PATHS OF RIGHT TO HEALTH IN BRAZIL

Series B. Basics Texts of Health

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Presentation

This publication joins together basic information on the Unified Health System (SUS, in Portuguese). It redeems remarkable aspects of its history, its principles, its structure and the main guidelines and strategies that rule its management.

Besides informing, it restates the advocacy of a system stepped on the principles of citizenship and commitment, from its base lines, with the right to health for all. Hence, as close as it is to the complete fulfillment of the ideals that inspire it, as decisive SUS becomes to the construction of a fair and developed country.

Health, even more than the absence of illnesses, is the result of conditions—objectives and subjective ones— which favors a worthy life. This means that the production of health for the population depends on a set of public policies. This understanding, which ruled the Sanitary Reform since its beginning, is vigorously recovered in the present context, where several re-politicizing initiatives of the struggle for the right to health in Brazil converge.

Presently, the expectation is that the 13th National Health Conference, occurring at the end of this year, contributes to this process. Thus, it is previewed an extensive process of debate among managers, workers and users of health, in municipal, state and national levels, which rules the needs and challenges of different management spheres and of the different sectors of the State to the consolidation of SUS.

In this re-politicizing process, it is worthwhile mentioning the National Commission on Social Determinants of Health (CNDSS, in Portuguese), designated by President Lula on 13th March 2006, which has been contributing to re-strengthen con-
ceptions that articulates health and the civilizing process, emphasizing that a healthy human life depends on worthy housing, food in good quality and quantity, basic sewage system, good quality health and educational services, peaceful process of intermediation and conflict resolutions and sustainable environmental relations. Depends yet on a social environment based on valorizing cooperation and solidarity and on the respect on sociocultural diversity.

This document restates the commitment of Brazil with the right to health and with the life quality of the Brazilian population, present on the Federal Constitution and characterized on the Social Welfare System, and is summed up to the historical efforts of social movements, technicians and managers of health and other sectors of civil society.
The Struggle for the Right to Health in Brazil

Right to Health was internationally recognized in 1948, when the UN Universal Declaration on Human Rights was approved. Here in Brazil, it was incorporated as a “right” to health assistance to workers with formal entailment to the worker market, which only considered the population which contributed to the social security fund and deprived the majority of the population to the access of health actions, letting them with the single option of the assistance furnished by philanthropic societies.

In this context, health was not considered a right, but only a benefit from the social welfare system, as pensions, illness-aid, maternity-license, among others.

Coherent to this vision, during decades, public health policies had as its objectives maintaining and recovering the workforce necessary to the social reproduction of the capital. At the same time, health sector was highly determined by an assistance and healing concept, with an increasing private-ruled characteristic, with little or no priority to health promotion policies.

The Sanitary Reform movement emerged from the indignation of some sectors of Brazilian society on the dramatic scenery of the health sector. Thus, since the beginning, it ruled its actions by questioning these sceneries of inequities. Its first articulations started in the beginning of the 60’s, when it was aborted by the military blow of 1964. The movement reached its maturity in the 70’s and beginning of the 80’s and has been in motion since then. It is composed by technicians and intellectuals, political parties from different tendencies and several social movements.
The struggle for the Sanitary Reform had as one of its main historical time, 1986, when occurred the 8th National Health Conference, event that, for the first time in the history of Brazil, permitted the participation of organized civil society in the building process of a new conception of health.

The conference was lead by the principle of “health as a right for all and a State duty”. Its main resolutions were confirmed by the Federal Constitution, promulgated in 1988. This triumph was the product of an intense popular mobilization, which resulted in the Popular Health Amendment, signed by more than 500 thousand Brazilian citizens.

In the constitutional text, health became part of the Social Welfare System, jointly with the social security fund and the social assistance. SUS was established as a care system, based on the universal right to health and in the integrality of actions, involving health promotion and surveillance and damage recover.

SUS principles, defined in the Federal Constitution, are specified in law n.º 8.080, on 19th September 1990 and law n.º 8.142, on 28th December 1990, the so-called Organic Laws of Health. To a better understanding of them, they can be divided into ethic-political and organizational ones.

Today, SUS ethic-political principles are understood as: a) universality of access, understood as the access to health services to all the population, in all assistance levels, without prejudice or privilege of any kind; b) integrality of care, as an articulate and continuous set of preventive and healing services and actions, individual and collective ones, in all levels of complexity of the system; c) equity, which is the foundation stone to equality promotion, based on the recognition of inequalities that reaches groups and individuals and in the implementation of strategic actions designed to overcome this status; and d) social participation, which establishes the right to the
population to participate of all management levels of SUS, through the participative management and the health councils which are forums where the society controls the system. This social participation means sharing co-responsibility between the State and civil society in health production, that is, on formulation, execution, monitoring and evaluation of health policies and programs.

SUS organizational principles are: a) inter-setoriality, which prescribes the commitment of all different sectors of the State with health production and the welfare of the population; b) political-administrative decentralization, according to the rationale of a unified system, which foresees, to each governmental level, peculiar attributions and unified command; c) hierarchization and regionalization, which organize health care according to complexity levels – basic, medium and high–, offered in accordance to a territorial and populational area, known as health regions; and d) transversality, which establishes the need to coherence, complementarity and reciprocal effort among agencies, policies, programs and health actions.

The concept of health sustained by the Sanitary Reform is in tune with that one of life quality, understood as the historical capacity of enjoying and creating a lifestyle that considers, within the patterns of human dignity, the demands to housing, work, transportation, recreation and that offers integral access to health actions, to good quality educational system and impartial and peaceful mechanisms of conflict resolution.

Thus, the consolidation of SUS, as a health care system is not enough to make effective the right to health of the population. Evidences are clear in appointing the limits of an assistance system. The conquer of health needs to be articulated to the systematic and intersectorial actions of the State on the social determinants of health, that is, the set of socio-economical and cultural factors that influence direct or indirectly on health conditions of the population.
SUS’s Walk of Life

SUS is a popular conquest in permanent process of construction and improvement, inspired in a Welfare State. This characteristic designed it as a counter-hegemonic system, contrary to the excluding mercantile vision, which centered in damage recover and in tune with the neoliberal ideals of exhausting the social commitments of the State. On the 90’s, neoliberal measures brought expressive impairments to SUS’s consolidation process.

The health financing withdraw from the Social Security Fund seriously shook the resource supplies to the sector, a problem that even today is maintained without a definite solution. Taken the amount of necessary resource aside, SUS has the tendency not to offer, in sufficient quantity and adequate conditions to attend the needs and demands for health of all the population, medium and high complexity services, that is, those ones which demand higher investments and which are of the interest, particularly, to the private sector.

From the ideological point of view, theses, which favored the individual consumption as the means to access health services and that understand health less as an universal right and more as an individual economical merit, got stronger.

This scenery contributed to the strengthen of private health insurance, which compose the supplementary system and serve specifically to categories of organized workers and individuals wealth enough to afford the monthly expensive to keep the assurance. Herewith, the participation and social control of SUS’s process have not much interest by these sectors. On this scope, from the ones entailed to private health insurance, most of the Brazilian population is excluded.
But the limitations of private health insurance are not only linked to its excluding and mercantile character: its conception of health is centered in recovering individual damages and not in the production of collective health.

The neoliberal wave was not even more successful due to the solidity and to the deepness of the roots, in the population’s heart, of health as a right for all, to be guaranteed by the State. Actually, every time this right was under threat, Brazilian society immediately reacted to defend it.

Thus, although the adversities in the paths ran by the system, from 1988 up here, successful steps were not few, what proves the viability and the resolutive capacity of a system based in the universal right to health.

In the assistance field, the annual health production in the country registers about 170 million medical appointments, 2 million hospital treatments and 15 thousand organ transplantations, which mobilize 260 thousand health community agents and 27 thousand health teams. With the purpose to consider health macro and micro demands of a continental country, SUS developed its National Program on STD/AIDS, which became an international reference; reached 100% of vaccine coverage; contributed to decrease the rate of child mortality, promoted the psychiatric system reform; developed programs on tobacco control; established popular pharmacies, the Emergency Mobile Service (SAMU, in Portuguese), the Family Health Program – priority strategy of primary care organization, in order to guarantee universal access – and the Smiling Brazil Program, the new national on policy oral health, articulated with the Family Health Program and constituted by a set of strategic actions turned to guarantee universal access and the improvement of the oral health of the Brazilian population.
Concerning the financing of the system, although the drawbacks caused by the neoliberal attacks, the struggle of the society democratic sectors guaranteed, through the time, an expressive improvement on health’s budget. At the same time, the dispatchment of federal resources to the state and municipal levels became regular, according to the budget rates, of each level, established in the Federal Constitution.

In relation to the management, it deepened the decentralization process and improved the reference and counter-reference system. Participative democracy forums and mechanisms, with emphasis on participative management, were strengthened, with the implementation of health council in all the 26 states and 5,564 municipalities, as well as in the Federal District. The strategic importance of this participation is directly associated to SUS’s own political-institutional nature, which has in popular mobilization one of its dynamic-structural elements. This means that, if SUS managed to be established only by popular struggle, is it walking through this path that it will have conditions to be consolidated.
The Health Agreement

Trying to consider the unsurpassable need to qualify SUS’s management, the Health Agreement was instituted, in 2006, as a strengthening factor of solidary management among the three levels of SUS – Union, states and municipalities –, aiming at considering the needs and demands of the population’s health. The Agreement is the expression, in the health sector, of the Federative Agreement established by the Federal Constitution, which sets the co-responsibility and cooperation among the parts of the Federation.

The Agreement, established among the Ministry of Health, the National Council of State Health Secretaries (CONASS, in Portuguese) and the National Council of Municipality Secretariats of Health (CONASEMS, in Portuguese), proposes a set of changes in the management and in the agreement process that involves managers and social participative forums of SUS. Its objective is establishing new management strategies, in system planning and financing, aiming at improving the consolidation of SUS. The Agreement also involves the commitment to increase popular mobilization and the movement for advocacy of SUS. It is the result of a process that has been built since 2003.

The Health Agreement has three dimensions: the Agreement for Life, the Agreement for the management of SUS and the Agreement for Advocacy of SUS.

The Agreement for Life is based on the commitment to face ceaseless situations that affect more vulnerable populations, defining health strategies and goals to improve health situations, aiming at equity promotion in health.
The Agreement for Advocacy of SUS establishes political commitments involving the State and the civil society, in order to consolidate the fulfillment of the process of the Brazilian Sanitary Reform, through the increase and improvement of participative democratic practices in SUS, aiming at strengthening political actions in advocacy of the right to health.

The Agreement for the Management defines the sanitary responsibilities of each municipal, state and federal manager to the management of SUS, concerning work management, education in health, decentralization, regionalization, financing, planning, agreed and integrated programming, action and service regulation, monitoring and evaluation, audit and social participation and control of these activities.

The Agreement qualifies decentralization, by strengthening the Bipartite Inter-managerial Commission (CIBs, in Portuguese), forums of agreement that act within the states in defining organizational models, based on guidelines and rules agreed in the Tripartite Inter-managerial Commission (CIT, in Portuguese), to be present to deliberation in the respective health council.

In turn, regionalization guideline indicates the creation of health regions, aiming at improving access to different health services. These regions should be considered and defined according to individuals and communities lifestyle, following the existence of health services in the area where people live and pass by.
The Challenges of SUS

In a country that presents deep social inequities, equity promotion is a priority challenge to be taken over by public policies. In health sector, it implies facing vulnerabilities and inequities that affect specific segments, such as women, elderly, children, black people, groups of sexual orientation—GLBT, in Portuguese—, populations who live in country area, in forests and on the streets.

It also means to step forward to consolidate principles of transversality and inter-setoriality, essentials to revert tendencies of fragmentation of State actions, within the health sector as well as in its interface with other sectors.

It also essential to improve the process of qualifying integral care made available by SUS units, in order to offer the population good quality health services and health preventive and promoting actions. This tends to strengthen the public sector and weaken spaces where health is seen as a commodity. Hence, it is necessary the commitment of supplementary sector with health promotion, and not only with assistance.

Thus, it is necessary to increase the furnishing of inputs and equipments, guaranteeing an efficient maintenance, improve the articulation among different levels of care, improve solidary management among the three management levels and qualify popular participation in health councils.

The implementation of these principles and action lines, among others, converge to increase and consolidate health conquests of the Brazilian population. In a deepen concern, it works to bring closer the real horizon of the Sanitary Reform and of SUS: a
civilizing project where health, instead of a commodity to serve for few, becomes – together with education, housing, work, security, recreation, healthy natural and social environment, and other conquests that produces a true human life – a right for all.

JOSE GOMES TEMPORÃO
Minister of Health
Present Priorities of the Ministry of Health of Brazil
(Extract from the speech of entrance into Office of Minister José Gomes Temporão, on 19th March, 2007)

1 To watch over the use of public resources, struggling against frauds and instituting controls that allow a better participation of the society in the use and destiny of health resources.

2 Strengthen, improve and qualify primary care as the central strategy to re-order the system, from the principles of integrality, equity and universality.

3 Strengthen, deepen and improve the Agreement for Life, Advocacy for SUS and its Management, through the decentralization process agreed and monitored by the Tripartite and Bipartite Commissions, qualifying them as the forums for policies management and formulation.

4 Struggle within the Government, in the National Congress and in the society in order to make health sector receiving the necessary budget to the complete fulfillment of constitutional rules.

5 Strengthen social participation with a democratic and participative management in SUS, increasing the level of sanitary consciousness, as was taught to us by Giovanni Berlinguer, and the level of the education of the population on health and its determinants, as well as the level of collective actions aiming at the changing of its structural determinants.
6 Adopt an interactive, multiple and integrated inter-institutional vision that narrows the spaces of health, education, sports, culture, sewage system, security, housing, with policies of social inclusion. Here we will possibly have one of our greatest challenges.

7 Strengthen and disseminate nationwide the Humanization Policy, expanding it to the set of practices in the process of production of health care and guaranteeing shelter, comfort, respect and technical qualification in health care to citizens, users of SUS.

8 Strengthen the National Policy on Sexual and Reproductive Rights, emphasizing the improvement of obstetric care, in combating gynecological cancer (the present situation of uterine cancer is a shame, 20 thousand new cases 2007), in family planning, in care to unsafe abortion and in the struggle against domestic and sexual violence; joining also the prevention and treatment to those women living with STD/Aids.

9 Improve the assistance performed to the population in risk situations, as the indigenous population, the quilombolas (population descendent of African people brought to Brazil as slaves), the population of settlements, and so on.

10 Institute the National Policy of Men Health Care.

11 Develop innovative approaches related to vulnerable populations, such as the elderly and the double relation between mother-baby in its first year of life, time knowingly as fundamental to the construction of shared social relational patterns and personality development.

12 Give priority to health promotion and preventive policies aimed at prevalent illnesses, as the cardiovascular ones,
cancer, the ones that result from violence, traffic and work accidents, from the use of psychoactive drugs and alcohol, from food habits, tobacco consumption, among others.

13 Call upon Oswaldo Cruz foundation (FIOCRUZ, in Portuguese) and the National College of Public Health Sérgio Arouca (ENSP, in Portuguese) to, jointly to the University of Brasília (UnB) and the National College of Public Management (ENAP, in Portuguese) immediately implement a “Government College in Health” – whose proposal has been established as an essential forum to qualify health managers – in the Federal Capital.

14 Strengthen the presence of Brazil in the international scenery – concerning the challenge launched by President Lula during the Congress of the Brazilian Association of Post-Graduation in Collective Health (ABRASCO, in Portuguese) –, narrowing the relationship with the Ministry of foreign Affairs, improving our presence in the governing bodies and in UN health programs – as the World Health Organization (WHO), the Panamerican Health Organization (PAHO), the program on International Drug Purchase Facility (UNITAID/FIAM) and many others –, as well as cooperating with the development of health systems in South America countries – especially the ones of MERCOSUR – and with the Portuguese speaking countries of Africa and the Community of Portuguese-Speaking Countries (CPLP, in Portuguese).

15 Give continuity and improve the Brazilian Psychiatric Reform.

16 Search for a higher integration between the activities and policies of the National Agency of Supplementary Health (ANS, in Portuguese) and SUS.
17 Establish with health workers a dialogue that allows to improve the discussion on income policies, on the conditions on professional acting, on struggling against precarious work, on their permanent qualification and adopting in this context the motto “taking care of those ones who take care”.

18 Strengthen the role of the Ministry of Health concerning research, innovation and the scientific and technological development, strengthening the brand-new policy on health technology management.

19 Establish a national strategy of development and innovation to the Productive Complex of Health Goods and Services in the country, recognizing health as a production, development, job and wealth creation space for the nation and as an vital factor to the development.

20 Guaranteeing the population access to necessary medicines through a pharmaceutical assistance policy that integrates and articulates the free delivery of these medicines with the new strategies established by the Popular Pharmacy Program.

21 Establish new management models that guarantee SUS principles, but that allows health institutions to work based on efficiency and quality. The newly regulation of the Partnership Law and the proposal of adoption of a new juridical-institutional model to the public hospital network open new perspectives.

22 Contribute to decipher Rio de Janeiro’s sphinx, in order to establish a re-agreement among municipal, state and federal managers, in understanding health as part of a civilizing Project as fundamental as the people from the state and the city of Rio de Janeiro.
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