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Future prospects for the SUS

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Abstract *The aim of this article is to present political strategies in relation to healthcare and management in order to support a strengthening of the Unified Health System (SUS). Rather than providing 'certainties', the intention is to suggest a basis for a wider discussion regarding the possibilities of universal health rights in Brazil.*
Key words *Unified Health System (SUS), Health policies, Health reform*

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Introduction

This article is written as a defense of the Unified Health System (SUS).

In order to suggest political and organizational strategies designed to consolidate and strengthen the SUS, I adopted an approach used by architects. After designing ten houses, architects also often design an eleventh house that would not be able to exist without the knowledge of the previous ten, but which, at the same time, is different from all those used as a reference. Drawing on existing knowledge about social reforms, public health systems and the history of the SUS, including the difficulties it has faced and the progress that has been made, I suggest interpretations and proposals that, at best, can serve as food for thought for those committed to the right to health and democracy.

I present five theses that I consider to be essential for the expansion and consolidation of the SUS.

Ensuring sustainability for public spaces and, consequently, the SUS

I consider it essential to think of the SUS as a public policy;the defense of its public management must recognize the SUS's problems and limitations in order to suggest changes that can strengthen the public character of health policies.

There is a wealth of evidence regarding the superiority, effectiveness and efficiency of public, universal health systems when compared to market models. The latter are characterized by excessive costs, inequality of care, the fragmentation of rights, and access to health defined not by need but by social security regulations and purchasing power. It is interesting to note the difference in spending between the United States (16.4% of GDP) and the United Kingdom (7.11% of GDP), and compare these figures with health indicators, or their equivalents, or with the slight advantage for the United Kingdom[1].

In Brazil, 54% of health spending occurs in the private sector, which serves only 25% of the population. The SUS, which is exclusively responsible for 75% of the population, provides services aimed at the whole of society but only receives 46% of the resources that are available. It would be impractical, both financially and socially, to extend a market-focused private health insurance system to the whole population. In a recent report, the World Bank[2] (2017) suggests that Brazil has spent excessively on health (9.3% of GDP); however, the report failed to point out that the largest portion of this spending relates to the wealthiest sectors of the population.

Public health systems, which have been implemented in various countries, constitute non-market spaces within capitalist economies. The sustainability of these policies depends on several factors, including the construction of a culture that is different from that which prevails in the market. It is a culture that considers human development to be more important than economic growth. From the public perspective,the concept of effectiveness should also consider social inclusion as one of its indicators in order to emphasize the idea that politics, public spending and service delivery have an impact on well-being. Likewise, the concept of efficiency cannot be calculated without considering the exclusion of people in care due to "rationalizing" measures suggested by economics.

In the aforementioned report, based on productivity indicators, the World Bank[2] stated that hospital care was inefficient because it does not consider the benefits in relation to access and the inclusion of people:

Rationalization of the service delivery network, especially the hospital network, to achieve a better balance between access and scale (efficiency). More specifically, this would require a reduction in the number of small hospitals (most Brazilian hospitals have less than 50 beds, and about 80% have fewer than 100 beds - when the estimated optimal size varies between 150 and 250 beds to achieve economies of scale)[2].

This type of calculation by the World Bank ignores the context of thousands of small municipalities and the outskirts of metropolitan regions in Brazil. It also disregards the fact that the solution for most of these small hospitals would be to transform them into mixed units, integrating teams dealing with issues such as family health, priority care, maternity, and surgical procedures of low complexity into the same services. This transformation would ensure greater population coverage, incorporating excellent care and financial rationality. Examples of this already exist in some Brazilian cities[3].

However, the same World Bank report recognizes and highlights the private use of public finance, as well as taxes being passed directly to business groups and to higher income groups:

The public sector also spends significant resources through tax expenditures, mainly to subsidize private health insurance (0.5% of GDP). Individuals can deduct health expenses from their

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taxable income and the same applies to legal entities that provide healthcare for their employees. The government also deducts taxes and contributions from the pharmaceutical industry and philanthropic hospitals[2].

The sustainability of the SUS depends on increased financial resources. It is not possible to finance the system by merely increasing the public deficit; it is necessary to highlight distortions in the use of that budget and to suggest that resources are transferred to fund public policies. Thus, a solution would be to pass legislation to prohibit the use of these budgetary resources to finance private health plans or health plans administered by companies. This would be a way to induce sectors of the economic and political elites to consider using the SUS, as well as increasing financial contributions to the SUS without increasing public spending.

This article is not intended to criticize each of the World Bank's analyses and recommendations, but rather to reject the reductionist rationality - which is averse to social policies - that presides over the construction of so-called indicators, analyses and solutions. The latter is an economistic rationality that does not take into account the right to health or possible changes in the model of management and care within the public sphere.

The previously cited World Bank report is part of a powerful political and cultural movement that aims to push back public spaces, replacing them with typical market processes (e.g. access mediated by an individual's purchasing power and competition, i.e. survival of the fittest or so-called Social Darwinism) andattributing priority to economic factors rather than human and ecological development. In terms of health, these measures imply a weakening and reduction in the scope of the SUS, both in relation to population coverage and services provided. The following recommendations have been monotonously repeated at regular intervals;privatization; outsourcing; public-private partnerships; decentralization, with deregulation and fragmentation of the network;and the end of free treatment; in short, the idea of a SUS restricted to the very poor and functioning as if it were a market-based entity, without notions of solidarity and the importance of ensuring rights. The mass media have uncritically publicized and recommended such counter-reform reasoning as a solution to healthcare problems and social policies in general.

The importance of planning a SUS for all Brazilians.

Throughout the twentiethcentury, researchers, intellectuals, populist political parties, and social movements have highlighted injustices and abuse of power, even in periods of economic growth. To deal with these problems, political and parliamentary struggles in favor of civil, political and social rights were organized. The concepts of "revolution" and "reform" were elaborated. The first suggested the abolition of the market economy and its replacement by a new economic and social regime. The second predominated in countries that constructed public policies which were intended to secure rights;policies that would nullify or control the effects of the concentration of income and power resulting from the free operation of the market[4].

In Brazil, in view of their inability to confront abysmal levels of social and political inequality, the dominant classes have occasionally misused the term "revolution" to refer to conservative political movements. The "revolutions" of 1930 and 1964 in Brazil, which were perpetrated by dominant groups, were presented as being in favor of the good of all[5]. From the 1970s onwards, a dispute arose around the concept of "reform": regressive actions, which were centered on the deconstruction of rights,came to referred to as"reforms", when in reality they are "counter-reforms". The current Temer government in Brazil is not reformist; on the contrary, under the pretext of ensuring economic growth and reducing privileges it has been concentrating income and political power in the hands of the representatives of capital.

Brazilian health reform is part of the tradition that has fought for the reduction of inequality; it was those efforts that produced the SUS.

Unfortunately, ideological polarity has produced division among intellectuals, researchers and SUS managers within the health reform movement itself, generating restrictive discourse around the issue of "universal health coverage"[6].

Reforming the reforms: a SUS for the twenty-first century.

Constructing a political grouping and social individuals capable of ensuring the right to health and public systems

In Brazil, the relevance of the SUS in terms of healthcare for at least seventy percent of the population has not been mirrored by a similar degree of political and ideological support for the entity. In recent years, there has been a certain conformity around the idea of dismantling

the SUS. Perhaps this paradox can be explained by the fact that, as yet, the SUS has only been partially implemented. The advent of the SUS brought with it an important expansion of access to primary healthcare, emergency care, vaccinations and pre-natal care, as well as specialized and hospital services; however, at the same time the issue of health has emerged as the country's main problem[7]. The strength of Brazilian public health policy is actually the SUS; it represents the extension of benefits to the whole population. However, the weakness of Brazilian public health policy is also the SUS as it currently exists, due to all its ills and shortcomings. As the SUS is intended, in practice, to serve the exploited majority of the population, the consideration of health problems and the quality of health services will largely reflect the neglect with which that sector of society is treated. In Brazil there are two different realities, one that is designated for the rich minority, and another, which is sub-standard, for the poor. There are two policies regarding pubic security, two transport policiesetc;in short, two systems for everything. Perhaps this is why the ambience within SUS services is so blighted, with such little respect for the dignity and humanity of service users.

Consequently, the struggle for the SUS depends on the struggle against inequality, against racism, against sexism, against the concentration of power in the hands of rulers, managers, authorities, and so on.

The Health Reform Movement is considered as one of the main social actors in the process of the invention and implementation of the SUS, and of the universal right to health[8]. The Health Reform Movement can be seen as a new type of social movement because it came into being as a sort of political grouping of different interest groups, in which people from varying social origins, genders and ethnicities came together around a common project: the right to health, the SUS and democracy. There were differences in emphasis in relation to strategies and forms of action, with some groups prioritizing institutional work, both at the base level in terms of the reform of knowledge and practices, and also in the implementation of new programs and arrangements. Some sectors of the movement preferred "entryism", participating in governments favorable to public policies; others preferred to make approachesto social movements and society, advocating the articulation of the construction of the SUS with the radicalization of the democratic process.

This movement resulted in the approval of the SUS by the 1988 Brazilian Constitution and the implementation of other organizational innovations such as participatory management and social control of the State by society. Throughout the three decades that the SUS has been operating, this movement has weakened due to the growing predominance of political influence within the state apparatus, as well as the crisis of representation of political parties and social movements, including those who supported the SUS.

Some of the main components of this movement were health workers, teachers, researchers and students. Only a small percentage of health workers participate in the movement, mainly those working in the areas of collective health, primary healthcare, mental health, AIDS/STD programs, etc. Various associations, including the CEBES [Brazilian Centre for Health Studies] and ABRASCO [Brazilian Association for Public Health], have worked to bring together these activists. Public universities have played a decisive role in promoting these doctrines and training professionals with a reflective approach who are willing to combine health work with democratic activism.

Currently, the defense of the SUS is mainly centered on this social segment. One of the innovative features of the Health Reform Movement was to seek changes at all levels of the system. Health workers, supported by service user groups, have explored the possibilities of co-management in the daily running of health services, with the aim of radically reforming work and management processes wherever possible. In many cases this has necessitated opposing managers who hold conservative views.

In order to provide guidance for this political and professional activism, the movement has producing innovative theory, methodologies and intervention strategies in accordance with SUS guidelines. Several of these critical elaborations became national SUS policies, such as: theNational Mental Health Policy;the National AIDS/STD Control Policy, the National Primary Care Policy, as well as national policies regarding hospital attention, oral health, urgent and emergency care, humanized care within the SUS, and continuing education, among others.

The strengthening and widening of this type of activism is of fundamental importance.

In order to expand the consolidation of the SUS and the right to health it is fundamental that the Health Reform Movement links up with the majority of Brazilian society. Nevertheless, this is

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not simple; health rights activists should be able to more easily align themselves with currently emerging movements, such as women, black people, young people, the LGBT community, as well as those fighting for issues such as housing and public education. However, the popular sectors are disorganized and there is a need to invest in the reconstruction of social movements. Although Brazil is encountering an historic period of attacks on social rights and policies, mere criticism of the government and the political establishment is not sufficient. It is necessary to highlight the problems within the SUS, within cities, and in relation to sociability,as well as suggesting solutions to these issues. Thus, in terms of health, the queues for hospital and specialized care are immediate and they indicate disrespect forhealth rights; our project needs to identify these difficulties and to fight to overcome them. For this to occur, it is critical to radicalize and increase effortsthat are directed in favor of adequate financing, changes in care models, humanization and participatory management.

Changes begin when there are possibilities and necessity–it is important not to wait for orders from above.

Despite the relevance of the SUS, the support it has received from politicians has been negligible. The SUS has not received major backing from any Brazilian government since its inception[9]. No government or political party has supported the funding and implementation of SUS as a national priority. Consequently, the SUS has been constructed incrementally and with a lack of resources[10]. During the first decades of the implementation of the SUS, municipal health secretariats and their representative body, CONASEMS [the National Council for Municipal Health Secretariats] played an important role in defending the system, but in recent years they have tended to argue in favor of decentralizing the system, which, in practice, reflects a weakening of various national policies. In fact, SUS managers are increasingly integrated with,and controlled by, the logic that predominates within Brazilian party politics and the presidentialism of the existing coalition. This has distanced SUS managers fromhealth needs and accentuated their commitment to patronage and patrimonialism.

Reconstructing the institutionality of the SUS to improve its public character

In order to ensure the sustainability of the SUS it is necessary to continue with the reform of the State and the management model of the SUS in order toovercomevarious structural and functional obstacles. One of these challenges is to find an organizational design which remains within the rationality of public affairs (centered on health needs), as well as being able to operate with sufficient autonomy in relation to the market, executive power and political parties. In general terms, it is necessary to reorganize the SUS, reinforcing its character as a national system (not only federal, but tripartite) and ensuring that the SUS remains stable despite the changes in government that are inherent to democratic systems.

The SUS as an autarkic system, but it is one that works in co-management with federated entities, health workers and service users;there is a need to expand and reinforce the capacity for fiscalizationand effective participation in SUS management, planning and evaluation.

It is critically important to reformulate existing rules regarding tendering, procurement, maintenance and accountability in order to provide flexibility and safety in relation to managing public finance, as well as combining centralized actions for the management of strategic inputs, with the transformation of programs and services into budgetary units with expanded managerial responsibilities.

The SUS is very fragmented, which makes its governance precarious in terms of comprehensive healthcare networks. It is essential that the systemic integration of the SUS be expanded. For this to take place,there needs to be a review of the dynamic that exists between centralization and decentralization. One of the elements that helpsto balance these two extremesare the National Health Policies, conceived by co-management and approved by the SUS co-management entities, i.e.tripartite conferences, councils and commissions. The recent trend of dismantling these agreed national policies has tended to further fragment the SUS, as well as exposing state and municipal administrations to the pressure of groups interested in exploiting the SUS for their own particular aims. For example, the National Primary Care Policy, which was approved and published in 2012 after a long struggle, has greatly contributed to the expansion and qualification of the system. The modifications approved by the Tripartite Inter-Agency Committee (CIT) represent a setback in that it they devolved the responsibility for the model for primary healthcare, and the strategies for organizing it, to each municipality. The same impasse occurred in relation to the National Mental Health Policy due

to the counter-reforms presented in 2017 by the Ministry of Health.

Another theme that is central to changing the dialectics of centralization and decentralization is the constitution of Health Regions responsible for network management, and not merely negotiation and planning. Initially, it would be important to redesign the Health Regions, reviewing the current division that created 404 regions, when there are indications that 200-250 would be sufficient. To strengthen the role of the Health Regions in terms of management, it is essential to establish a Regional Health Fund, with its own budget through lending from federal entities, especially the Federal Government. The Health Regions should be responsible for medium and high-complexity management and health surveillance. Until now, the SUS has had great difficulty managing its own hospitals andthose that it is contracted to manage, which has operated in disconnection with urgent and primary healthcare, as well as general problems of efficiency and effectiveness. Similar problems have occurred regarding the control of epidemics, in which coordinated actions have not been conducted in the territories.

In order for the Health Regions to operate in this way, it would be crucial to approve modifications regarding SUS operating rules, creating a health authority in each Health Region, as well as a management structure with the support of state and municipal personnel and resources.

The crisis of sustainability facing the SUS can be mitigated if legislation is approved to drastically reduce the positions of trust - or of free provision - in SUS management. Only ministers, state and municipal health secretaries, and a small group of advisers would be appointed according to political interest; all other system managers would be recommended based on technical health criteria and experience of dealing with the SUS.

None of these changes would depend on alterations to the Constitution.

A unified personnel policy for the SUS

The sustainability of the SUS depends not only on the training of a new type of health professional butalso on a personnel policy and management that understands the functional diversities of the various professions and specialties that comprise the SUS, as well as the diversity of health conditions and contextswithin the various Brazilian regions.

The tradition of public management of personnel favors bureaucratization, de-humanization and alienation in the work of caring for people and communities. I consider the organization of careers based on professional categories to be superior. Health work has special characteristics; it depends on the motivation and the involvement of each worker with the health of other people. The importation of management models used in factories or private services has not obtained good results when applied to the area of health. Health work is of the so-called praxis type, i.e. in general, it does not work in mechanized production lines, which require that workers and multi-professional teams operate as much with norms and protocols as with variations of procedures and behaviors, depending on the specific case and context. Moreover, the SUS has been organized along the lines of shared work, using teams, matrix support and working within care networks. Thus, it is important to consider policies and careers that respect the identity of each specialty or profession, but which also stimulate interdisciplinary practice and the sharing of responsibilities and tasks. The fragmentation of the care process into compartmentalizedtasks, and the shuffling of patients between professionals and services as if they were piecesmoving along a production line,produces ineffective, inhuman and inefficient results.

The SUS incorporates several types of career, which are organized on the basis of the characteristics of the main areas of the health system. There are five thematic areas within the SUS: primary care; medium and highly-complex care (secondary and tertiary network, outpatient clinics, reference centers, homecare services and hospitals); the urgent care and emergency network; the health surveillance network; and the SUS management support system (the administrative, maintenance and financial sectors).

Labor rights, as defined by law, and the specificities of the practice of each profession or specializationshould be considered in a matricial manner in relation to each career within the five thematic areas. Thus, the norms and characteristics of nurses, doctors, dentists and pharmacists, etc. should be considered in the organization of each of these thematic careers and would serve as matrix vectors for horizontal, thematic careers.

The development of careers with double conditioning (one that is vertical and favors collaborative and interdisciplinary work, and another that is horizontal and respects the rights and specificity of each profession and specialty)

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would weaken corporatism among the health professions, especially physicians, and strengthen the dialogical relationship with service users. It is a strategy to expand the conditions of possibility for the constitution of a new type of health worker for the SUS.

Each of these thematic areas would have an organizational logic and specific function[11].

A single body responsible for personnel policy should be implemented. Given the current complexity of personnel policy it would be impossible to transfer the responsibility for its construction and maintenance to municipalities or to local or regional health providers. The management of this new policy would be shared between the Union, states and municipalities; it would be the responsibility of the Tripartite Committee of the SUS, through the creation of a public body (autarkic or a public foundation) and a Budgetary Fund for Personnel Policy.

Consolidating and qualifying health policies and practices

Issues such as access, humanization and the quality of care are those that most concern the population; all other issues are means to achieve the overriding purpose of the SUS, which is to defend people's lives.

A fundamental strategy to educate the population is to always link the fight for budgetary resources for the SUS to specific projects, such as the expansion and qualification of primary care, eliminating waiting lists through investment, and better management of hospitals and specialized services, personnel policy expenses, medicines, innovation and science and technology in health, etc.

Communication and integration with society is fundamental for the democratization and sustainability of the SUS. It is essential to analyze and publicize information about the pattern of expenditure regarding public budgets, the difficulties and problems that face the SUS, and the negative repercussions on health resulting from cuts in funding and health services.

The expansion of the Family Health Strategy to cover 80% of the population is a priority. Its qualification should also be a priority for the SUS. The re-ordering of the operation of the service network implies reinforcing the regulatory role of primary healthcare and computerizing the SUS through an integrated system. The regulation of access to the SUS should not be bureaucratized or delegated to isolated instances within the network. In traditional public health systems, regulation is the responsibility of health professionals and network teams through defined norms to facilitate access according to criteria of risk and vulnerability.

The queues for healthcare in Brazil are due to insufficient installed capacity and also to the lack of adequate referral criteria. The hospital and specialist services network need to be integrated in order to function as a territorial reference, and also support primary and urgent care. Planning for the implementation of new programs and services should be carried out in the Health Regions.

It is fundamental to reorganize the models regarding hospitals and specialist services. In order to achieve this,the following measures should be adopted: apply primary healthcare guidelines in outpatient clinics; set up inter-professional referral and matrix support teams; create team responsibility for patient cohorts; link up continuity and case coordination; introduce technological densification and pro-activity; broadenscenarios regarding practices, groups, observation beds, and diagnostic,therapeutic and surgical procedures; facilitate services that are on demand (not scheduled) and scheduled; and implement increased specialized clinics that are shared with service users.

Policies regarding hospitals, as well as their management, have undergone little change since the creation of the SUS. The model is of traditional management and care. Services are isolated (interconnection is performed by the patient/family); departmentalization is carried out according to professional categories/specializations; responsibility for procedures lies with professionals; and there is fragmentation in terms of management and care. It is essential to extend health reform to hospitals; to integrate them to into the health network as reference for medium and highly-complex cases; to create departments that are organized by function or subject areas (Production Units); to organize interdisciplinary teams as reference and support matrices;to instigate a management model that has responsibility for cohorts: to strengthen links between continuity and the coordination of care, and to introduce forms of co-management of care and participatory management.

Let's debate and build a project that unifies us!

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