Normative moment of National Health Plans of Brazil and Canada in the light of Mario Testa

Momento normativo dos Planos Nacionais de Saúde do Brasil e do Canadá à luz de Mario Testa

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ABSTRACT The study aims to compare the main guidelines of the National Health Plans of Brazil and Canada in the light of Mario Testa. The normative moment of both documents were compared, considering the guidelines of the mentioned plans, analyzed according to the strategies of strategic thinking addressed by Mario Testa. The Atlas.ti program was used, exploring as analysis categories the keywords that identify each of the guidelines, as well as the three strategies: institutional, programmatic, and social. As main results, we find that the national health plans of Brazil and Canada converge on the keywords related to care actions directly, although the North American country plans a greater number of health surveillance activities compared to Brazil. Both countries guide the normative moment of planning through programmatic strategies, which are intersectoral in the Brazilian scenario. Differences point to intersectoral action in Brazil and the organization of care with well-defined hierarchical levels of health care. However, the predominance of programmatic strategies in Canada allows us to infer that this scenario enjoys the consolidation of decision-making processes, as well as ensuring the social rights of the population, resulting in specific institutional and social strategies.

KEYWORDS Health planning. Health policy. Strategic planning. Health management. Health systems.

RESUMO *O estudo objetivou comparar as principais diretrizes dos Planos Nacionais de Saúde do Brasil e do Canadá à luz de Mario Testa. Foram analisados o momento normativo de ambos os documentos, considerando as diretrizes dos planos citados, analisadas de acordo com as estratégias do pensamento estratégico abordadas por Mario Testa. Foi utilizado o programa Atlas.ti, explorando como categorias de análise as palavras-chave que identificam cada uma das diretrizes, assim como as três estratégias: institucionais, programáticas e sociais. Como principais resultados, encontrou-se que os planos nacionais de saúde do Brasil e do Canadá convergem quanto às palavras-chave referentes às ações de cuidado diretamente, apesar de o país norte-americano planejar um maior número de atividades de vigilância sanitária em relação ao Brasil. Ambos os países norteiam o momento normativo do planejamento por meio de estratégias programáticas, as quais têm caráter intersetorial no cenário brasileiro. As divergências apontam para a atuação intersetorial no Brasil e para a organização da assistência com níveis hierárquicos de atenção à saúde bem delimitados. No entanto, o predomínio de estratégias programáticas no Canadá permite inferir que esse cenário goza de consolidação dos processos decisórios, bem como assegura os direitos sociais da população, resultando em estratégias institucionais e sociais pontuais.*

PALAVRAS-CHAVE *Planejamento em saúde. Política de saúde. Planejamento estratégico. Gestão em saúde. Sistemas de saúde.*

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Introduction

The dominant conception of the act of planning in health is associated with the complex process that requires a theoretical mastery of the field of public administration, however, in addition to this knowledge, the appreciation of the social aspects and nuances of political action must also be prioritized. It is important to understand that governing today requires, in addition to traditional normative planning, the development of strategic planning stages[1].

It starts from elements and aspects that must be identified and addressed during the planning process, such as the actors, the scenario, the limiting aspects, the time, among others that are fundamental in order to reach the expected results, taking into consideration the complexity of the interactions between them. This dynamic of interactions is a game of comings and goings between power and social actors, which exist uniquely in each culture[2].

Historically, the term strategy emerges as a military concept, which after the great transformation of modern society, with the conquest of the power of Russia by the forces of communism, becomes a 'way of ascending to power'[2]. In the health field, Mario Testa points out that planning can be strategic as long as it considers the behavior of actors and seeks the transformation of power relations; therefore, the teams of planners must pay attention to the diagnosis of the situation, analyzing its viability from the social practice of interactions between actors, scenarios and ideologies[3]. From this perspective, health management practice applies from three strategies: institutional, programmatic and social.

In this study, an investigation will be carried out on the guidelines described in the National Health Plans of Canada and Brazil, that is, it is time to set a goal, where one wants to get from that previous diagnosis, named by Carlos Matus[1] as normative moment that must be objective and clear, built from the cognitive repertoire of the planner as a social actor[4]. Contemporary of Mario Testa, economist Carlos Matus adds that the planner cannot be a mere observer of the situation, therefore he proposes the Situational Strategic Planning (PES), not abstaining, either, from incorporating the concept of strategy and its typologies[2] in the second moment of the PES.

The PES consists of four moments: explanatory, when the situational diagnosis is made and problems are identified; normative, already characterized above; strategic, which is the moment to analyze the political, economic and organizational viability of the proposals, it would be how to do each action; and the tactical-operational, time to perform the action, perform what was planned and assess its consequences[1]. Therefore, understanding that the planners of Brazil and Canada guide their actions in PES, and in the normative moment it is possible to identify the typologies of the strategies proposed by Mario Testa, which is the focus of the study.

Given the relevance of universal health systems in the world, as a triumph of historical struggles for health as a right and as an example of health reforms, that emerge with responses to the growing demands and needs of societies, it is important to reflect on the development of health planning in these universality scenarios, in this case, in two countries of the american continent that have a universal health system.

Therefore, this article aims to compare the main guidelines of the National Health Plans of Canada and Brazil, in the light of strategic thinking, more specifically, the normative moment proposed by Mario Testa.

The normative moment from the concepts of strategies by Mario Testa

In the reflections of Mario Testa[2] on strategic thinking and the logic of programming, relevant elements for planning are identified, such as power, which is the ability of the actors to achieve the goal, and may be administrative, technical and political; strength, while intensity of power's movement; ideology, conceived

by the conception of the world of a subject and his/her conduct in respect to it[2]; actor, such as people or groups of people who defend an ideology; space, understood as a place of grouping of actors with similar ideology; and scenario, understood as an arena in which action is developed, not just the physical space, but also the relationship between the elements already presented in this paragraph.

Therefore, it is important to emphasize the strategies and their concepts comprising the moment of definition of the planning goals.

INSTITUTIONAL STRATEGIES

They refer to those strategies developed in and from the institutional space, and may, even, originate before the existence of the institution, as strategies of constitution of the institution. Institutional strategies aim to strengthen the organizational structure of that institution, in order to maintain its ideology based on internal and external relations. Mario Testa explains that internal relations also coexist with diversity of ideologies when it comes to the social and technical and/or intellectual and manual division of labor, which is the maximum contradiction that can exist in an institution.

The objective of the institution is to establish itself, to consolidate its objectives, mission, values and principles; in the meantime, the instituting process moves, exerting power over the workers and their relations[5]. Therefore, institutional strategies transform the daily lives of workers and society indirectly[2].

In this study, the institutional strategies are those directed to the technical, administrative and political strengthening of the institution responsible for the planning and execution of health actions in Brazil or Canada.

PROGRAMMATIC STRATEGIES

They are characterized as a proposal for the distribution of power through a delimited program, which orders available resources with a specific purpose, well-defined objective and by single normative approach. These strategies may be mistaken for the institutional ones, but differ in their transitional character from the program, making the conception of ideology and power difficult[2]. Therefore, the programmatic strategies may be directed to the qualification of the institution, people's health care, community strengthening or other objectives, but with a temporary nature, such as vaccination campaigns, financial incentive programs, combating arboviral vectors, among other actions.

SOCIAL STRATEGIES

These strategies are planned for the good of all people, society, in accordance with policies focused on the totality, thus, they seek to ensure actions in the global space. The guidelines also planned in sectorial spaces, such as the specific activities of health, education, economy and environment, when integrated, also include social strategies[2].

Institutional and programmatic strategies can be understood as analytical categories of global space, as critical categories of sectoral spaces, which, in doing so, also modify the global space. Therefore, social strategies are planned by the State, based on its instituted power, but built on the participation of social actors and/or group of actors.

In this study, the main defining characteristic of social strategies will be their beneficence for the whole, for Brazilian or Canadian societies.

Methodological path

This is a comparative study with a qualitative approach of the exploratory type. The object of the study will be the National Health Plan made by the federal entities of Canada and Brazil. These countries were eligible, because

they are located in the Americas and have a universal health system.

For data collection, the Canadian National Health Plan for the 2017-2018 biennium was explored, available on the website of the Ministry of Health of that country – http://www.hc-sc.gc.ca/ahc-asc/index-Eng.php[6]; as well as the Brazilian National Health Plan for the 2016-2019 quadrennium, available on the website of the National Health Council – http://conselho.saude.gov.br/ultimas_noticias/2016/docs/PlanoNationalSaude\2016\2016\2016\2016\2016\2016\2016\2016.f.f.pd[7].

The drafting teams for each document used the terms 'guidelines' and 'objectives' at normative time; however, justified by the semantic similarity, the term guideline will be adopted in this study. Those terms that were often cited in the guidelines in both documents were chosen as keywords.

For the organization of data collection, as well as for analysis, the Atlas.ti software was used, a computer program based on the Grounded Theory of Glaser and Strauss, with application in various fields of knowledge, such as psychology, sociology, anthropology, education, economics, political science and also its use in qualitative health research[6]. Atlas.ti software has great potential for the use of multimedia in qualitative analysis, because it accepts text, direct observations, photographs, graphic, sound and audiovisual data.

The use of Atlas.ti allowed the coding of sentences of the two documents under analysis, indicating which words, terms and expressions appear frequently. Next, the program builds relationships between coded data, with varieties of combinations[8].

For the analysis of information, it was used as categories of analysis the three strategies – institutional, programmatic and social – proposed by Mario Testa[2] on strategic thinking in health planning and programming. It is important to note that for each guideline, one keyword was assigned, as well as each guideline was classified as a single strategy.

Results and discussion

The following two sections present the central elements of the organization and of the content of both the National Health Plan of Canada and Brazil, as well as describe the guidelines contained in each of them. In the end, some reflections are made that place in contrast the normative moment of the two management tools.

Considerations on the organization and content of the National Health Plan of Canada

Canada is a country known worldwide for the health status of its population, confirmed by positive health indicators such as life expectancy of 83,6 years for women and 79,4 years for men, as well as economic indicators that signal the country as the tenth largest economy in the world based mainly on its resources and trade[10,11].

In order to maintain or raise health indicators, Canada relies on Health Canada, which is the federal department responsible for helping Canadians promote or rehabilitate their health conditions or cure their disease process, while respecting the uniqueness of people[6]. In this sense, Health Canada 2017-2018 (name given to the National Health Plan) summarizes the priorities and proposed actions for the years 2017-2018, favoring assistance to the health needs of people[21].

To achieve such purpose, Health Canada addresses four priorities, which are: supporting innovation in the health system; strengthen openness and transparency such as modernization of legislation, regulation and health care; strengthen the health programming of the First Nations and Inuit (indigenous and eskimos nations); and, finally, recruit, maintain and promote a committed, high-performance and diverse workforce within a healthy working environment[12].

The Health Plan has several sections that define its role, its functions, according to

the principles of the federal department, in addition, the document considers aspects such as context, the conditions that affect its work and the risks that could affect the ability to make the plan effective and achieve the proposed results.

After these sections, the plan presents the Planned Results which are structured through three programs which, in turn, are divided into 13 specific guidelines[12], which will be the analysis *corpus* of this study, presented in the *chart 1*.

Chart 1. Guidelines contained in National Health Plan of Canada (Health Canada) 2017-2018

List of guidelines of Health Canada
1. Provide advice, research and analysis of strategic policies to support decision-making on health care issues, as well as support from programs to provinces and territories, partners and interested parties on health system priorities.
2. Ensure the continuity of occupational health services of federal civil servants who can deliver results to Canadians in all circumstances and organize health services for Internationally Protected Persons (IPP).
3. Improve access to health services in minority communities of official languages and increase the use of both official languages in the provision of health services.
4. Ensure that health products are safe, effective and of high quality for Canadians.
5. Manage the health and safety risks of Canadians associated with food and its consumption and allow them to make informed decisions about healthy eating.
6. Protect the health of Canadians through the assessment and management of health risks associated with environmental contaminants, particularly substances, and provide advice and guidelines to Canadians and government partners on the environmental impacts of environmental factors such as air and water contaminants and a changing climate.
7. Identify, assess, manage and communicate health or safety risks to Canadians associated with consumer goods and cosmetics, as well as to communicate the dangers of chemicals at the workplace.
8. Minimize the health risks for Canadians associated with the use of tobacco products and the illicit use of controlled substances and precursor chemicals.
9. Environmental and occupational radiation monitoring, management of inter-organizational plans, procedures, capabilities and committees for a nuclear emergency that requires a coordinated federal response, a national radon program and regulation of radiation emitting devices.
10. Protect the health and safety of Canadians over the use of pesticides.
11. Contribution and direct expenses related to child development, mental well-being and healthy life, control and management of communicable diseases, environmental health, clinical and customer care, as well as home and community care.
12. Provide benefits in a way that contributes to improve the state of health of the First Nations (indigenous nation) and Inuit (indigenous Eskimo nation).
13. Help improve the capacity of the First Nations and the Inuit to influence and/or control the provision of health programs and services for individuals, families and communities of the Inuit and First Nations.

Source: Health Canada, 2017[6].

Each of the guidelines in *chart 1* are presented in five subsections: overview, planning highlights, planned results, financial resources, and human resources[12].

The National Health Plan also describes Internal Services as "groups of activities and resources needed to support program needs and other corporate obligations of the organization"[12(56)], finally, Health Canada 2017-2018 counts on total public spending and resources.

Considerations on the organization and content of the National Health Plan of Brazil

Instituted in the Federal Constitution of 1988, Brazil enjoys a Unified Health System (SUS) conceived as a duty of the State to regulate, finance it, and to propose a set of health actions that ensure the right of the population in question. be universally assisted, with equity and comprehensiveness[13].

Health plans refer to the planning of health actions, with analysis of the health situation, objectives, goals, responsible people and evaluation indicators, which may have a quadrennial or annual periodicity. National health policies guide fundamental practices, as they define goals to be achieved, determining the directions and strategies to ensure better quality of life for the population[14].

The National Health Plan of Brazil, 2016-2019 quadrennium, is structured in four sections besides the introduction and the annex. The introduction describes the participation of all sectors of the Ministry of Health, compliance with the National Health Council guidelines and the overall objective of the plan to the

expansion and qualification of universal access, in a timely manner, contributing to the improvement of health conditions, promotion of equity and quality of life of the Brazilian people[7(3)].

The attached item presents the evaluation indicators of each guideline.

The first section presents the legal foundations that support the construction of a health plan; the second one describes health conditions and needs, including resources currently being exploited by the federal entity; in the third section, reference is made to objectives and goals; while the latter thus exposes the plan management interface, such as the relevance of monitoring and follow-up of actions and its relationship with the management report[7].

Next, the objectives and goals of the plan are presented, in which the 13 guidelines[7] are presented, in *chart 2*, in the order they appear in the National Health Plan.

Chart 2. Guidelines in the National Health Plan of Brazil 2016-2019

List of guidelines of the Brazilian National Health Plan
1. Extend and qualify access to health services in an appropriate time, with emphasis on humanization, equity and health care needs, improving the policy of primary and specialized care, ambulatory and hospital.
2. Improve and implement the Health Care Networks in the health regions, with emphasis on the articulation of the Urgency and Emergency Network, Stork Network, Psychosocial Care Network, Care Network for the Disabled Person, and the Health Care Network of People with Chronic Diseases.
3. Promote comprehensive care for people in life cycles (child, adolescent, young, adult and elderly), considering gender issues, sexual orientation, race/ethnicity, situations of vulnerability, specificities and diversity in primary care, thematic networks and health care networks.
4. Reduce and prevent risks and harm to the health of the population, considering the social determinants, through surveillance, promotion and protection actions, focusing on the prevention of chronic non-communicable diseases, accidents and violence, the control of communicable diseases and the promotion of healthy aging.

Chart 2. (cont.)

5.	Promote the health care of indigenous peoples, improving the actions of primary care and basic sanitation in the villages, observing health practices and traditional knowledge, and articulating with other SUS managers to provide complementary and specialized actions with social control.
6.	Increase the population's access to medicines, promote rational use and qualify pharmaceutical assistance within the scope of SUS.
7.	Promote the production and dissemination of scientific and technological knowledge, health situation analysis, health innovation and the expansion of national production of strategic technologies for SUS.
8.	Improve the regulatory framework and health surveillance actions, to ensure health protection and sustainable development of the sector.
9.	Improve the regulatory framework of supplementary health, stimulating innovative management and surveillance solutions, focused on efficiency, access and quality in health care, considering the sustainable development of the sector.
10.	Promote, for the needs of the SUS, training, permanent education, qualification, the appreciation of workers, the devaluation and the democratization of labor relations.
11.	Strengthen the instances of social control and the channels of interaction with the user, with guarantee of transparency and citizen participation.
12.	Improve the inter-federative relationship and the work of the Ministry of Health as federal manager of the SUS.
13.	Improve spending patterns, qualify tripartite financing and resource transfer processes, with a view to stable and sustainable SUS financing.

Source: Brazil, 2016[7].

Weaving reflections that contrast with the National Health Plan of Canada and Brazil

Initially, from the analysis of the keywords, a greater variety of codes can be identified in the Brazilian plane, with strong evidence for social control issues, but, on the other hand, the same document did not present guidelines directed to workers' health and food security for example. In Canada's case, the plan repeated several of the keywords, such as health risks and health problems, indigenous health (in this scenario understood as natives and eskimos) and health surveillance. In the end, the three categories (keywords) that were most frequent in both plans were health risks and health problems, indigenous health and health surveillance.

This result indicates the relevance and prioritization of themes to be addressed in both study scenarios, which may or may not coincide by studying in-depth specific programs of each country.

Table 1. Keywords present in the National Health Plans analyzed

Keywords	National Health Plan – Brazil 2016 to 2019	Health Canada 2017 a 2018	Total
Access to health services	1	2	3
Primary Health Care	1	1	2
Social control	2	0	2
Comprehensive care	1	0	1
Funding	1	0	1

Table 1. (cont.)

Training/qualifications of health worker	1	0	1
Role of the manager	1	1	2
Health research	1	0	1
Attention Networks	1	0	1
Health and harms risks	1	3	4
Worker health	0	1	1
Indigenous health	1	3	4
Supplementary health	1	0	1
Food safety	0	1	1
Pharmaceutical assistance	1	1	2
Health surveillance	1	4	5

Source: Own elaboration.

According to Conill[15], health systems show similarities as well as differences, which are identified by comparative analysis: while similarities are given by more inclusive social policies, differences are rooted in people's access to the services offered, the organization of these services and the quality of health or their performance. Even though Canada and Brazil have universal health systems, there are historical, economic, political and cultural divergences between the two countries that determine health planning and policy making processes.

By exploring *table 1*, it is inferred that the Brazilian health plan has a comprehensive character, in order to plan aspects directed to financing, supplementary health, social control, health research, training and qualification of the worker, as well as comprehensive care and Health Care Networks.

In this regard, it is noteworthy that the Brazilian health system is valued for its consistency between constitutional guidelines, financing, management model and qualification of professionals. Therefore, when compared to other systems mostly composed of private services, there is a complex system, organized from Primary Health Care (PHC) and efficient in health promotion and harm and health prevention[16]. Therefore, the purpose of the Brazilian system goes beyond purely curative care, that is why it requires expanded clinical practice and intersectoral actions.

The categories mentioned above illustrate the interdependence of the Brazilian Ministry of Health with other institutions in favor of SUS efficiency. Thus, it is understood that the resolution of health problems is complex, therefore, the Brazilian Ministry of Health carries out health planning shared with other Ministries[17], such as Education and Management of Science, Technology and Innovation, in addition to regulatory agencies and deliberative bodies such as health councils.

As for the Canadian health plan, it is considered that its focus is on specific actions that can be developed autonomously by the federated health organization itself.

Table 2 presents the classification of the guidelines based on the planning strategies designed by Mario Testa and presented in the introduction. It is observed that in both health plans, programmatic strategies and a shortage of institutional strategies predominate. Even with the predominance of programmatic strategies, the Brazilian document contains a more equitable distribution among the other strategies when compared to the Canadian one.

Table 2. Typologies and quantity of strategies present in the National Health Plans analyzed

Planning Strategies	National Health Plan – Brazil 2016 a 2019	Health Canada 2017 a 2018	Total
Institutional	2	1	3
Programmatic	6	10	16
Social	5	2	7
Total	13	13	26

Source: Own elaboration.

The information in *table 2* allows us to infer about the health concept of the planners of both countries and the health needs of the population. By proposing guidelines classified as social strategies, both planners seem to conceive that the health-disease-care process is shaped by social determinants, as outlined in the guidelines "promote integral care for people in life cycles and promote the production and dissemination of science and technology knowledge in health" [7(6)]; as well as "promoting the ability to design, manage, develop and evaluate health programs and services by indigenous and Eskimos"[6(49)] and "emphasize the vitality of communities with minority languages and the recognition of English and of the French"[6(22)].

Social strategies can be considered as health innovations[11,16], represented by communication and information technologies in order to ensure quaternary prevention, patient safety and the horizontal relationship between health professionals and patients, themes that have been little discussed before.

The guidelines that address the health of the indigenous seek to ensure comprehensive care for such a population group, and favor the social inclusion of indigenous people who were once marginalized and whose rights to health were curtailed.

The greater number of social strategies in Brazil is justified by the health needs of the population to ensure social rights not yet realized since the Brazilian Constitution of 1988, for example, promote the health care of indigenous peoples, the strengthening of social control instances and channels of interaction with the user and their social participation, and the strengthening of the training of health workers[6(5)].

The realization of the right to health is up to the State, as the foundation of human right and as a 'primordial social right', thus, the Brazilian State must ensure the protection of the health of all people, enabling, for example, the access of minority populations, such as of indigenous peoples[18].

In contrast, Canadian society, based on health plan analysis, is considered to enjoy consolidated social rights, as emphasized in the Canadian Charter of Rights and Freedoms Canada, document that composes the Constitution of Canada and seeks to ensure the rights of society, be they fundamental, rights to mobility, legal rights, equal rights, official languages of Canada and educational rights in minority languages[19]. In this sense, 25 years after the letter was published, it still stands out as a model for other countries[20]. Like the historic approach to rights in Canada, the health plan guidelines emphasize programmatic strategies based on the guarantee of social rights.

Next, by relating the keywords of the guidelines to the strategies, we built *table 3*, allowing the analysis and inferences survey. The guidelines that imply an institutional strategy deal with financing and the role

of management in the health system. The institutional strategies of Brazil's health plan are reserved for the strengthening of the Ministry of Health as an organization and the improvement of its decision-making process.

Table 3. List of strategies and keywords of the guidelines of the National Health Plans analyzed

Keywords	Canada			Brazil		
	Institutional strategies	Programmatic strategies	Social strategies	Institutional strategies	Programmatic strategies	Social strategies
Access to health services					1	
Primary Health Care					1	
Social control						2
Comprehensive care						1
Funding				1		
Training/qualifications of health worker						1
Role of the manager	1			1		
Health research						1
Attention Networks					1	
Health and harms risks		2			1	
Worker health		1				
Indigenous health		2	1			
Supplementary health					1	
Food safety		1				
Pharmaceutical assistance		1			1	
Health surveillance		3	1			
TOTAL	**1**	**10**	**2**	**2**	**6**	**5**

Source: Own elaboration.

Similarly, the only institutional strategy of the Canadian health plan seeks to provide strategic policy recommendations, investigations and analysis to support decision-making on health system issues, as well as to support programs for provinces and territories, partners and interested parties in health care priorities[6].

As for the programmatic strategies, these were defined by guidelines that described specific actions, in which it was possible to identify a deadline for termination of the action. Programmatic guidelines are mainly aimed at vulnerable groups and specific policies. Among them, the theme of access to health services and medicines, the deployment of health networks in different health regions, the development and implementation of regulatory frameworks on health and protection for citizens of substances and products harmful to health are emphasized.

Guidelines related to the most specific elements are perceived, such as PHC, health care

networks, health risks and health problems, worker health, indigenous health, supplementary health, food safety, pharmaceutical services and health surveillance. In turn, social strategies require an intersectoral approach, such as the guideline codified as 'health research':

> promote the production and dissemination of scientific and technological knowledge, health situation analysis, health innovation and the expansion of national production of strategic technologies for SUS[7(69)].

It is important to highlight that Latin American countries live with the epidemiological profile of continuous transition, acting concomitantly with chronic and infectious morbidities and 'traditional' or 'typical' problems of social and economic backwardness, a different scenario from that experienced in Canada[15]. This may also be related to the fact that the guidelines of the Brazilian National Health Plan prioritize both social and programmatic strategies, while the Canadian National Health Plan highlights programming ones by probably having a better resolution of those social problems that generate injustices and inequities in health.

For the Brazilian scenario, it is worth discussing the specificities of PHC and indigenous health that led the classification as two strategies, the programmatic type and the social type, respectively. PHC is understood as the most interconnected hierarchical level of health care, bringing together health practices that mainly aim at health promotion and prevention of risks and health problems[21]. Guidelines directly related to PHC were classified as program strategies according to the Canadian health plan guidelines.

> Primary health care includes health promotion and disease prevention, public health protection (including surveillance) and primary care (where individuals receive diagnostic, curative, rehabilitation, support, palliative care and end-of-life care)[6(43)].

Furthermore, because of the potential for high capillarity, PHC must act to strengthen the principles of solidarity, justice, citizenship and community protagonism[22], aspects that can be put into practice through social strategies, such as the guideline of the health plan of Brazil:

> promote the health of indigenous peoples, improving the actions of primary care and basic sanitation in the villages, observing health practices and traditional knowledge, and articulating with the other SUS managers to provide complementary and specialized actions with social control[7(65)].

For their part, Santos and Melo[23], in their comparative study of PHC models in Brazil, Canada, and Cuba, concluded that a marked difference between the Brazilian and the Canadian health system corresponds to decentralization: "the fact that Canada has thirteen health systems (ten provincial and three territorial) confers a fundamental difference between the Canadian system and the Brazilian system, characterized by being a single system"[23(94)], which may be acting in the manner in which the national health plans for each of the above countries are understood and drawn up. About this, Rabello[24] refers to decentralization as consolidated in Canada, where health is the responsibility of the provinces and territories, while in Brazil it is considered incomplete, because norms and resources are concentrated in the federal entity.

Santos and Melo[23(95)] evaluated that "although constantly cited as a reference in many academic texts, the Canadian influence on the Brazilian system, in practice, is quite limited", which can be evidenced by seeing that, with similarities in the principles that guide both health systems, there are substantial differences between their national health plans.

Final considerations

The national health plans of Canada and Brazil converge on the keywords for care actions directly, although the North american country plans a greater number of health surveillance activities.

The divergence of the documents lies in the diversity of strategies that are proposed by the guidelines contained in the Brazilian Health Plan. Therefore, it is considered that Brazilian society lives with health needs that permeate the socioeconomic, cultural, environmental, work and income conditions, and people's lifestyle, justifying the planning of programmatic and social strategies. The SUS, based on universality and equity, seeks to ensure health care to people long neglected by the State, such as indigenous people, quilombolas, settlers, homeless people, refugees, among others. Therefore, it stands out and distinguishes itself from the Canadian for its comprehensiveness.

Based on this scenario, it is permissible to assume that the struggle of social movements, especially those that emerged with greater vehemence in the years 2000, provoked a severe power dispute[2] identified by the results of this study, when goals that were previously planned for all citizens, but without achieving them, were replaced by goals for all, including vulnerable groups, justifying the multiplicity of guidelines analyzed in this study.

It is worth noting that the analysis of a document such as the National Health Plan limits the understanding of strategic thinking, such as the actors involved, the power game, the dynamism of intersectoral relations and the scenario in question. Therefore, other data collection techniques could be used to deepen these elements.

In this regard, both Brazil and Canada guide the normative moment of planning through programmatic strategies, which have an intersectoral character in the Brazilian scenario. The differences point to intersectoral action and the organization of care with well-defined hierarchical levels of health care in Brazil. However, the predominance of programmatic strategies in Canada allows us to assume that this scenario enjoys the consolidation of decision-making processes, as well as securing the social rights of the population, resulting in specific institutional and social strategies.

Collaborators

Vale PRLF (0000-0002-1158-5628)* and Lizano VCG (0000-0002-7391-8176)* also shared the following responsibilities: 1) contributed substantially to the design and planning, and the analysis and interpretation of the data; 2) contributed significantly to the drafting and critical revision of the content; and 3) participated in the approval of the final version of the manuscript. ∎

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