers accountable, warranting resources and strategies for following-up planned actions.

In 2012, greater importance was assigned to making care available for handicapped persons, established as part of the care network. The opportunity was also used to straighten out actions and services offered to users, with standard price lists and tripartite financing, through the National List of Health Actions and Services (Relação Nacional de Ações e Serviços de Saúde – Renases). In 2013, Home Care (Atenção Domiciliar – AD) was re-defined under SUS, and the Chronic Diseases Care Network and the National Program for Patients' Safety (Programa Nacional de Segurança do Paciente – PNSP) were created.

The contents of these normative documents in the second period of analysis can be organized in three groups: a) adjustment in the determination of care and management relationships under contract; b) improvement of hospital care planning in care networks; c) conceptual re-definition of hospital care under SUS.

It is worth stressing that PNHOSP does not explicitly consider Administrative Act #1.034/2010, which deals with the complementary participation of private and

non-profit health care institutions in SUS. This Act is important because it considers outsourcing tools as covenants – where the partnership is established with a private non-profit institution – and administrative contract – where a relationship involving services sale is established between a public entity and private institutions, either profit or non-profit. A further relevant aspect of this Administrative Act is that it compels the public entity to comply with requisites under Law #8.666/1993 on norms ruling auctions and contracts signed by the public administration.

CNS AND PNHOSP: CONVERGENCES AND DIVERGENCES

In order to create articulations and convergences between the normative-juridical mark and CNS deliberations, some important aspects related to the management of hospital care can be highlighted. In line with the structure of periods and analyses in this paper, we first present the set of deliberations produced between CNS editions VIII and XI, whose themes have emerged in the context of political re-democratization of the country and SUS implantation. Next, the focus is the period starting in 2003 with the government change in the federal sphere, which is responsible for CNS editions XII to XIV.

We point out the continuity of tensions provoked by the CNS editions in first period, due to the lack of convergences between the Federal Executive Power and SUS implementation process. Considerations on hospital care in respective CNS reports are presented in *chart 2*.

Chart 2. Deliberations of National Health Conferences – periods of the PNHOSP formulation, post-1988 Federal Constitution in Brazil

Period	CNS	Deliberations
First normative period of the formulation	VIII CNS	Occurred during the Constituent Assembly, this conference is a decisive landmark concerning the formulation and inclusion of SUS into the 1988 CFB. It established directives, systematization of ascendant management levels, complexity of health problems, stimulus to the public state character and need for hospitals to be unified under SUS.
	IX CNS	This was the first one to take place in the context of SUS implantation, of the implementation of the Health Organic Law and first NOB. It opened the chance for intense debates aimed at prioritizing health, against the dramatic scenery of recession and unemployment at the time. Resistance was manifested to the multiple forms of privatization (recommending the character of public right or covenant in contracts involving services complementarity. The need for changes as to the hegemonic model in place was pointed out, as well as the dependence on the private sector and the limited assistance coverage.
	X CNS	Opposition to NOB was manifested, attributions for managers were defined and concern was made clear as to the direction RAE was taking, characterized by the wider relationship between public and private sectors. Therefore, this Convention defended the character strictly complementary, refusing management contracts, outsourcing and privatization of public services.
	XI CNS	Discussions on fiscal adjustments impelled by the State reform, the scenery of ever growing plans and private security, disarticulation of care levels, precarious access and insufficient control by the government. The Conference recommended strengthening regulation, improvement of the public services, inclusion of a culture of evaluation/auditing/control, new mechanisms for social control and refusal to the LRF.
Second normative period of the formulation	XII CNS	Concerning the tax reform, the cause of democracy is supported, besides effective integrality and social welfare, reiterating the importance of assuring social control, regionalization, decentralization and less bureaucratic services management and social welfare funds. The Conference opposed to private initiative in mediation in financing and regulation activities of medical-hospital assistance. As to health management, SUS consolidation by means of decentralization was defended, with mechanisms that may hinder client-like and merchant attitudes in health assistance, with pacts flow regulations. Redefinition of the relationship of university hospitals and integration of the Sara System (Rede Sara) to SUS. Assuring resources for investments and for costs of urgency and emergency services, home care and widening reference public hospitals with less than 50 beds, financial incentive to those that reach the goals established in the National Program for Evaluation of Hospital Services (Programa Nacional de Avaliação dos Serviços Hospitalares - PNASH) and equitable dealing when transferring resources to both public education and philanthropic hospitals.
	XIII CNS	It was stressed that SUS is a State policy and, particularly concerning hospital management and assistance, the Conference points out to the need of assistance networks, humanization, integration of University Hospital to SUS, existence of a managing council and rendering of accounts in services financed by SUS, state and municipal support to HPP, establishment of protocols for assistance and referral procedures, as well as beds and coverage.
	XIV CNS	Considered SUS as a public policy and patrimony of Brazilian people. Refused management alternatives involving Social Organizations, Civil Society Organizations of Public Interest, State Foundations of Private Law and the creation of Brazilian Company of Hospital Services. The Conference manifested concern about DRU, the regulation of EC #29, how to guarantee financing for health care in the Tax Reform, specific resources for maintaining the Regulatory Complex and exclusion of expenses with health personnel under the Fiscal Responsibility Law. The creation of Organizing Contracts of the Public Action was recommended (pursuant Resolution #7508/2011) and the Health Pact agenda. The suggestion to create the Sanitary Responsibility Law was maintained, as well as implementing a National System for SUS Regulation, besides structuring the National Audit System (enlarging control, evaluation, and auditing procedures on contracts and expenses). As to the health care and hospital network, recommended university hospitals to become 100% SUS; implementation of the Home Care Program (Programa de Internação Domiciliar - PID) and the Out-of-Domicile Assistance (Tratamento Fora do Domicílio - TFD); optimization of flows and creation of central offices for regional regulation. The Conference manifested concern about qualification of the urgency and emergency hospital network and widening the number of beds available (Intensive Therapy Units, trauma-orthopedics, perinatal, children, obstetrics, oncology and rehabilitation, and high complexity procedures and exams. It pointed out to the need to widen resources for acquisition of equipment and permanent materials, of debates on integrating emergency assistance units (Unidades de Pronto Atendimento - UPA) to the basic care network, and of yearly updating procedures costs under SUS, according to inflation rates.

Source: Brasil (1986, 2012).

The VIII CNS was the stage where health issues emerged (ANDRADE ET AL., 2013) and that allowed for the organic participation of the civil society in the re-democratization process and in the construction of what would later become the SUS in 1988 Brazilian

Federal Constitution. The IX CNS took place in the midst of intense debates on the State's crisis, and stood out due to its defense of municipal decentralization, communities' participation in public policies, changes in the care system, tripartite financing and

private complementation submitted to public contracts or covenants (ANDRADE *ET AL.*, 2013).

The X CNS was strengthened by the importance of adjustments in the care provision model, increased autonomy and social control in public health services, and refusal of alternative management models. The XI CNS supported definitive and sufficient financing, and exclusion of contracts and covenants that would replace the public management (CONASS, 2009). Problems that stood out were lack of management models for the effective implementation of SUS, inadequate follow-up, evaluation and regulation tools, and the persistence of a hospital-centered health care model (ANDRADE *ET AL.*, 2013).

With the political change in the Federal Executive in 2003, the coming post-constitutional CNS editions maintained the sanitizing militancy and a firm position against alternative management models, but new tensions emerged.

In the XII CNS, the expressive popular participation was aligned with Brazilian sanitary movement. Four out of ten central axes of the report must be highlighted: confrontation against the tributary reform process, system management, aspects of hospital care and financing (CONASS, 2009). The report was opposed to the participation of private initiative; it supported the relevance of the Social Accountability Decree (ANDRADE *ET AL.*, 2013), the improvement of monitoring/control of contracts and of the quality and accounting of philanthropic covenanted entities, and prohibition of privatized or outsourced hospital services. As to hospital care, the emphasis was on the need for an integral and more comprehensive coverage, improvement of facilities available and accountability as to referrals.

In the XIII CNS, other challenges emerged: human resources management; the quality of care and access; control mechanisms; increase and efficient allocation of resources. Concerns about financing problems, Disentailing of the Union's resources (Desvinculação de Recursos da União - DRU), opposition to neoliberal rationalization and privatization were intensified. Rejection was manifested to the adoption

of models proposing management by State Foundation of Private Rights, Public Interest Organizations of Social and Civil Society and public concessions regimes, in order to avoid SUS privatization, an issue that motivated three motions.

In the XIV CNS, one of the 15 thematic directives was focused on hospital care. Indirect management alternatives were rejected and concerns about the continuity of problems related to financing were expressed (ANDRADE *ET AL.*, 2013). Integral support was granted to SUS against the expansion of covenants and contracts in the system. The need to strengthen the regulatory role of the State was approved and alternatives to be adopted in hospital care were defined: implantation of home care and out-of-domicile treatment, creation of Regional Regulation Centers, qualification of the network and increased offer of urgency and emergency hospital beds. It was established that the epidemiological and socio-demographic profile was a parameter for the construction of hospitals and medium complexity units.

In this second period of analysis, the relationship between normative marks and CNS promotion unveils the existence of a mix of convergences and divergences. Among the alignments are the increased concern of the federal government with the establishment of rules to improve the management capacity by means of pacts, implantation of new financing processes (CARVALHO, 2007) and legitimation of Constitutional Amendment #29, although it has frustrated expectations about the financial bonding of the federal level with health actions and public services. There was also a correlation with the process of RAS implantation, re-establishing the relevance of HPP in the network; expansion of the assistance coverage, with the establishment of regulatory flows; priority granted to previously marginalized populations, like handicapped persons; improvements in the process of participative management, with managing councils, and advances regarding outsourcing procedures, in order to favor the regulatory action by the State (CARVALHO *ET AL.*, 2012).

However, the Conference led to two dis-alignments. First, the continuity of DRU as an economic policy option adopted in the 2000's, which has aggravated the sub-financing of Social Security (PAIM, 2013), and, as a consequence, the continued and warranted budget for hospital care. The second dis-alignment was the increase of indirect management alternatives, with the resulting sanction of laws that created Public-Private Partnerships (PPP), the Brazilian Company for Hospital Services (Empresa Brasileira de Serviços Hospitalares – EBSEH) and the Civil Society Organization (Organização da Sociedade Civil – OSC) – a strong decentralizing aspect for making administrative procedures more flexible (PESSOA, 2015)

FEDERAL EXECUTIVE STRATEGIES FOR CNS AND PNHOSP

Considering the important role of the CNS for bringing relevant questions into the governmental agenda, the process of formulation of public policies on health, and taking

into account that the governmental period from 2003 on was characterized as an opportunity window (PINTO, 2008) for PNHOSP, it is relevant to reflect on strategies chosen as priorities in the second formulation period, from 2003 to 2013.

The synthesis of PNS 2004, 2008 and 2012 (chart 3) unveils that hospital care was one of the challenges posed for the second governmental period analyzed here. An alignment between normative marks and CNS occurred when the government recognizes the need to change the care model, aiming at: integration of care levels and management spheres; incorporation of management models with improved performance; joint management and redefinition of the role of hospital as guidelines for health care (DEUS; MELO, 2015). The latter was an experience aimed at overcoming the systemic fragmentation by means of RAS, particularly those related to urgencies and emergencies, which would qualify the units for trauma-brain-cardiovascular care, and extra beds for hospitalization and intensive care (SOARES; SCHERER; O'DWYER, 2015).

Chart 3. Health planning strategies by Brazilian Federal Executive for the formulation of the PNHOSH from 2003 to 2013

Period	PNS	Strategies
Second normative period of the formulation	PNS 2004-2007	The Multi-annual Plan and the XII CNS are the basis the proposal is grounded on. The document mentions the need to consolidate the Brazilian Sanitary Reform and presents the following strategic actions: adjustment of resources allocation, EC 29 regulation and reform of the assistance model. For those purposes, some aspects must be prioritized: management improvement, financing and social control and reorganization of hospital care, with wider coverage and alignment of ambulatory, urgency and emergency care, as well as high complexity procedures.
	PNS 2008-2011	One purpose was to strengthen SUS management in all three government levels, acknowledging the challenges posed to hospital assistance, the need to improve resolution capabilities, wider access, re-structuration of contracting procedures and qualification of the regulatory function. Aspects supporting the 4th. Directive include embracing services organization in attention networks that involve pre-hospital care, both mobile and fixed; hospital care; re-habilitation care and organs raising and transportation; increased number of beds for intensive care. A remarkable suggestion is fostering contract procedures as a management model to lead public hospitals to provide services that lead to solutions.
	PNS 2012-2015	The relevance of hospital units for structuring RAS was considered, and is more deeply linked to urgency and emergency assistance. Thus, some aspects are prioritized: widening the regulatory function, remodeling the network so as to improve its quality, solving capacity, distribution over the territory, and increased number of high complexity beds. Concerning management, the Pact for Health is stressed, with the prerogative of the commitment agreement for management, adoption of contracting procedures tools and the constitution of councils for regional management, backed by the National Audit System, and qualification of tools for immediate accomplishment. All these proposals are intended to improve hospital care by means of productivity and efficiency gains. Thus, the following planned interventions are highlighted: (1) follow-up, evaluation and internal control over SUS management, focused on results, connected with organizational contract for public action and access warranted; (2) implementation of management based on competences and administrative modernization; and (3) qualification and rationalization of expenses and wider resources provision.

Sources: Brasil (2005, 2010, 2011).

The experience above led to remodeling the decentralization process of SUS and empowered states and municipalities for pacts aimed at the regionalization of health care. The advances mentioned were accomplished as a consequence of the budgetary restructuring of the Health Ministry, transferring resources for the implantation of PNAU and RAS, and the Constitutional Amendment 29 (EC-29), approved although investment percentages were not specified (CARVALHO, 2007).

As to management improvements and outsourcing procedures presented in the PNS, findings unveil a sort of 'continuum of management based on contracts', in two senses: the generalized municipalization and indirect management alternatives.

The first step was fostering management improvements, which was followed by incipient regulatory qualification and restructuring of contracts by means of management procedures that would allow for better solving services. Finally, with PNS 2012-2015, administrative modernization was given priority as a strategic action, introducing commitment agreements and outsourcing tools, aimed at making better use of resources, with productivity gains.

It is widely known that management contracts, besides being a strategy of the 'new public administration' for the improvement of public services, including the health sector organizations, must be administrative tools able to measure results attained, both qualitatively and quantitatively. This is also about strengthening the conception of decentralized management, assigning responsibilities and reinforcing transparency and social control.

A further aspect that stands out in the period analyzed is the introduction of management alternatives such as: the creation of State foundations of private law for federal public hospitals; EBSEH as a new management model, characterized as a public company of private law, for university hospitals (SODRÉ ET AL., 2013); and the creation of a legal concession landmark through public-private partnership, which allowed for

the Federal Executive to draw private investment for the development of infrastructure and services management (GIAMBIAGI, 2004), and made it possible to put in operation the Hospital do Subúrbio (Outskirt Hospital), a new unit of the public network in the state of Bahia.

Evidences produced by the analysis of documents make it clear that management improvement and outsourcing procedures were PNS strategic aspects in the second period of PNHOSP formulation, as well as complementary performance adopted by the government regarding the coexistence of the double decentralizing pathway: by means of regionalized municipalization and either profit or non-profit public-private partnerships. Actually, these aspects are the central axis of the dis-alignment between all three PNS analyzed here and deliberations made in the Conferences, which opposed the indirect public management alternatives proposed from IX CNS to XIV CNS. Likewise, another dis-alignment can be noticed with respect to challenges that finally refrained the advance of the Fiscal Responsibility Law (Lei de Responsabilidade Fiscal – LRF).

Conclusions

Assuming the meaning of health policy as a governmental action able to explicit or to overlook actions, strategies, services and service regulations to face health needs and conditions (PAIM, 2013), it can be stated that hospital care was formerly defined by constitutive aspects and directions of Administrative Acts #3.390/2013 and #3.410/2013, particularly with respect to the outsourcing procedures. Taking into account the correlations between socio-political conjunctures, juridical-normative landmarks and the deliberations of post-1988 Conferences, the analyses presented here focused the formulation of PNHOSP over two periods: 1988- 2002 and 2003-2013.

It can be observed that PNHOSP was created ten years after RAHB was proposed

– a document that somehow marks a new governmental strategy in the renewal of Brazilian hospital care, which did not create an effective opportunity window, but enables an initial reflection: the guiding elements of the policy making were essentially built-up by the organic character of governmental actors who took over the Federal Executive Power from 2003 on.

A transversal dimension of the formulation along the analyzed 25-year period is the implementation of decentralizing strategies and the fostering of social control. In the first period analyzed, the formulation process was driven by the government's project of privatization, transference to third parties and administrative-financial reform, which created to the public administration the alternative of transferring to private entities both the management and the rendering of health services. In the second period, the route led to municipalization and regionalization, and to strengthening outsourced services as tools for improving public administration through commitment agreements between public entities and management contracts, yet strengthening indirect management alternatives.

Aspects that support two considerations of this study are: the concomitant development of two decentralization routes – regionalized municipalization and partnership alternatives of indirect public management –, while preserving the administrative patrimony of the previous period, with emphasis on the creation of new corporate entities.

The time-line points to incentives for management improvements and reinforcement of the state's regulatory role in 2004; in 2008, outsourcing aimed at better results; and finally, in 2012, the search for formal outsourcing tools, which could allow for productivity and efficiency gains. Then, the Federal Executive mentioned the introduction of competence management, administrative modernization and rationalization of expenses. The OSC alternative – transferring to the private sector responsibilities the

public administration used to be accountable for – was thus restated, and new corporate entities were created, characterized as indirect management – that is, concessions by PPP and partnerships with State foundations, EBSEH and OSC.

The alternative strategies adopted by the government lead to the fourth consideration: in the second period, the Federal Executive strategy based on developing the *continuum* of management by contracts in the double decentralization route finds in non-state owned and private law modalities the disalignment regarding opposing deliberations pointed out since IX CNS.

The considerations that emerged in this study point to juridical-normative advances that were sanctioned between 1988 and 2003 and their effects on the process that led to the PNHOSP. Political-administrative conjunctures were prominent determinants of governmental strategies. It must be recognized, however, that the change in the Federal Executive Power in 2003 did not represent a normative rupture in the implantation of hospital care policies. On the contrary, it represented an advance for the new public administration, which aligned with the managerial conception – a phenomenon that stepped back to the 1990's when it comes to deliberations by post-1988 CNS that opposed to indirect management.

Collaborators

Thadeu Borges Souza Santos made a substantial contribution to the conception, planning, data analysis and interpretation, as well as to the first draft, the critical revision and the approval of the final version of this paper.

Isabela Cardoso de Matos Pinto has substantially contributed to the conception, planning, data analysis and interpretation, as well as to the first draft, the critical revision and the approval of the final version of this paper. ■

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