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The first 30 years of the SUS: an uncomfortable balance?

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Abstract *This article takes stock of the implementation of Brazil's public health system in the period since the promulgation of the 1988 Constitution, which enshrines the right to health. It analyzes issues affecting the organizational effectiveness of health service provision such as funding and relations between different spheres of government. It focuses on the role of local government, the centralization of legislative powers, which has been shown to weaken the member states, and the financial dependence of local and state governments on federal government and how this has affected policy implementation. It also touches on other issues such as regionalization, poor planning, federal centralism, and Ministry of Health-local government relations, which have hampered state coordination of regional health systems. To close, we put forward some final considerations for improving the implementation of policies oriented towards the development of SUS structures.*

Key words *SUS, Federalism, Funding*

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Introduction

Commemorating the 30th anniversary of the Brazilian Constitution reminds us of Rubem Alves' quote "Today there is no reason for optimism. Today it is only possible to have hope"[1]. This date is commemorated without any optimism in face of the corrosive political power that sours the life of citizens and constant attacks on the rights enshrined in the Constitution. We must have the spirit of the strong who resist and persevere, because hope and renaissance are the ferment of the process of political and social evolution. We do not hold onto optimism, but we do have hope. And when optimism fails, we must be more active and combative so that hope will turn into reality.

After 20 years of penumbra, at the end of the 1980s, Brazilian society made the winds blow in its favor, giving birth to the Constitution, which held that respect for human dignity, solidarity, and social justice are matters of paramount importance, abandoning the remnants of meanness and obscurantism that had plagued the state for the previous two decades.

A Constitutional Charter whose normative geographies prioritize human well-being over state structures and budgetary and economic matters by setting out the fundamental rights and guarantees that all citizens are entitled to. *As a starting point, the 1988 Constitution adopts the grammar of rights, which conditions the constitutionalism therein invoked*[2]. A Constitution in favor of its citizens. It was hope (and fear) that rekindled the spirit of a citizens' constitution that guarantees individual and social rights and imposes the reduction of social and regional inequalities and poverty eradication as objectives of the Republic. Rights associated with ethics gave rise to the constitutional principle of human dignity, recognizing the intrinsic value of human nature.

Unfortunately, after reaching its 30th anniversary, we are witnessing the serious disruption of the political, social and moral order. The cracks in the foundations of the Republic are in need of urgent repair to lay bare the promiscuous nature of the relations between the public and private sector and legislative and executive branches. With the latter entangled in their roles, the only safeguard for society is the Judicial Branch, which in turn has also shown signs that ruin is also knocking on its door and that the door is sometimes open. Law in a democratic state cannot be legislated to meet interests that are detached from the bedrock principals of democracy such as equality and freedom, using political power to provide selective benefits in a society that has yet to shake off its oligarchic bias because Brazil has hardly managed to live the welfare state. With the globalization of financial capitalism, which weakens individual and social guarantees and turns citizens into consumers, where purchasing power is the distinctive mark between people at the expense of dignity, the situation of those who have never lived the welfare state in its full depth is aggravated.

Many beliefs, which were perhaps naive given the historical configuration of the country, have not been realized. A case in point is the belief that political and administrative decentralization implied by trilateral federalism would strengthen and improve public services. Since local governments often do not have the fiscal capacity to raise sufficient funds on their own, the majority have not attained the political, administrative and financial autonomy necessary to meet their duties and responsibilities set out in the Constitution and remain dependent on federal government transfers.

"Compadre politics" and *apadrinhamento*, whereby politicians bestow favors on, hire and award public contracts to friends and relatives, political subservience, administrative delays, and low expectations of reducing social inequalities, which are rife in local government, obscure social justice and emancipatory development. Several authors have addressed the issue of compadre politics and political cooption, notably Raymundo Faoro, who portrays the Brazilian state apparatus as a bureaucratic state at the service of the dominant elite, rather than, as it should be, the result of a historical cultural, social and economic construction[3].

Despite this situation, unparalleled progress has been made in the health arena in Brazil over the last three decades. However, much remains to be done to fully consolidate the country's public health system. The long struggle to ensure universal access to adequately funded, quality public services that meet the health needs of all citizens and to combat claims that rights such as health that have costs (which, according to Scaff[4], are all rights due to their protection apparatus) "do not fit into the public budget" continues. A claim built upon the fallacy proffered by post-modern capitalism that fiscal austerity alone is the driving force behind social development and that protection of rights is one of its outcomes.

Furthermore, the government has failed to modernize the management of the healthcare

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system, which requires administrative reforms to improve service quality, and steps have not been taken to improve the public apparatus necessary for achieving it goals, prioritizing the control of "roles" over and above results. One could be forgiven for thinking that maintaining shortcomings is actually a *project* aimed at promoting the dogmatic belief in public-sector incompetence. Why is it that nobody denies but nothing is done against the opportunism of legislators and the executive branch, who are not interested in real change, thus maintaining public sector efficiency?

This article takes stock of the organization and operation of Brazil's Unified Health System (*Sistema Unico de Saúde* – SUS)over the last 30 years, focusing on the following issues: the lack of a structural policyfor the health sectorfounded in law; underfunding;poor planning and implementation of the health regions and regional health networks; and the persistence of regional inequalities in access to healthcare.

Federal entities and their role in healthcare delivery: political and executive decentralization

Article 23 of the Constitution provides that the responsibility for health actions and services shall be shared equally across the three spheres of government. The federal and state government are vested with concurrent powers to legislate over matters regarding health (Article 24). The Constitution also provides that the organization of the SUS shall be decentralized, unified across each sphere of government, and based on the principle of subsidiarity, which holds that federal government should only perform those tasks which cannot be performed effectively at a more immediate or local level, thus bringing health services as close to the citizen as possible[5]. Governing is not maintaining a distance from society, voters and the voice of the people. Proximity facilitates transparency and public participation and guarantees true democracy, which should combine representativeness with direct participation. In this respect, it is important to draw attention to the fact that the common responsibility for providing healthcare held by each sphere of government should not be taken to be solidary in the sense that they should provide healthcare *in the same manner.* Although responsibilities may often be differentiated to guarantee health equity, health actions and services should be *integrated* within the same system, founded on the same underlying principles, and organized based on the same guidelines.

Although the 1988 Constitution aimed to decentralize the policy implementation, notably social policy, it assigns50 material and legislative functions to the federal government, centralizing the legislative initiative, especially tax legislation, leaving the states with residual functions and thus diminishing their independence.

Even health, which is conceived as being inter-federative in the Constitution (Article 198), did not escape centralism. The SUS was envisioned as an integrated model for the provision of public services across all levels of government, characterized by systemic interdependence (cooperative federalism), which requires that planning encompasses local and regional health needs so that the local level is not "lost" in the national level. However, this has not always been the case due local government dependence on federal and state transfers and state dependence on federal transfers (carrot and stick politics[6]). According to the legislation, these transfers should be based on previously defined criteria. However, these requirements are not fully met.

Apart from the need to align policies to maintain the systemic nature of health service provision, infra-legal regulatory centralism has outstepped its limits. As a result, the federal government, through the Ministry of Health, has produced over 700 regulatory instruments since the beginning of the 1990sdetailing the allocation of funding transfers and designing health policies that should have come from the legislative branch, given their structural dimension. In this respect, it is worth highlighting that, between 2016 and 2017, the Ministry of Health, in partnership with Oswaldo Cruz Foundation conducted a study that analyzed around 17,000 regulatory and nonregulatory ministerial orders. The study showed that around 700 regulatory instruments were produced by the Minister's Office, outside those produced by the ministries that were not within the scope of the study. These instruments were consolidated into six consolidated orders containing over 10,000 articles by a team of researchers under the SUSLEGIS project.

Despite a tripartite decision-making within the Tripartite Inter-managers Commission (*Comissão Intergestores Tripartite* - CIT), holders of power can *impose* consensuses through political cooptation. Arretche[7] adopts the term *joint-decision trap* (based on a theory put forward by the German Fritz W. Scharpf[8]), which is particularly fitting for our political model that centralizes power in the federal government. Would anyone doubt the power of influence of a federal

government responsible for transferring resources if the criteria were not set forth in law? Although carrot and stick politics may sometimes be useful for aligning policies of national interest, it can also serve other interests and should not prevail in the SUS because legally established requirements for transfer of funding exist, despite lack of compliance.

Despite the above, there has been a move towards decentralization. In the 1990s, local governments adopted the motto "municipalization is the way", implying that the federal government should transfer services ran at federal level that were the responsibility of local government to them and vice versa.

This should have resulted in a new role for federal government in relation to the SUS, where it would be responsible for regulating the system at national level in order to maintain its national unity and act as the linchpin for reducing regional inequalities, equalizing differences between the different sphere of government, evaluating and monitoring, developing computerized health information systems to unify national data infrastructure, and promoting health surveillance. In this role, the federal government would act as a regulator of federative asymmetries in order to reduce them, without forgetting the role it plays together with the relevant ministries in concretizing intersectorality, which is crucial to avoiding health problems.

The exclusion of the states – which, alongside local governments, are the main architects of the regional health system – from direct negotiations between the Ministry of Health and local governments from beginning of the1990s, strained tripartite relations, which had been strengthened by a significant reduction in the role played by the federal government (including its regulatory role), which acted as if municipal asymmetries could be overcome by issuing ministerial orders determining blanket rules for the organization of health services across the country as if regulatory metrics were capable of wiping out regional inequalities. Member states play the leading role in all of the country's health regions and that is why they are not a concrete reality to this day. Health regions continue to be an unattained goal in the 438[9] regions across the country.

Since the creation of the SUS, many of country's 5,570 municipalities (73% of which have under 20,000 inhabitants[10]), instead of uniting around the health regions, have debated in the public arena in a struggle for financial survival in face of their responsibilities. Without a glimpse of hope of emancipatory economic growth, they are subjected to federal and state political power (the same can be said for certain states). Data issued recently by the National Treasury[11] show an alarming level of financial dependence on the federal government: 81.98% depend on federal government transfers, while a mere 1.81% of local government are financially independent.

The tripartite system therefore leaves a great deal to be desired. Divided, the effectiveness of local government in providing public services is severely undermined. The situation is likely to get worse as growing responsibilities are not accompanied by an increase in funding, particularly in light of Constitutional Amendment 95 that came into force in 2016. However, we should not fail to admire local government efforts in assuming its role in the implementation of health policies, especially when we consider that federative decentralization was not accompanied by numerous national intersectoral measures to improve its development. Local government has been the mainstay of the SUS. Over 40% of the country's states fail to allocate the statutory minimum of 12% of the total budget to health, while 100% of municipalities allocate well over their 15% budgetary requirement, spending on average 26% of their budget on health[12]. Not to mention the need to modernize the widely criticized public administration, which has not lifted a finger to change. Despite widely reported problems, those who hold the power remain alarmingly indifferent to the urgent need for major reform of public administration structures.

From decentralization to regionalization: what happened along the way

Why has the regionalization of the SUS not been effective up until now, with health regions defined more according to the proximity of territories rather than capacity to meet health demands? The majority of health regions are not capable of responding their region's health demands, with only 90% of the country's 438 regions having a satisfactory level of resolvability and various regions that refer demands that they should be able to meet to other regions.

Article 198 of the Constitution provides that the provision of health actions and services shall be integrated across all three levels of government through the creation of health regions and healthcare networks. However, the regulations governing health regions only came into force in 2011 with the publication of Decree Nº 7.508.

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During this 21-year interim period, their implementation was based on a ministerial order, which was limited in scope, both in terms of concepts and regulatory force. Health regions and the role of member states should be governed by a national policy. In this respect, two bills on this subject are currently under considered by legislators: Bill Nº 120 in the Legislative Assembly of the State of São Paulo and Bill Nº 1.645 in the lower house of the Brazilian National Congress.

Being systemic, unified and decentralized from a political point of view requires regional amalgamation to guarantee that the health needs of citizens in small-sized municipalities are met through a network that is coordinated, regionalized, continuous and delimited into regions. Such a level of organizational complexity, autonomy and interconnection across spheres of government, clearly requires a law that determines limits, composition, health responsibilities, inter-federative governance, scale, points of reference and other aspects, as is the case at a much smaller scale with metropolitan regions[13], which are regulated by law. Decree Nº 7.508 might be considered the "most recent" in the 21 years since the creation of the Basic Health Law (*Lei Orgânica da Saúde*), without overlooking the merits of Basic Operational Norms 01/93 (*Norma Operacional Básica* - NOB 01/93), which is perhaps the most innovative ministerial order after Law Nº 8.080.

Decree Nº 7.508 closed organizational gaps and is an important landmark in the regionalization of the SUS, creating, for example, the Public Health Action Organizational Contract (*Contrato Organizativo De Ação Pública da Saúde* – COAP), which guarantees legal certainty and transparency in relations between government spheres at regional level. Unfortunately, however, this has not been fulfilled, as if the administrating authority was able to pick and choose the rules and regulations that should be fulfilled.

Small hospitals, which account for the majority of the country's hospitals[14] and are an example that shows that the health regions and referral within the networks do not work, are sustained only by the desire to overcome gaps in care that can only be overcome by health regions. Health regions must meet the health needs of at least 90% of their population, meaning that the construction of health centers that do not comply with the guiding principles of regionalization, which state that they should be incorporated into the inter-federative regional healthcare network, should be prevented. In the twenty-first century, these types of mistakes are unforgiveable.

From regional to national planning

The lack of long-term planning (with a horizon of at least 10 years), which requires in-depth knowledge of health needs from an epidemiological, socioeconomic and demographic perspective, and the definition of clear and precise goals, such as the provision of adequate healthcare of appropriate quality for at least 85% of the population, is another flaw in the organization of the SUS.

Local and regional conferences are an essential component of bottom-up planning because they are held across the entire country, paving the way for the National Health Conference. However, we cannot deny that their executive format does not always capture regional needs to inform the formulation of national guidelines. National health conferences should strengthen the articulation of locally resolvable regional health needs into the national arena, but in a more comprehensive manner, as standards, since national policy makers do have a clear understanding local policy issues. Public participation is imperative for an effective SUS and health conferences and health councils are important mechanisms for facilitating public participation in health policy formulation and implementation.

On this point, it is important to mention that the lack of *macro* health policies based in law, guidelines and systemic bases is perhaps one factor that has fueled underfunding and helped lead to fragmented and individualized judicialization, whereby the judiciary defines in the individual that which should be collective. The representatives of the people, the legislative branch and the executive branch, should decide on policies, while their implementation and minutiae should fall on public administration. Paula Dallari Bucci[15] holds that interaction between the Legislative Branch and Executive Branch in defining the guidelines for the implementation of policies by public administration *has become an ideal rather than a fact*. Referring to Muller and Surel[16] the author maintains that "This conflict reveals not only a crisis between the executive and legislative branches in terms of ownership of legislative initiative, but also (the act of) overcoming all formal organization of the liberal state".

Designing guidelines for *macro health policy and state structures as national healthcare policy*, which should encompass, among other things, primary, specialized and hospital care, and pharmacy, could have changed the role of the Public Prosecutor's Office and judiciary in relation to

the rejudicialization of health to the supervision of compliance with health policy. Minister Gilmar Mendes referred to this need during a public hearing in 2009[17], when he suggested that the judiciary should require compliance with public policies that are not implemented by the executive branch.

When designed by ministerial orders, SUS-oriented macro policies and primary care – the backbone of the system – are weakened. Organizing healthcare in specialized networks, brings with it state powers that should be laid down by law.

Funding should be required in accordance with the policies that shape the SUS and not the reverse, where policies have to fit within the budget. The law governs parameters, guidelines and social pacts regarding specific issues, such as the adoption of technology, which is one the main bottlenecks and requires a rod of iron given it primary goal of profit. All this should be derived from policy guidelines discussed by the legislative house and involving meaningful public participation beyond voting, where citizens' voices are heard through public hearings, surveys and the day-to-day activities of health councils.

Funding and public management of policies

The main impasse encountered by the SUS throughout the years has been insufficient funding and inefficient management, which feedback on each other. Although one might blame the other, they are really the result of lack of government commitment to health and a patrimonial-bureaucratic state that believes in stamps and paper-pushing. The funding problem can only be resolved through tax reforms that promote a shift in the centralist federal model, with progressive taxes and other appropriate policies.

Society awaits administrative reform to modernize public administration in order to deal with the challenges of the twenty-first century and, as Carlos Ari Sundfeld[18] said, we are still in the age of "paperclip administration". How is it possible to integrate services without computerizing this integration? The SUS card, for example, which had been in discussion since the 1990s, rather than acting as the key for health professionals to access patient data to integrate examinations, diagnoses, therapies, outcomes and, ultimately, the entire health patient medical record, has ended up becoming nothing more than an identify card.

The problem of underfunding dates back to the creation of the Constitution in 1988. A detailed analysis of the events that have contributed to this problem, which did not take place by chance, but rather designed to strangle constitutional rights by restricting funding, is beyond the scope of this article. However, it is important to point out four key events that have complicated public funding: a) The Unlinking of Federal Revenue (*Desvinculação de Receitas da União* - DRU), beginning with the Emergency Social Fund (*Fundo Social de Emergência*) in 1993, which removed funding from the SUS that today comprises 30% of the volume of permission of its contingency; b) The approval of Constitutional Amendment 20 linking a large part of social security contributions to the social welfare system; c) The conversion of the Real Value Unit (*Unidade Real de Valor*– URV), resulting in the loss of 20% of original resources; d) The removal of 40% of the additional value of the Provisional Contribution on Financial Transactions (*Contribuição Provisória sobre Movimentação Financeira* – CPMF) and the subsequent extinction of this instrument; and d) Constitutional Amendment 95, issued in 2016. These and other events have caused significant damage to SUS funding, whereby government spending on health is only 4% of Gross Domestic Product, in comparison to at least 7% in countries with universal access to healthcare.

Another factor burdening SUS budget management – apart from the DRU being a blank check for the National Treasury – is the fact that unpaid expenditures transferred to the subsequent fiscal year are also controlled by the National Treasury Secretary, which, as Élida Graziane Pinto warns, means that this body *has the 'freedom' to ... discharge the flow of payment of its committed budgetary allocations*[19].Francisco Funcia also warns that *in 2018, elevated registering and reregistering values in unpaid expenditures transferred to the subsequent fiscal year will have to 'dispute financial space' with other costs (from the Ministry of Health and other ministries) in the context of the ceiling for primary expenditure (established) by CA 95/2016*[20]. Underfunding aggravates public administration challenges and vice versa.

The low level of resolvability of public administration led to the creation of legal instruments that have yet to be adequately understood by public managers. In this respect, it took 18 years for Brazil's Supreme Federal Court to decide on the constitutionality of civil society organizations, which, apart from the proliferation of legal "insecurity", lost their original conception in state and municipal laws that have changed its scope. As a result, we do not know if the matters

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that have been judged by the Supreme Court are actually being implemented by local and state government.

Furthermore, the management of the SUS is hampered by inadequate doctor training which has kept the approach adopted in the 1980s, oriented towards hospital-care rather than primary care, making it necessary to import doctors to treat the poorest half of the country's population. Not to mention market protection proposed by the so-called *Ato Médico* or medical act, which is likely to take its toll on primary care services.

Public managers and other authorities did not pay due attention to the scope and nature of the judicialization of this policy that began at the beginning of the 2000s, meaning that they were unable to understand the phenomenon and act to overcome its short comings and prevent abuses by opportunists. Today, there are over one million lawsuits and public managers and other authorities involved in the health and justice system do not know what to do.

Health is one of the greatest assets a country can have and the twenty-first century brings daily discoveries, increasing personal demands as the dissemination of health discoveries expands people's knowledge of technology and its possibilities. The three branches of government should therefore have the necessary decision-making capacity and agility so as not to be held hostage by the market and the desire to turn healthcare into a consumer good.

Why is it necessary to defend the SUS?

Why should we defend the SUS in the face of so many challenges? The following assertion made by Sérgio Arouca perhaps best expresses the reason why we should struggle to improve services towards universal access to healthcare: *Health reform is not a technical-managerial, administrative, and technical-scientific project. The health reform project also belongs to human civilization; (it is) a civilizing project, which, to be organized, needs to contain valuesthat we must never lose, since what we want for health, we want for Brazilian society*[21].

Despite chronic underfunding and numerous other challenges, in the last 30 years, this civilizing project has helped the SUS to take major strides in moving from medical and hospital care provided by the National Institute of Health Care of the Welfare System (*Instituto Nacional de Assistência Médica da Previdência Social* – INAMPS)to workers covered by the welfare system to wards universal access to healthcare.

That is why it is necessary to defend the SUS from lack of adequate funding, abandoning the fiscal health-people's health dilemma, a crossroads that seems more like an economic trap of disregard for constitutional rights. Society must have social thresholds as structures for safeguarding psychological and physical security. Without the guarantees provided by social policies, insecurity will afflict the poor, leading to the erection of walls by the privileged classes to protect themselves from the insecurity that they themselves have created[22].

The SUS cares for 150 million people directly and 207 million indirectly. Society cannot renounce this set of actions and services, because the only option available beyond them is paid health, sold on the market like a good to the privileged few who can afford it. Without the SUS we are left with "health barbarism".

In this respect, it is important to point out some exemplary policies (a concretized possible hope that is fully compatible with fiscal and economic health),such as Brazil's national blood policy and quality control respected throughout the world, its transplant policy, HIV patient care policy, immunization policy, and Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* – SAMU).

Final considerations

The implementation of the SUS has involved a number of struggles, in a country of continental proportions whose political culture denies funding for policies aimed at reducing inequalities. How many unnecessary hospitals are there and how many nonexistent necessary ones?

Promoting the health and well-being of citizens is the primary duty of the government, which through socioeconomic measures should guarantee quality of life, promoting sanitation and providing adequate funding for health surveillance and qualified professionals to prevent the risk of illness due to preventable disease.

When thinking about the SUS, we must reflect upon the high cost of unnecessary technology, an issue that should be addressed by a national policy, remembering that the European Union[23] reported that two-thirds of new technologies are not actually innovations. It is necessary to control interest in profit, given that the pharmaceutical industry is by no means altruistic, being oriented towards profit rather than well-being.

Self-care needs to take shape and be the responsibility of the whole of society, especially in

the twenty-first century, where health knowledge is widely disseminated. It is necessary to promote health awareness to avoid health problems that could be avoided by making healthy lifestyle changes.

The CA 95 imposed on society in 2016, which ignores the health needs of the population over the coming 20 years, is an affront to the fundamental objectives of the Republic, and poses a severe threat to the right of health. Fiscal health must not cause physical and moral damage and neither should it affect only social policies. All fiscal measures that affect people should be widely debated in a transparent and responsible manner. Highly regressive taxes penalize the poorest half of the population, while tax expenditures are not considered government spending and lack adequate controls.

We must turn this uncomfortable balance into national concern and bear in mind that effective public participation has been the mainstay in the fight to overcome the challenges faced by the SUS over the last 30 years, and that only a population engaged in shaping the destiny of a nation has the power to promote change towards achieving social justice, equality, solidarity and, above all, the protection of human dignity.

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