The SUS and the Brazilian's right to health: a reading of its principles, with emphasis in the universal coverage

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Resumo Este artigo discute a questão do acesso aos serviços de saúde brasileiros, com ênfase na universalidade da assistência. Discorre sobre os conceitos de justiça e saúde; faz breve reflexão sobre os sistemas de saúde nos Estados Unidos da América do Norte, na França, Inglaterra e Canadá; realiza uma apreciação do sistema de saúde brasileiro, em suas vertentes pública e privada, e historia o papel dos conselhos de medicina e das entidades médicas na garantia do acesso aos serviços de saúde.

Palavras-chave: Equidade. Justiça social. Sistemas de saúde. Bioética.

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Health and bieothical concept of justice

Justice is first virtue of the social institutions, just as truth is for the Thought systems. A theory must be refuted if not shown as true as well as laws and institutions must be depreciated and not complied if they are not fair[1].

A society is considered fair when human being is respected as a moral absolute, for Rawls, since by achieving reason is owner of autonomy and the discernment of what is fair. A society will be fair when opportunities, wealth, and respect are distributed equally among all or unequally when in order to equate distortions and to benefit the most needed. This is justice view, *equity*, which compels an effective action of the social forces of the destitute. At the same time when Rawls published *A theory of justice*, Robert Nozick published *Anarchy, state and utopia* [2] considering that the role of a fair State would be limited to protection of individual rights, from which each one would be capable to care for himself – a view supported by the neoliberal ideal of a minimum state.

Today, the principle of justice is discussed at a *front* where arms of a utilitarian justices with collective maximization of results overlaying to individual interests, and an equal justice proposing distribution of opportunities to all in accordance to their needs. This is one of the current health care dilemmas, whose demands are high and growing and scarce resources, many times badly employed. In addition, the population, health professionals, and managers are found amidst this contention. It is in this context that the most diverse types of health services are generated, managed, and used.

Biotherics and health concept

Health concept reflects a social, economic, political, and cultural conjuncture. That is, health does not represent the same for all people. It will depend on the age, place and of the social class. It will depend on individual values, scientific conceptions, religious and philosophical beliefs [3]. Equally, the concept f illness underwent strong changes with time and medical knowledge. Initially, the gods were the cause to get ill. Hippocrates of Cos (460-377 A.C.), the father of Medicine, was the first to consider sickness as a natural phenomenon. His reference to epilepsy in the text *The Sacred Disease* is a chant to rationality and, perhaps, the emancipation letter for medicine from superstitions and absurd beliefs [4].

The United Nations Organization (UN) states, in its charter of principles of April 7, 1948, that health is the state of most *complete physical, mental and social well being and not merely the absence of disease or infirmity* [5]. This concept, built after World War II, points toward more a utopia to be pursued to than a achievable real possibility that for some bioethicists would attempt against personality's own characteristics[6]. Influenced by the *Declaration of Alma-Ata*, which privileged basic and universal care, countries such as Brazil[7] and Canada[8] were enthusiastically engaged, decreeing in their respective constitutions, in the end, that health is a right of all and a duty of the State [9].

The truth is that this definition is ever more criticized, under the most diverse justifications, from epidemiological issues[10], going through epistemological doubts [11] up to the advocacy from a psychoanalytical point of view[6].

Health services in the United States of America, France, Canada and England

• United States of America (USA)

Health, in the USA, has very interesting features: the largest expenditures, the greatest worldwide technological progress and the most advanced and influent medicine in terms of scientific progress, but where about 30 million of people are marginal to any real medical care.

Expenditures running around U$ 2.5 trillion yearly in the health sector are extremely complex, getting to the point of been wasting. It is badly target, inefficient and unfair. Its medicine is of renown quality, but the

system through which these care are financed presents lots of difficulties. Within a period of two years, one out of three American elders remains without health insurance during some time, majority of them for over nine months.

However, growing costs became a threat ever more serious not only for family's financial security but also for American economy itself. The US spends with health care, in terms of its gross national product, more than any other nation. Despite that, they were not able still to buy the only thing that health insurance are supposedly capable to provide: an efficient health [12].

In the US, access to health is mostly through health insurance, existing subsidiarily three state systems: *Medicare*, *Medicaid* and the Veteran's System. Health insurance works according to market laws and organized by the HMO (*Health Maintenance Organization*) and PPO (*Preferred Provider Organization)*. In an analogy to the Brazilian supplementary health system, HMO would correspond to the health plans and PPO to health insurance, in which, in the first case, a network of service renderers would be contracted and, in the second case, the choice of the professional, or service would be free by means of previously agreed reimbursement.

President Obama, to face this situation, got approved in the American Congress a reforming Bill aiming at expanding coverage of the system. The reform assures a health plan for 32 million Americans who are currently unassisted, expands the health federal program for the poor, imposes new taxes for the rich and prohibits insurance companies of practices like rejecting coverage to clients with preexisting diseases. It is the greatest change in social policies during the last decades in the country.

• France

Analysis of the French health system based on a text by Jean de Kervasdoué, is available at the Internet homepage of the Embassy of France in Brazil. In it, the author analyzes that country health system pointing its characteristics, its strong and weak points.

We stress as synthesis the text that follows: *in terms of health, Frenchmen have innumerous rights and, at times exceptional, due to their diversity and importance of the guarantees granted by them. In that country, all legal residents have health insurance coverage. For over 96% of Frenchmen, medical treatments may be totally free or reimbursed in 100% and, what is even more exceptional, Frenchman may have total freedom of choice, independently of their income level. They may go directly, in the same day, to several general practicioners or specialists, choose a public or private hospital, go to a University hospital or a general hospital. There is not a waiting list for surgical interventions, or rationing, except in certain cities, concerning heavy equipment for production of medical images*[13].

The exams and appointments are not necessarily free because a patient may consult with a physician whose fees are not reimbursed by his mandatory or supplementary health insurance – in these cases, he does it knowingly. In France, there is solidarity among sick and healthy people, as well as among rich and poor, through health insurance, one of Social Security branches. Its financing comes from contributions on wages (60% of total revenue), of indirect taxes (taxes levied on tobacco and alcoholic beverages) and, above all, from direct contribution– the generalized social contribution (CSG) – paid by all levels of income, proportionally, inclusively from retirements and income over capital. Apparently, reimbursement for treatment through health insurance treasury is weaker in France than in other European countries (75%).

Nonetheless, over 80% of Frenchmen have supplementary insurance, paid by themselves or by their firms. It should add to these the 10% poorer, for whom insurance is free. It is the universal disease coverage (CMU, in French), financed by taxes. Finally, for 6% of the population reached by a *long lasting affection* (ALD), treatments also are totally reimbursed. Health insurance chronic and recurrent deficit is topic of jokes. Frenchmen continue demanding for more services although they abominate the idea to take more charges or to have higher mandatory wage discounts. In 2000, health expenditures amounted to 140.6 billion of Euros, 55.3 billion in hospital treatment. 31.9 billion in outpatient treatment and 25.9 billion in medicines[13].

• Canada

Canada has a medical care system financed predominantly by the public sector and provided by the private sector. It may better describe as an intertwined set of ten provincial health insurance plans and three territorial ones. Known by Canadians as *Medicare* (do not mistake with the American homonym), the system provides Access to universal and broad coverage of medical-hospital, internal and external, services that are clinically needed. This structure results from the constitutional mandate of jurisdiction over the majority of medical care components at provincial government level.

The system nominated as a national health insurance set, given that all provincial and territorial medical-hospital insurances are colligated by adhesion to national principles established at federal level. Health services management and rendering is in charge of each province or territory. Provinces and territories plan, finance, and evaluate medical care rendering as well as other correlated service, as well as certain features of providing medicines and public health. The role of the federal government in medical care involves set and managing national principles or Standards of the medical care system (*Canada Health Act*),

providing financial assistance to provincial medical care services, through fiscal transfers and to exercise functions which are constitutionally of its competence.

One of these functions is direct medical care rendering to specific groups, inclusively veterans and military personnel, indigenous people living in reserves, prisoners in federal penitentiaries and the personnel of the Royal Mounted Police of Canada. Among other functions of the federal government related to health is health protection, prevention of diseases and health promotion[14].

• England

The English health system, *National Health Service* (NHS, in English), was created in 1948 in the post-war administration of Clement Atllee as a great solidarity project among citizens. Its financing – complicated since the beginning, when its implementation was only possible with assistance of the Marshall Plan – is public, as well as its management. NHS has a varied structure, comprising the following departments: 1) basic care; 2) ambulance service; 3) general care; 4) hospital; 5) mental health.

The system bases in the figure of the *general practitioner* (GP), responsible for a set number of people from a certain geographic area. The access to specialists and specialized services takes place from his guidance and reference. Due to growing expenditures with the system, which associated to health technological demands, NHS went through several reforms and the most intense during Margareth Thatcher's conservative administration, accused of attempting to privatize the NHS, although Tony Blair's Labor administration has stirred hospital services outsourcing [15].

Users' opinion on health service in these countries

A recent survey undertaken by the *Health Consumer Powerhouse* showed that the best health service for European users is the Austrian, followed by Dutch and, then, by French that lost the leadership gotten in 2006. In 2007, France scored a total of 786 points out 1,000 possible, while England ranked in 17th position with just 581 points[16].

In the USA, the feeling of having the most developed medicine in the world is not enough to make citizen at ease. There are around 45 million people without any kind of health coverage and, despite the large investment in the sector; the feeling is that of insufficiency, inefficiency, and lack of effectiveness [17].

In Canada, despite integrality of care, there are strong complaints related to difficulties to access to certain procedures and treatment. The percentage of people who stated that the health system worked very well and that Just small changes were needed dropped from 56% in 1988 to 20% in 1998[18].

To evaluate the performance of such complex service such as health care is not an easy task, although extremely necessary[19].

Even the World Health Organization (WHO), a significantly respected agency, is not exempt of critics when such task is undertaken [20].

Brazil – Health Sector before the Unified Health System

Before the establishment of the Unified Health System (SUS), the Ministry of Health, with the support of states and municipalities, developed almost exclusively health promotion and disease prevention activities, highlighted by vaccine campaigns and control of endemies. All these activities had a universal feature, that is, without any kind of discrimination related to beneficiary population[21].

Regarding health care, the MH worked only through a few specialized hospitals in psychiatric and tuberculosis areas, in addition to the activity developed by the Public Special Health Services Foundation (Fsesp) in specific regions, mainly in the interior of the Northern and Northeastern regions.

This activity, also called medical and hospital care, was rendered to part of the population designated as poverty-stricken by some municipalities and states and, mostly, by philanthropic institutions. This population did not have any rights and the care received was as favor, as charity. The National Social Security Institute (INPS), previously denominated as the National Institute of Medical Care of Social Security (Inamps), an autarchy of the Ministry of Social Security and Assistance undertook public sector major activity in this area. INPS resulted from merger of the Institutes of Retirement and Pensions (the so-called IAPs) of different organized professional categories (banks, commerce and industry employees, among others). Inamps had the responsibility of rendering health care to its associates, which justified the construction of large outpatient units and hospitals, as well as contracting private services in the large urban centers where lived the majority of its associates.

Health care developed by Inamps benefited only workers in formal economy, who had *signed contract booklet*, and their dependents, that is, it did not have a universal feature that becomes one of the basic principles of SUS. Thus, Inamps allocated in states, by means of its regional superintendences, funds for health care more or less proportionally to volume of beneficiaries and collected resources. Therefore, the more developed the economy of a state, with larger presence of formal work relations, greater the number of beneficiaries and, consequently, higher need of funds to ensure assistance to this population. Thus, Inamps invested more resources in the states of the South and Southeast regions, the richest ones, and in these and other regions, in higher proportion in larger cities. Three categories divided Brazilians, at that time, regarding health care:

those who could afford to pay for the service; those who had the right to care rendered by Inamps, and those who did not have any rights, denominated as poverty-stricken.

SUS institutional model

The definition in the Federal Constitution (FC) regarding the health sector was the first and major conquest of the Sanitary Reform Movement in 1988. The Article 196 of the FC states that *health is a right of all and a duty of the State* [22]. Here is clearly defined the Unified Health System universal coverage. In Article 198, First Paragraph establishes that the u*nified health system will be financed, according to Article 195, with funds from social security budget, from the Union, States and Federal District, and Municipalities, in addition to other sources*[22]. This is an extremely important issue since in all debates on SUS financing, it is stressed the participation of the Union as if it was responsible solely.

Law no. 8,080/90[23], an infra-constitutional regulatory norm of the system, defined SUS as the sole command in each sphere of government and set the Ministry of Health as the manager within the scope of the Union. The legislation establishes, in Art. VII of Chapter II – *On Principles and Guidelines* – among SUS principles the *universality of access to health services in all levels of care*. Such statement constitutes a major change in the situation in force until then. Brazil began to count on a unified and universal public health system. This is the official speech, but would that actually happens? This is the question that we will try to answer next.

Is it a really unified and universal system?

Although the Brazilian judicial ordainment, in the Carta Magna, points to a unified, universal system under State tutelage, at a single glance it can be verified that is not true. Then, let us see: when the former social security system was still in force, an alternative health care system took shape within an adequacy process of the productive forces in interests of production, better saying, of workers' health. It meant implementation of group medicine and a system managed by companies, aiming at keeping the worker in good sanitary conditions so the productive process continuously benefited by its working force and did not undergo any type of continuity solution in the production line. This model, because of its dependence in strong economic capacity and union power initiated, not without reason, began in the large industries of greater Sao Paulo.

Reacting to the growing power of group medicine, physicians constituted a cooperative system of work– the Unimeds – through which they tried to control sale of the physicians' work to companies interested in providing supplementary care to their workers. With this market in great expansion, other economic agents directly linked to the financial sector began to have interest in the

business of *selling health plans* creating their own products: health plan *strictu sensus* and health insurance, in an analogy to the American HMO and PPO. All of this with SUS in force. Today, around 42 million citizens look for care in a supplementary medicine for their health. This one of the major paradoxes of the Brazilian health system. It universal inclusion proposal seems ever more to have a strong exclusion aspect when it expels the middle class and the working class from its midst[24].

Currently, to have a health plan is one of the objects of desire for a Brazilian citizen. A job, nowadays, is valuated not just for the value of the wage, but also by the offer of this kind of protection[25]. What would have induced such feeling since unarguably SUS brought in a huge load of equity for the Brazilian population by including the poverty-stricken as citizens? Part of the answer relies in the fact that proposed universality invariably falls in the trap of services rationing and loss of quality, at least perceived as such by users, what stirs the search for other ways of care [24]. SUS difficulties are the better media that supplementary health care system has [26].

Would the supplementary health care system be better than SUS?

As previously discussed, health supplementary system arises with very clear targets: 1) to serve production means need to keep workers in action (group medicine); 2) counterbalance medical labor hand exploitation by group medicine(Unimed); and 3) to take advantage of emerging economic niche (financial groups). If at the start motivations were diverse, today, all want to exploit economically the market, equalizing their objectives.

If target is profit, even if in cooperatives system there is the Idea of internal distributive justice, there is no escaping from the fact that it links to maximization of outcomes and minimization of costs, an imitation of utilitarian justice. Despite sector regulation with Law no. 9,656 (Health Plans Legislation) [27], it is extremely excluding when it creates the preexisting disease feature, as well as the period of Grace and procedures roll as regulating elements to access services. These situations, presented as mechanism of contractualist justice, actually work as dikes to prevent patient in accessing needed health care.

SUS and supplementary health care are equal in this aspect: the first because it promises but does not fulfill the promise due to lack of finance resources and ineffective management; the second also promises and does not comply, because by doing it would see its profiting objective jeopardized.

How do people evaluate SUS?

A survey by the Brazilian Institute of Public Opinion and Statistics (IBOPE), undertaken in 1998 under request of the National Council of Health Secretaries (Conass) and the National Health Foundation (FNS) of the

Ministry of Health [28], shows that SUS actual coverage could be smaller than the estimated 99 million of Brazilians. The survey reveals that:

- 38% of population stated to use public services or under agreement with public sector exclusively;
- 20% stated using SUS frequently (most of the time), but not exclusively;
- 22% stated using private services most of the time, using both public services (eventually) and the supplementary segment;
- 15% of people declared as non-users of SUS, either for being part of the segment that uses private services exclusively (via health insurance of any kind or via direct disbursement) or because never using any kind of medical service.

The Ministry of Health contracted, in 2006, a survey from the University of Brasilia (UnB) to evaluate satisfaction level of SUS users. The aim of this study was to build a replicable methodology for later use in other members of the federation as a means to provide capacity building in evaluation policy to managers[29]. The survey outcome was not available to authors of present work, even after exhaustive search in the Internet, particularly in the sites of Ministry of Health and UnB.

If we consider information of a 1999 study and set it for now, we see that those 15% of yesterday declared non-users of SUS, currently they are 20¨%.

Certainly, something is occurring that makes people to directly (own expenses) or indirectly (job) look for supplementary health care. This situation is partially similar to France where, despite existence of health public service, citizens also look for supplementary health care.

The question imposed is why this happens. Been a huge problem, it shall certainly have several causes concurring to its occurrence. However, the outcome is only one: whoever looks for supplementary health care does not feel suitably sheltered by the system feeling the need to search for security somewhere else.

The medical category and access to health

Brazilian physicians, through their class representations (Federal Council of Medicine – CFM, Brazilian Medical Association – AMB and the National Federation of Physicians – Fenam), had a major role in creation of SUS and in health plans regulation in Brazil. Their participation in national health conferences and in the National Congress was basic stages in building the system. After this initial phase, efforts were made in building social control by participating in health councils at federal and state levels, in system financing, in adequate remuneration of medical work and in expanding health care.

Concerning supplementary health care, medical participation has been to make the system more equalitarian.

At the beginning, there was not any kind of sector regulation and everything was allowed, that is, it was allowed everything and to all to set difficulties in the access to health care. The first national legislation aiming at ensuring a fair and needed access to supplementary health care services was established by the Federal Council of Medicine with Resolution no. 1,401[30], in which is stated:

Art. 1 – Health insurance companies, group medicine firms, medical work cooperatives, or any other working in direct rendering or intermediation of medical-hospital services, must ensure serving all illnesses related in the International Classification of Diseases of the World Health Organization, not been allowed to impose quantitative restrictions or of any other nature.

Art. 2 – Principles that companies must comply stated in Art. I are:

a) broad and total freedom of choice of physician by patient; b) fair and dignified remuneration for physician's work; c) broad and total freedom of choice of diagnosis and therapeutic means by the physician, always in patient's benefit; d) total freedom of choice of hospital establishments, laboratories and other complementary services by patient and physician.

Notwithstanding its validity been upheld by court decision, the issuance of the Law on Health Plans, two years later, is based in this resolution. Despite this regulation bringing forth considerable progress in terms of equity to the system, permanence of partial coverage regulated by a roll of procedures and limitations in caring for some diseases, such as, for example, outpatient chemotherapeutic treatment, it mobilized physician to search for a ethical parameter for treatment offered to patients [31].

The Brazilian Hierarchical Classification of Medical Procedures (CBHPM) founded in Evidence Based Medicine (MBE) methodology, and it tried to adequate all scientific progress duly proved and considered as ethical in Brazil into the Brazilian medical practice. Despite praised collaboration, CBHPM has met many obstacles for its full implementation, including in the Unimeds. However, the major constraint derives from the lukewarm attitude by the National Supplementary Health Care Agency (ANS) that stubbornly continues to use a roll of excluding procedures for scientific progress opportunities and to favor a policy that benefits companies that are not forced to care for their patients in plenitude. This policy is "beneficial" to the government itself, which, by facilitating the financial life of health plan companies, enables them to continue keeping out of the SUS system a larger number of users, working off public demand even if at expenses of indirect incentives and fiscal waiving.

Perspectives of improvement

All know the facts now reported and in face of such situation a few measures have

been developed searching to slow down the picture. The National Humanization Policy for Caring and Management in SUS (HumanizaSUS)[32] is the most interesting proposal and that with the highest potential of success, which aims at making effective the principles of the Unified Health System in the daily care and management practices, and to promote solidarity exchanges between managers, workers and users in producing health and subject production.

This proposal tries to realize a reduction in queues and waiting time, with expansion of the access; in warming and resolute attention based in risk criteria; in implementing an accountability and binding care; in assurance of users' rights; in valuation of work in health and management of participative in services.

Final considerations

The Brazilian health system is including, generous and utopist in its imaginary. In its purposes, it searches to do a distributive justice, equalizing people and trying to provide a dignified and quality care to all. However, in practice, it remains favoring a neoliberal policy of a minimum state since around 20% of people look for complementary health care, for understanding that SUS has difficult access and low quality. The universality proposed by SUS, to be real, must contemplate not only intent, but also mainly affectivity.

The absurd is greater when the government itself a supplementary health plan for its workers, tacitly acknowledges SUS incapacity – not the imaginary but the real – to provide health care with quality, at least, that workers want. Thus, we can conclude that the Brazilian health system, despite stated in the Federal Constitution, in not single or integral or universal as it divides, consensually, space with a supplementary health care system. It restricts the access to treatment notoriously valid and it presents an excluding universality when it sees 40 million of Brazilian migrate to supplementary health care because they are badly care by the public system.

Certainly, it may be discussed that operational difficulties, associated to notorious lack of resources, are the cause for not achieving wanted universality. However, these justifications are not supported in face of a public policy that boosts supplementary health care with fiscal incentives and a control system that is not submitted to SUS principles.

Ways to improve quality of service offered by SUS, with potential of attracting through gaining the trust of citizens who are within the supplementary health care system, needs to be looked for. Projects such as HumanizaSUS are important and needed. It should be stressed that it is full of good objectives, but there are not information capable to change this reality yet.

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Resumen

El SUS y el derecho a la salud del brasileño: lectura de sus principios, con énfasis en la universalidad de la cobertura

Este artículo aborda la cuestión del acceso a los servicios de salud en Brasil con énfasis en la universalidad de la atención. Describe los conceptos de justicia y salud; proporciona una breve reflexión sobre los sistemas de salud en los Estados Unidos de América, Francia, Inglaterra y Canadá; lleva a cabo una evaluación del *Sistema Único de Saúde - SUS* (sistema de salud) en sus aspectos públicos y privados y describe la história y el papel de los consejos médicos brasileños ü instituciones médicas para garantizar el acceso a los servicios de salud.

Palabras-clave: Equidad. Justicia social. Sistema de salud. Bioética.

Abstract

The SUS and the Brazilian`s right to health: a reading of its foundations, with emphasis in the universality of coverage

This article discusses the issue of access to health services in Brazil, with emphasis on the universality of the assistance. It discusses the concepts of justice and health. It provides a brief discussion on health systems in the United States of America, France, England and Canada; conducts an assessment of the Brazilian Unified Health System - *SUS* in their public and private aspects, and it describes the role of medical councils and medical institutions in ensuring access to health services.

Key words - Equity. Social justice. Health systems. Bioethics.

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