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A CRITICAL LOOK AT THE DECENTRALIZATION OF PUBLIC HEALTH SERVICES IN HOSPITAL CARE

Um olhar crítico à descentralização de serviços públicos de saúde em atenção hospitalar

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ABSTRACT

This study aims to identify the hiring overview of the non-profit private sector by the Brazilian National Health System (SUS) to perform medium and high complexity health services in hospital care and its relationship with the SUS decentralization guideline, which must guarantee assistance from large urban centers to areas where public services are most scarce. In this regard, it question whether the expanded hiring of private hospital services represents a departure from the national and state directorates of the execution of health services from the generalized municipalization of health services. The research methodology is exploratory and descriptive, based on the literature of Health and Administrative Law. Especially from the analysis of public expenditure on hospital services, collected from the Department Informatics of the National Health System, in the last five years, it is identified that non-profit entities had more investment in hospital production than the direct and indirect public administration spheres of all entities. As a contribution to the search for solutions to the problem, it is concluded that the smaller participation of the national management of the SUS in the provision of health services leads to greater purchase of private services sector by the entities, disregarding the constitutional determination of complement the participation of the private sector in the SUS. In addition, the provision of hospital services in this way promotes the lack of balance in the allocation of hospital beds, which compromises equal conditions in access to health actions and services, the objective of decentralization, and the proper functioning of the SUS.

Keywords
Decentralization; Hospital Network; Brazilian National Health System.

RESUMO

Este trabalho objetiva identificar o panorama de contratação do setor privado sem fins lucrativos pelo Sistema Único de Saúde para realização de serviços de saúde de média e alta complexidade em atenção hospitalar, e a relação desse panorama com a diretriz de descentralização do Sistema Único de Saúde, que deve garantir atendimentos desde os grandes centros urbanos até as zonas onde os serviços públicos são mais escassos. Nesse aspecto, questiona se a contratação expandida de serviços hospitalares privados representa um afastamento das direções nacional e estadual da execução dos serviços de saúde a partir da municipalização generalizada de serviços de saúde. A metodologia de pesquisa é exploratória e descritiva, com base bibliográfica na literatura do Direito Sanitário e do Direito Administrativo. Especialmente a partir da análise dos gastos públicos com serviços hospitalares, colhidos do Departamento de Informática do Sistema Único de Saúde, nos últimos cinco anos, identifica-se que as entidades sem fins lucrativos tiveram mais investimento em produção hospitalar do que as esferas da administração pública direta e indireta de todos os entes. A título de contribuição para a busca de soluções para o problema, conclui-se que a menor participação da gestão nacional do Sistema Único de Saúde na prestação de serviços de saúde acarreta maior compra de serviços da iniciativa privada pelos entes, descumprindo a determinação constitucional de complementariedade da participação do setor privado no Sistema Único de Saúde. Ademais, a prestação de serviços hospitalares nesses moldes promove a falta de equilíbrio na alocação de leitos hospitalares, o que compromete a igualdade de condições no acesso às ações e aos serviços de saúde, objetivo da descentralização, e o adequado funcionamento do Sistema Único de Saúde.

Palavras-Chave
Descentralização; Rede Hospitalar; Sistema Único de Saúde.

Introduction

In order to achieve universality and equality in access to health actions and services, as well as the reduction of diseases and inequalities - objectives of public social and economic policies -, the Federal Constitution of 1988 (CF/88)[1] designed a public health system that valued prevention and was integral, unique and free. The organization of actions within this public system, established by CF/88, would occur in a regionalized and hierarchical network. This network would be structured around decentralized actions and comprehensive service, with the participation of the community.

Furthermore, a complex health system could not be built without an adequate interpretation of these characteristics that the Brazilian constitutional model determined for health. In this sense, it is important that scholars from the Brazilian National Health System (SUS), as well as those who are part of it, are willing to debate the most current and practical arguments and issues that arise about public health in Brazil. In this regard, it is appropriate to address, even with critical nuances, SUS guidelines such as **regionalization** - considering that the World Bank's recommendations for Brazil in 2017 arouse reflections about the limits of local health care networks and how they can be, to some extent, harmful especially in smaller municipalities - and the **hierarchization** - as the division of health competencies can collaborate with better health provision.

The revision of the criteria for apportionment among federal entities based on their health responsibilities is a goal of Objective 13 of the National Health Plan (2016-2019)[2], which is "to improve the spending pattern, qualify tripartite financing and the transfer of resources process, in the perspective of the stable and sustainable financing of the SUS".

This work is part of a bibliographic search in the literature of Health and Administrative Law that deals with the guidelines of the SUS, together with the research and analysis of data available in the Hospital Information System of the SUS (SIH/SUS), via public data tab developed by the Informatics Department of the SUS (TABNET-DATASUS)[3], about medium and high complexity expenses with hospital services, according to the legal nature of the production owner (direct and indirect public administration of all entities and non-profit entities), in the period between January 2014 and September 2018. With this, it propose to discuss the nuances of the decentralization of the health care network and to study the reflexes

[1]BRASIL. *Constituição da República Federativa do Brasil de 1988.* Available at: http://www.planalto.gov.br/ccivil_03/constituicao/constituicaocompilado.htm. Accessed on: 11 Dec. 2019.
[2]MINISTÉRIO DA SAÚDE – MS. *Plano Nacional de Saúde*: PNS 2016-2019. Brasília-DF: 2016. p. 89. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/plano_nacional_saude_2016_2019_30032015_final.pdf.
[3]MINISTÉRIO DA SAÚDE - MS. Sistema de Informações Hospitalares do SUS (SIH/SUS). *DATASUS*. Available at: http://tabnet.datasus.gov.br/cgi/tabcgi.exe?sih/cnv/qgbr.def. Accessed on: 21 Nov. 2018.

of the municipalization of medium and high complexity health services in the hospital production acquired by the SUS with the private non-profit sector, limited to hospital production ceilings without really considering local health needs.

In this sense, the work questions what is the panorama of the service hiring of private hospital by the SUS during the period examined, and how the largest private hospital production stems from the removal of national and state directions from the execution of health services, delegating health management to municipalities, regardless of their capacity, and then to non-profit entities.

The solutions adopted until September 2018, consistent in hiring the private network to supply the absence of public administration services, should not be the rule, in order to prevent the public system from being permeable and dependent on private initiative.

I. Regionalization and hierarchization as a mark of the decentralization of the health network

The health system proposes to be unique, however regionalized, at the organization level, and hierarchized, in order to assist its functioning in the most diverse service complexities. In addition, the organization of the SUS as a system traces a certain disfigurement of the federal logic, in which the entities have more autonomy: in it, a mandatory integration between the federal entities is identified for the coordination and cooperation of the actions and resources made available.

Gilberto Bercovici[4] best explains the tone of coordination and cooperation in the Brazilian legal system, highlighting that CF/88 is the source of cooperation between entities and, although outside the cases mentioned in the Magna Carta as hypotheses for cooperation, separation and independence predominate in the exercise of constitutional powers. Coordination presupposes that the Union and federated entities have the same function, but in different scope and intensity, with prevalence of federal allocation[5], this being the type of competence to legislate on health protection (art. 24, XII, CF/88). Cooperation, in contrast, designates the Union and the other entities to exercise competence together with the others, but with interdependence, making it difficult for an entity to perform with exclusivity or prevalence a given function; cooperation is revealed in the common competences[6], like the competence to care for public health, common to all entities (art. 23, II, CF/88).

[4]BERCOVICI, Gilberto. *Desigualdades regionais, Estado e Constituição*. São Paulo: Max Limonad, 2003. p. 151-154.
[5]*Id. Ibid.,* p. 151.
[6]*Id. Ibid.,* p. 152-153.

Considering that a single health system could not be built based on cooperation between state entities without an organization mechanism, the CF/88, when establishing the bases of the SUS, also determined that the organization of this public system be regionalized and hierarchized. Article 198 of the CF/88 presents the guidelines, as contours and characteristics, of the public health system, among them decentralization, alongside comprehensive care and community participation, which must take place in the context of regionalization and hierarchization.

According to Fernando Aith[7], regionalization concerns a political decentralization, established at levels of competence of each federal entity, added to the cooperation between these various entities. In other words, regionalization is based on federal autonomy linked to the consensus obtained in administrative bodies created to favor this cooperation, such as the Bipartite and Tripartite Inter-Management Commissions (CIB and CIT).

Hierarchization, in contrast, is related to the organization of care at different levels of complexity[8]. Care should start from the simplest (primary care, such as consultations and dressings) to the most complex (secondary care, such as minor surgeries; and tertiary care, such as larger surgeries).

For Sueli Gandolfi Dallari and Vidal Serrano Nunes Júnior[9], while regionalization concerns an organization by territorial constituencies, hierarchization is related to an organization at different levels of complexity, in a reference and counter-reference system that allows the rationalization of the use of resources, considering that the primary care unit both performs its case of reduced complexity and references cases of greater complexity to a secondary or tertiary service.

Thus, all these contexts of the network express their decentralized characteristic, assuming, consequently, that the services must be provided by the municipalities except when they have a national or regional dimension. This conception, warns Jorge Munhós de Souza[10], does not eliminate the characteristic of our federal model, in which the Union concentrates the collection, but establishes execution responsibilities to entities in reverse to their own investment power – that is, the Union remains the collecting entity in essence, but the execution of services, including health, must be carried out, as a rule, by municipalities, except those of regional and national dimension or when the municipality responsible cannot carry it out.

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[7]AITH, Fernando Mussa Abujamra. *Teoria geral do direito sanitário brasileiro*. 2006. Tese (Doutorado em Saúde Pública) – Programa de Pós-Graduação em Saúde Pública, da Faculdade de Saúde Pública da Universidade de São Paulo, 2006. p. 395 -396.

[8]SOUZA, Jorge Munhós de. *Diálogo institucional e direito à saúde*. Salvador: Editora Jus Podivm, 2013. p. 210-211.

[9]DALLARI, Sueli Gandolfi; NUNES JÚNIOR, Vidal Serrano. *Direito sanitário*. São Paulo: Editora Verbatim, 2010. p. 83-84.

[10]SOUZA, Jorge Munhós de. *op. cit.,* p. 212-213.

It is identified that the federalism of the health system, in the face of the decentralization guideline, can be considered **centrifugal** (which tends to move away from the center), in view of the great autonomy of subnational entities for the application of health policies. The federal model of organization of the Brazilian State is more **centripetal** (which tends to approach the center), granting powers to subnational entities while still concentrating the capacity of unity in the national entity, through its high material and normative power.

Thus, it can be said that, in essence, regionalization presupposes a decentralization coordinated by norms that divide the allocation of the Union, states and municipalities in the SUS. Based on the division of the system in terms of complexity of services (hierarchization), and even if the Union has greater power of collection – and, therefore, expenditures – it is denoted that the national direction of the SUS would be more able to afford the financing of high complexity systems and that local management would be better able to manage low complexity systems. This is how regionalization and hierarchization can be related and harmonized.

The coordination and consensus stemming from the proper understanding of these concepts entail the debates and decisions around the CIB and CIT, which are collegiate administrative bodies created to favor the consensus that organizes the regionalization[11], territorially speaking, but also around the types of care based on the complexity of the service (hierarchization).

However, the current model of the health system, structured in decentralized networks, does not allow great reflections on the confusion that can be caused when regionalization becomes justification for the execution of health actions and services almost entirely by the municipalities, disregarding that the hierarchization could advance more in the decisions of the CIB and CIT.

Thus, it is important to debate the municipalization of health services, notably those that the municipalities are unable to provide, even although the constitutional intention to establish decentralization is to guarantee access to these services in the most diverse realities of Brazil and that, for this, the country has chosen to assign greater responsibilities to municipalities in the 1990s.

II. The movement of health provision by municipalities at all levels of care

The provision of public health actions and services in Brazil was structured around care networks, giving a systemic perspective to health issues. From the creation of the system, it is possible to establish health prevention and promotion programs and, thus, enable network health actions to be within the objectives of universality and equity. As pointed out in the qualification manual of the SUS managers:

[11] AITH, Fernando Mussa Abujamra. *Teoria geral do direito sanitário brasileiro*, *cit.,* p. 396.

> In a network, equipment and services do not function in isolation, taking joint responsibility for access, comprehensive care and continuity of health care for people. [...] For this, it is necessary to define the units that make up the network according to levels of care (hierarchization) and distribute them geographically (regionalization). At a more basic level, there would be units equipped with technologies and professionals to carry out the services most frequently needed (e.g., vaccines, consultations with general practitioners, doctors with basic specialties and other health professionals). At a more specialized level, hospitals, ambulatories and diagnostic and therapy units capable of performing those less frequently needed procedures (e.g.: cardiac surgery, neurosurgery, nuclear magnetic resonance, bone marrow transplants) would be located [12.]

Furthermore, the organization by health regions is part of the configuration of a decentralized health network, which may cover more than one municipality. This even stimulated the realization of health consortia, which began to be widely celebrated in the 1990s as an alternative for managers for a municipalization "accelerated in a federation marked by a large proportion of small municipalities that are unable to guarantee in isolation the supply in isolation the provision of services necessary for the health care of the population in its territorial scope"[13]. Still in the context of the reconfiguration of health care networks around the municipalities, there is the greater participation of the private initiative in public health expenditures in the face of the increase in the allocation of health actions and services to municipal governments in the 1990s and 2000s[14], at all levels of attention.

For no other reason, as Nilson do Rosário Costa[15] points out, the participation of municipalities in total health expenditure rose from 12.3% in 1995 to 18% in 2012. The states maintained the same 25% of total public expenditure. The proportional share of federal expenditure was reduced from 61.7% to 57% between 1995 and 2012. The author analyzes that, despite recognizing that SUS has been successful in primary care, "it is necessary to draw attention, however, to the fact that the Brazilian central government allocates a small portion of the financial execution as an incentive for municipalities to develop primary care"[16]. On the other hand, a

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[12] KUSCHNIR, Rosana *et al*. Configuração da rede regionalizada e hierarquizada de atenção à saúde no âmbito do SUS. *In*: OLIVEIRA, Roberta Gondim de; GRABOIS, Victor; MENDES JUNIOR, Walter Vieira (Orgs.) *Qualificação de gestores do SUS*. Rio de Janeiro: EAD/Ensp, 2009. p. 128.

[13] *Id. Ibid.,* p. 135.

[14] COSTA, Nilson do Rosário. Austeridade, predominância privada e falha de governo na saúde. *Ciênc. saúde coletiva*, Rio de Janeiro, v. 22, n. 4, p. 1169, abr. 2017. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232017002401065&lng=en&nrm=iso. http://dx.doi.org/10.1590/1413-81232017224.28192016.

[15] *Id. Ibid.,* p. 1169.

[16] *Id. Ibid.,* p. 1170.

large part of the Union's resources is destined to the purchase of high complexity services by all entities, including states and municipalities, as highlighted by Costa:

> The stagnation of the decentralization process in the current decade resulted in 37% of federal health resources being executed in 2013 directly by the MS [Ministry of Health] via the National Health Foundation, and the remaining 45%, also intended to purchase by central, state and municipal governments admissions, services, and high-cost medication[17].

If for primary care there seems to be a reduction in importance, with insufficient transfer of resources by the Federal Government to this level of the network, for high complexity care there is a greater transfer of resources, aiming at the purchase of services by the municipalities. This disparity, in addition to disregarding the greater vocation of municipal entities for primary care, reveals a regional planning process that is inadequate to SUS order, with only formal implementation of the hierarchization concepts and justifying more comfortable trends, such as the transfer of service provision of more complex services to municipalities and to private initiative.

According to Technical Note no. 28/2016 of the Institute for Applied Economic Research (Ipea)[18], the percentage of the Gross Domestic Product (GDP) applied to health in Brazil ranged from 3.19% in 2002 to 3.94% in 2015. This growth in health investment based on GDP was largely due to the increase made by states and municipalities in the financing of the SUS. Health expenditures in the Union went from 1.66% of GDP in 2002 to only 1.69% of GDP in 2015. In the same period, states went from 0.72% to 1.03% of GDP, and municipalities from 0.81% to 1.22% of GDP in expenditures on public health actions and services.

The growth in investments by subnational entities in health has also occurred with the use of own resources. It is identified that, in 2004, own resources represented, on average, 18% of municipal expenditures in health and, in 2015, this percentage reached 23.3%. In contrast, the states increased from 11.9% to 13.5% the participation of own resources in the total applied in health between 2004 and 2015.

The SUS service network has also been questioned because of the lack of regional planning for defining and ordering of services. Chioro Reis et al.[19] point out that the expansion of networks occurs from decisions taken separately by the entities,

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[17] COSTA, Nilson do Rosário. *op. cit*., p. 1170.

[18] VIEIRA, Fabiola Sulpino; BENEVIDES, Rodrigo Pucci de Sá. *Os impactos do novo regime fiscal para o financiamento do Sistema Único de Saúde e para a efetivação do direito à saúde no Brasil*. Brasília-DF: Ipea, 2016. p. 18-25. (Nota Técnica; n. 28). Available at: http://ipea.gov.br/portal/images/stories/PDFs/nota_tecnica/160920_nt_28_disoc.pdf. Accessed on: 04 Jun. 2018.

[19] REIS, Ademar Arthur Chioro dos *et al*. Reflexões para a construção de uma regionalização viva. *Ciênc. saúde coletiva*, Rio de Janeiro, v. 22, n. 4, p. 1045-1054, abr. 2017. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232017002401045&lng=en&nrm=iso. http://dx.doi.org/10.1590/1413-81232017224.26552016.

followed by requests for resources from the Federal Government in a disarticulated way. Thus, they conclude, "it is a 'wandering expansion', which does not consider planning and regional agreement necessary for the sustainability of the system.

In this context of the health decentralization process in Brazil, a World Bank report indicated that most Brazilian municipalities have high productivity in primary care even in the face of resource constraints, which influences their low performance, according to the indicators of the analysis performed. In secondary and tertiary care, the productivity of the municipalities is low, that is, it has little efficiency. The report concludes:

> Most of the inefficiency is motivated by the large number of small hospitals and the small size of the municipalities (which are too small to provide health services on an efficient scale). Efficiency varies according to location and population, as much of the inefficiency derives from the small size of hospitals (less than 100 beds), which impairs their efficiency. In fact, the Brazilian health system is characterized by a large number of small hospitals, which were built to provide services in less urbanized regions. Most Brazilian hospitals operate on a small scale, and 61% have fewer than 50 beds (the estimated ideal size is 150 to 200 beds for economies of scale). Bed occupancy rates are also very low: on average, 45% in the SUS hospitals, and only 37% in intensive care units. These figures are well below the OECD averages (71%) and the desirable occupancy rate (between 75% and 85%)[20].

With regard to hospital care, the manual for SUS managers highlights that the other components of the network influence the performance of hospitals, especially that "the characteristics of the first level of care - the level of coverage achieved, accessibility, degree of resolution - determine the demand that will be generated for the care performed in hospitals"[21].

Hence the importance of municipalities fulfilling their demand in primary care, considering that success in activities at the basic level impacts hospital demands. However, there is a big difference in the configuration of health regions, considering that there are smaller municipalities and municipalities that meet the demands of populations from the most diverse locations, including other municipalities and states, known as "city-states".

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[20] UM AJUSTE justo: análise da eficiência e equidade do gasto público no Brasil. Brasil: revisão das despesas públicas. Brasília-DF: Grupo Banco Mundial, 2017. p. 115. Relatório elaborado por uma equipe do Banco Mundial chefiada por Antonio Nucifora (Economista-Chefe para o Brasil, Banco Mundial). Available at: http://documents.worldbank.org/curated/en/884871511196609355/pdf/121480-REVISED-PORTUGUESE-Brazil-Public-Expenditure-Review-Overview-Portuguese-Final-revised.pdf. Accessed on: 14 Dec. 2017.

[21] KUSCHNIR, Rosana *et al*. *op. cit.,* p. 150.

However, it can be seen that the movement of the municipalization of health services at all levels of care did not observe these particularities and ended up developing the same health bases that exist in the social security model. Vasconcelos and Pasche[22] point to the maintenance of the centralized and permeable nature to market interests in health institutions, although incompatible with SUS, which made the decentralization of health services in favor of the municipalities occur in a contradictory way, considering that the resources and control of the system remained centralized at the federal sphere. Additionally, the contradiction also affects the execution of high hospital complexity services, as discussed in this paper.

Since the administration of system resources is still centralized and with a low investment grade by the federal sphere, the performance of the services is hampered, especially those more expensive, that the municipalities would not have structure to perform, such as health services of high hospital complexity.

Therefore, it is essential to make critical readings about the decentralization process of public health services in the context of the gradual decrease in the participation of national in the system, which can damage the configuration of the SUS itself, as we approach next.

III. Issues arising from the decentralization of hospital care on the way to municipalization

Before the interpretation given to the constitutional guideline for the decentralization of the health care network, as discussed in the previous topics, it is necessary to reflect what is the participation measure of the municipalities in the SUS. One consequence that can be pointed in face of the municipalization of health services, especially secondary attention and the tertiary one, is the large number of hospital services financed with medium and high complexity (MAC) resources performed by non-profit entities without lucrative ends (private foundation, autonomous social service, trade union entity, religious organization and private association). In analysis of the data contained in SIH/SUS for the last five years, available in DATASUS, identifies that the value of the SUS resources destined to non-profit entities for hospital care is higher than that applied by the direct and indirect public administration of all entities.

Analyzing the data from SUS[23]hospital procedure, between January 2014 and September 2018, with the criteria "legal nature"[24], "year/month of processing",

[22] VASCONCELOS, Cipriano Maia de; PASCHE, Dário Frederico. O Sistema Único de Saúde. *In*: CAMPOS, Gastão Wagner de Sousa *et al*. *Tratado de saúde coletiva*. São Paulo: Hucitec, 2006. p. 554.

[23] MINISTÉRIO DA SAÚDE - MS. Sistema de Informações Hospitalares do SUS (SIH/SUS), *cit.*

[24] The legal spheres correspond to the first level of this classificatioņão, with details of the government sphere, when applicable: **administração public: federal, state or Federal District, municipal and others**; business entities: public or mixed company and other business entities; **non-profit entities**; physical person; extraterritorial institutions; unspecified or ignored.

"hospital services value", non-profit entities had more investment in medium and high hospital complexity production than the spheres of direct and indirect public administration of all entities. From January to September 2018, private associations and other non-profit entities received between 10% and 12% more investments in hospital production than the direct administration units. In 2017, this difference was lower, varying between 3.8% and 10%, as pointed in Table 1.

Table 1. Values of hospital services per year/month of processing, according to legal nature of the recipient, in 2017 and 2016.

Year/Month	Legal nature: public administration (R$)	Legal nature: non-profit entities (R$)	Higher payment for non-profit entities (%)
2018			
September	419.466.642,40	473.957.948,34	12,99%
August	450.676.494,70	498.943.534,64	10,71%
July	445.239.849,13	499.366.017,66	12,16%
June	435.645.907,74	488.322.238,12	12,09%
May	442.340.368,17	488.185.770,91	10,36%
April	432.731.256,18	484.698.629,69	12,01%
March	428.429.893,54	477.489.335,90	11,45%
February	401.365.946,16	442.724.293,21	10,30%
January	422.196.068,21	466.785.725,06	10,56%
Monthly average	**430.899.158,47**	**480.052.610,39**	
2017			
December	381.374.933,83	422.904.351,58	10,89%
November	396.508.948,89	426.428.066,83	7,55%
October	410.964.364,43	428.341.269,73	4,23%
September	403.554.916,73	432.992.241,38	7,29%
August	422.141.502,90	439.977.715,46	4,23%
July	416.793.899,35	440.707.495,59	5,74%
June	407.409.451,87	429.709.186,37	5,47%
May	423.908.545,79	445.300.336,69	5,05%
April	386.719.846,98	410.563.431,12	6,17%
March	411.173.548,19	426.871.920,54	3,82%
February	365.019.892,47	394.101.989,25	7,97%
January	385.143.903,52	411.322.628,91	6,80%
Monthly average	**400.892.812,91**	**425.768.386,12**	

Source: Hospital Information System (SIH/SUS) consolidated in DATASUS.
Own elaboration.

In 2016, non-profit entities received, in January, 23% of higher payments than public sector entities in hospital production. In 2015, in December, the percentage difference higher investments of MAC in private hospital care in relation to public administration reached 31%. In 2014, the greater proportion of payments to the private sector of hospital production was identified; make up to 39% more than the expenses in the direct and indirect administrations of all entities, which occurred in December, as detailed in the Table 2.

Table 2. Values of hospital services per year/month processing according to legal nature of the recipient, in 2014, 2015 and 2016.

Year/Month	Legal nature: public administration (R$)	Legal nature: non-profit entities (R$)	Higher payment for non-profit entities (%)
2016			
December	387.060.385,67	456.337.250,32	17,90%
November	386.420.567,41	447.953.532,84	15,92%
October	395.523.799,00	462.139.000,50	16,84%
September	407.251.815,94	451.682.602,71	10,91%
August	430.749.529,02	468.079.013,70	8,67%
July	415.130.736,09	469.406.816,69	13,07%
June	417.903.451,05	462.798.259,42	10,74%
May	388.002.746,84	473.204.095,95	21,96%
April	382.031.516,82	460.095.559,25	20,43%
March	380.189.101,95	469.141.478,58	23,40%
February	360.506.927,64	437.990.163,17	21,49%
January	360.711.159,83	446.176.089,13	23,69%
Monthly average	**392.623.478,105**	**458.750.321,855**	
2015			
December	347.798.697,14	457.823.264,97	31,63%
November	364.832.454,32	466.211.359,12	27,79%
October	373.274.699,86	467.144.423,52	25,15%
September	375.542.561,95	481.435.470,46	28,20%
August	384.722.068,32	480.393.829,62	24,87%
July	387.552.735,19	488.636.088,58	26,08%
June	375.878.801,17	476.463.492,86	26,76%
May	371.191.921,84	471.546.674,70	27,04%
April	364.680.432,54	459.108.437,37	25,89%
March	357.808.877,00	465.350.375,33	30,06%
February	338.743.274,82	428.764.651,83	26,58%
January	347.843.410,97	447.934.053,03	28,77%
Monthly average	**365.822.494,59**	**465.901.010,11**	

Continue

Continuation

Year/Month	Legal nature: public administration (R$)	Legal nature: non-profit entities (R$)	Higher payment for non-profit entities (%)
2014			
December	322.755.460,04	450.680.141,86	39,64%
November	347.789.872,92	461.355.413,49	32,65%
October	362.153.905,05	478.586.164,35	32,15%
September	361.388.515,97	476.110.551,69	31,74%
August	365.978.771,79	480.240.572,07	31,22%
July	363.135.748,85	479.564.274,92	32,06%
June	339.853.586,26	453.871.524,01	33,55%
May	359.632.192,85	460.429.228,88	28,03%
April	325.911.549,08	439.739.556,60	34,93%
March	332.565.708,38	422.460.159,51	27,03%
February	324.916.055,53	421.072.702,80	29,59%
January	343.288.270,52	429.189.538,48	25,02%
Monthly average	**345.780.803,10**	**454.441.652,38**	

Source: Hospital Information System (SIH/SUS) consolidated in DATASUS.

Own elaboration.

Note from this analysis that, in the face of a tendency of providing hospital health care by the private sector, there is a rupture of the complementarity provided by CF/88. Thus, it is argued that the movements of hospital services provided by the SUS, by private entities and the regionalization of the system, which is increasingly localized, are phenomena with reciprocal implications. If the responsibility for hospital services is fragmented, the private initiative will eventually be more contracted as a consequence, given that the smaller municipalities are not able to perform, actions and services of medium and high hospital complexity, having to hire them from philanthropic institutions in general.

Analyzing the tendency of public services, notably the privatization of essential services, Nuria Cunill Grau[25] highlights that, in countries that have undertaken reforms, two sectors active in health and education are identified: a large private sector, and a small public sector, supported by direct payments and that finances the first. Thus, the experience of services that were transferred to execution at the subnational level tended to favor private initiative, either by delegating the execution

[25] GRAU, Nuria Cunill. O que tem acontecido com o público nos últimos trinta anos? Balanços e perspectivas. Trad. José Geraldo Leandro Gontijo e Telma Menicucci. *In*: GONTIJO, José Geraldo Leandro et al. *Gestão e políticas públicas no cenário contemporâneo*. Rio de Janeiro: Editora Fiocruz, 2016. p. 330.

of services or by privatization, "or were even more fragile, behind the figure of shared financing, impossible to be assumed by municipalities or poor local entities"[26].

In this regard, the World Bank report[27] produced in 2017 pointed out that Brazil spends poorly and unevenly on health, indicating that this inefficiency results mainly from **fragmentation** of the public health system, especially the high number of small hospitals, which prevents economies of scale in the provision of services.

Even if this investigation by the World Bank is contested about the poor distribution of hospital beds in Brazil, in view of the well-known capacity problem in hospitals in large centers, it cannot be said that the investment grade in private health to perform hospital services, as highlighted in Tables 1 and 2, is irrelevant data.

If each entity assumed the execution of its health care responsibilities, the significant transfer of hospital care to the private sector would be avoided, considering that the fragmentation of specialized services is not very efficient. In the most diverse realities existing in Brazil, not all local public services can satisfactorily perform the provision of health care in specialized care (secondary and tertiary), either due to the lack of physical and technological structure, either because of a lack of financial and personnel resources.

It is clear that a proposal to improve the hospital care network by identifying the capacity of certain municipalities to maintain and manage hospital units or hospital care services does not mean breaking with regionalization, a principle of the SUS expressed in Article 198 of the CF/88. Despite the questions surrounding the intentions of the World Bank in the development of social rights, it is undeniable that having a more efficient health system is the intention of the defenders of the SUS. As Ocke-Reis questions, "after all, who would argue against introducing a government program or hospital service that is cheaper, comprehensive and effective?"[28]

In fact, in order to avoid the misuse of beds in small hospitals and also the lack of beds in other hospitals (a problem not mentioned by the World Bank, but common in the reality of health institutions), it is important that first beds are built in larger size hospitals that can absorb the demands of smaller hospitals and overcome the problem of location. It should be noted, therefore, that the conclusion of the World Bank, even those that can reinforce the adoption of a good strategy in the management of the SUS, must be carefully analyzed, considering

[26] GRAU, Nuria Cunill. *op. cit.*, p. 350.

[27] UM AJUSTE justo: análise da eficiência e equidade do gasto público no Brasil. Brasil: revisão das despesas públicas, *cit.*

[28] OCKE-REIS, Carlos Octávio. Os problemas de gestão do SUS decorrem também da crise crônica de financiamento? *Trab. educ. saúde*, Rio de Janeiro, v. 6, n. 3, p. 613-622, 2008. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462008000300012&lng=en&nrm=iso. http://dx.doi.org/10.1590/S1981-77462008000300012.

that they can lead to a discourse on reduction of funding the importance of the SUS, which is unacceptable.

It cannot be believed that simply closing small hospitals[29] will improve the provision of public health services if the resources are not used to build and equip hospitals that are proven to be most necessary, thus reducing the hiring of private initiative for these demands. A clue to the needs for investment in hospital care may be exactly where and in what type of service is hire most from the private sector.

Jonh Lister[30] points out that the World Bank data, in general and not only in the Brazilian case, provide a single total of hospital beds of all kinds, for acute cases, prolonged hospitalizations, maternity, psychiatry and specialized facilities, and should therefore be analyzed with caution. The efficiency of simple reduction of beds is, therefore, questionable due to the lack of analysis on which beds need to be reduced and also on the increase of costs in larger hospitals. In addition, the same author points out that the reduction of beds in poorer countries represented an absolute cut in the provision of medical care, without considering health needs.

That is, the improvement in the distribution of beds can be a contributory measure to SUS, but rather it requires investment from the State, which may, at first, generate an increase in expenses, but that will be compensated with the best and most adequate allocation of beds in hospital units in Brazil, consequently without it being so directly dependent on the beds of the private initiative.

Ocké-Reis points out that, "in fact, the increase in efficiency should not be taken as an excuse to cut financial or organizational resources from SUS, as well as queues in a universal health system cannot serve to restrict access"[31]. On the contrary, improving the efficiency of the system may require increased investments.

Furthermore, sanitary federalism can hide an inertia in the health responsibility of all entities, including because, under the pretext of decentralization, some studies[32] have already argued that the sanitary cooperation leads to centralization

[29] RAMALHO, Guilherme. Brasil perde 34 mil leitos hospitalares do SUS em oito anos: a diminuição significou queda de 10% no total de leitos entre 2010 e 2018. As informações são do Cadastro Nacional de Estabelecimentos de Saúde. 2018. *G1*, 09 maio 2018. Available at: https://g1.globo.com/ciencia-e-saude/noticia/brasil-perde-34-mil-leitos-hospitalares-do-sus-em-oito-anos.ghtml. Accessed on: 11 May. 2018.

[30] LISTER, Jonh. Perguntas equivocadas, respostas equivocadas. *In*: LISTER, Jonh *et al*. ¿Por *nuestra salud? La privatización de los servicios sanitarios.* Madrid: Traficantes de Sueños, 2010. p. 25.

[31] OCKE-REIS, Carlos Octávio. *op. cit.,* p. 613-622.

[32] RIBEIRO, José Mendes; MOREIRA, Marcelo Rasga; OUVERNEY, Assis Mafort; SILVA, Cosme Marcelo Furtado Passos da. Políticas de saúde e lacunas federativas no Brasil: uma análise da capacidade regional de provisão de serviços. *Ciênc. saúde coletiva*, Rio de Janeiro, v. 22, n. 4, p. 1031-1044, abr. 2017. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1413-81232017002401031&lng=en&nrm=iso. http://dx.doi.org/10.1590/1413-81232017224.03732017.

of the decisions on investments in the mayors and governors, besides low accountability of federal entities for the results observed.

Another major factor resulting from the municipalization of health services is the possibility of masking policies to cut social spending. Luciana Dias de Lima[33], analyzing the federal pact in conjunction with the financial logic of the State (power to tax and power to spend), states that there is a tendency to shift spending power to the peripheral levels of the federal organization, but points out that decentralization does not necessarily lead to expenditure restraint, since subnational entities can expand the offer of services and generate more expenses.

Thus, the proposal for a review of the distribution of beds in Brazil, besides not being an idea that would challenge the guideline for the regionalization of health networks, aims at fulfilling the hierarchization of the public health service, considering that the location of services under the responsibility of the minor entity (municipality) is not always the most appropriate, being better performed by the major entity, that is, state or federal. In this regard, the hierarchization allowed, even, the division of the treatment specialties into low, medium and high complexity. Thus, the idea gains reinforcement when analyzing the division of competences carried out by Law no. 8.080/1990[34]. When this law establishes the attributions of the national, state and municipal directorates of the SUS, specifically in the items dealing with hospital care, it can be identified that the high complexity care network cannot be attributed to local administration, being the responsibility of the national administration to define and coordinate this network. The state administration is responsible for identifying referral hospitals and managing highly complex public systems. For the local administration, the possibility of entering into agreements with private institutions, which can be contracted by the municipal entity to provide high hospital complex services, is identified with regard to hospital care.

In spite of the fact that it is the competence of all spheres to execute services regionalized and hierarchicalized network of the SUS, including local care, it cannot be overlooked that hospital care, especially of high complexity, has a role reserved more expressively for national and state directions. Otherwise, let's see the text of Law no. 8.080/1990:

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[33] LIMA, Luciana Dias de. Federalismo fiscal e financiamento descentralizado do SUS: balanço de uma década expandida. *Trab. educ. saúde*, Rio de Janeiro, v. 6, n. 3, p. 573-598, 2008. Available at: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1981-77462008000300010&lng=pt&nrm=iso. http://dx.doi.org/10.1590/S1981-77462008000300010.

[34] BRASIL. *Lei n. 8.080, de 19 de setembro de 1990*. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Available at: http://www.planalto.gov.br/ccivil_03/leis/l8080.htm. Accessed on: 11 Dec. 2019.

> Art. 16. The national administration of the National Health System (SUS) is responsible for:
>
> [...]
>
> III - to define and coordinate the systems:
>
> a) integrated networks of high complexity assistance;
>
> [...]
>
> Art. 17. The state administration of the National Health System (SUS) is responsible for:
>
> IX - to identify reference hospital establishments and manage high complex public systems, of state and regional reference;
>
> [...]
>
> Art. 18. The municipal administration of the National Health System (SUS) is responsible for:
>
> [...]
>
> X - observed the disposition of art. 26 of this Law, concludes contracts and agreements with entities that provide private health services, as well as monitor and evaluate their execution;

In this sense, an important facet of the system's national coordination consists of its financing, which cannot be dissociated from the respective need to perform the health services necessary to maintain the SUS. However, when the central entity of the federation has greater collection power, but transfers the execution of public services to subnational entities without the corresponding source of financing, the service itself will be impaired. According to Luciana Dias de Lima[35], there is a fiscal imbalance between the government spheres resulting from the lack of correspondence between the spending power and tax transfers. For the author, imbalances can be generated by the high power of central collection, while the subnational entities assume charges (vertical imbalance), or by variations in public expenditure in the face of different demands (horizontal imbalance).

Analyzing the data on health financing, Ricart Santos[36] argues that the Union has used some instruments to reduce its investment grade in health, such as

[35] LIMA, Luciana Dias de. *op. cit.,* p. 573-598.
[36] SANTOS, Ricart César Coelho dos. *Financiamento da saúde pública no Brasil*. Belo Horizonte: Fórum, 2016. p. 109.

the Untying of Federal Revenues (DRU), which allows the application in a diverse purpose of 20% of the resources that should be applied in social security. Thus, he concludes that "the federation fined itself unbalanced in terms of health: states and municipalities are carrying a greater burden when compared to their respective possibilities"[37].

With regard to health services, the national administration, when transferring the execution of high hospital complexity services to the municipalities without considering their ability to directly provide this type of health care, paves the way for the hiring of the private contracted network, maintaining the remnants of the previous health model, whose nature was centralized in the federal entity and permeable to market interests.

It should be emphasized that the return to a centralized health management in the federal entity is not advocated, but that decentralization is better structured so that health services are guaranteed according to constitutional guidelines, including the complementary participation of the private sector and the division of health competences among all entities.

In summary, health services must be based on decentralization in order to reach the largest possible number of people, that is, every health service must be based on this guideline. For this purpose, the network that gathers all these services is organized in order to be regionalized and the services, hierarchized according to the level of complexity, also characterized by the "executive synchronization between the components of the Federation" [38] in the field of health.

Traditionally, especially after the Basic Operating Standard of 1996 (NOB 96), the logic of political and administrative decentralization within the SUS is the transfer to the municipalities of the role of directly carrying out most of the actions and health services for people who live in their territory or to hire third parties to do so, with states having the function of promoting the harmonization, integration and modernization of municipal systems[39].

What is proposed is that the hierarchical division of health competences may justify a reallocation of responsibilities, especially when talking about high hospital complexity under the responsibility of the municipalities. Thus, it is believed that SUS needs lasting solutions that observe health needs, in addition to electoral periods or mere political management, identifying that the decentralization of the

[37] *Id. Ibid.,* p. 112.

[38] SIQUEIRA, Cláudia Aguiar. O município e a saúde: reflexões sobre as balizas impostas pelo ordenamento jurídico vigente para a atuação do poder público local. *Revista de Direito Sanitário*, São Paulo, v. 4, n. 1, p. 41-49, mar. 2003. Available at: http://www.revistas.usp.br/rdisan/article/view/82416/85402.

[39] AITH, Fernando Mussa Abujamra. A saúde como direito de todos e dever do Estado: o papel dos poderes Executivo, Legislativo e Judiciário na efetivação do direito à saúde no Brasil. *In*: AITH, Fernando *et al.* (Orgs.) *Direito sanitário*: saúde e direito, um diálogo possível. Belo Horizonte: ESP-MG, 2010. p. 91.

guideline of the SUS should favor universal and equal access to health services. public health actions and services, and not the realization of services limited to production ceilings of private sector.

Final Considerations

From the CF/88 we can read that public health actions and services integrate a regionalized and hierarchized network and constitute a single system. However, it should be questioned, from a critical perspective, what limits should be given to the decentralization of services in order not to convert regionalization into municipalization of all levels of health care, including care that municipalities, especially smaller ones, would not have the operational conditions and adequate structure to provide. This leads to the hiring of the private network of services, which is no longer complementary (art. 199, §1º, CF/88) and becomes one of the main providers of public services of hospital care.

In view of the large presence of private entities in this sector and the imbalance in allocation, the structural failure in the provision of hospital services by the SUS is related to the regionalization of the public health system increasingly localized. Given these elements, the more fragmented is the responsibility for hospital services, the more private hospitals will be hired, given that smaller municipalities are unable to perform, directly, actions and services of medium and high hospital complexity. In addition, the capacity of hospital units in large centers it is also identified, with demands that prevent a viable and lasting health planning.

These issues are the result of a process of municipalization of health services, accompanied by policies to cut social spending by the national management of the system. Even if it is recognized that the competence to perform health actions and services is solidarity between national and subnational entities, and even though decentralization, with a single direction in each sphere of government, is a guideline of the SUS, hospital care, especially of high complexity, has a role reserved more expressively to the national and state administration of the SUS. Law no. 8,080/1990, in Articles 16 to 18, formulates that definitions, coordination and management of high complexity systems are the responsibility of the national and state administration of the system.

In this sense, the expansion of health expenditures in recent years was due to efforts made more by municipalities and states than of the Union itself, which has greater power of collection. This circumstance has great potential to be aggravated by the effects of Constitutional Amendment no. 95/2016[40], which will limit the growth of any federal expenditure for the next 20 years.

[40] BRASIL. *Emenda Constitucional n. 95, de 15 de dezembro de 2016*. Altera o Ato das Disposições Constitucionais Transitórias, para instituir o Novo Regime Fiscal, e dá outras providências. Available at: http://www.planalto.gov.br/ccivil_03/constituicao/Emendas/Emc/emc95.htm. Accessed on: 11 Dec. 2019.

The large hiring of hospital services provided by non-profit entities and, also, the existence of beds in small units without material and professional structure – a reality present in many Brazilian municipalities – generate the need to better discuss the decentralization of public health services.

The idea that decentralization would represent greater autonomy of subnational entities – as a change in the existing parameters before the Sanitary Reform, when there was intense centralization in public health services– ends up bringing distortions to the SUS itself. In certain cases, such as high hospital complexity, the promise of regionalization or municipalization of health services functioned as a mechanism for omission of the national administration in strategic services that needed greater long-term investments.

It is believed, therefore, that there should be reflection around the provision of specialized hospital health so that real gains can be analyzed with the maintenance of beds under the administration of the municipal subsystem to higher levels of complexity, considering that not all municipalities have the same structural conditions to implement and maintain them as the states and the Union.

The discussions proposed in this work, as well as the data collected that show the higher expenditure of the SUS in hospital production in the private sector than in the public administration in the last five years, intend to open ways and alert to an adequate interpretation of the decentralization of health actions, which respects the distribution and accountability of public health services among federal entities.

The objective, with the exposure of these data, is to avoid that, because it is not possible for the smaller entity to provide services of greater complexity, it remains to hire non-profit entities permanently, favoring the permeability of private entities within the SUS and breaking with the constitutional determination of private complementarity in the public health system.

Based on the research produced, it is concluded that the permanent and increasing hiring of hospital services of those with a private legal nature could not be a constant in services of medium and high complexity, as has been happening in the last five years, especially since it systematically violates the constitutional pact of construction of an integral, universal public health and provided directly by the State. In these terms, the need to refer to the guideline of the decentralization of the health care network necessarily linked to the financing and direct management of public entities is reinforced.

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