

## GOVERNANCE AND ORGANIZATIONAL STRUCTURE: AN ANALYSIS OF SUS AFTER THE CONCRETION OF THE BRAZILIAN SANITARY REFORM

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### Abstract

This case study describes the organization SUS – Sistema Único de Saúde (Unified Health System) adopted in Brazil, by a strategic point of view, according to the traditional governance mechanisms. SUS is an organization that has as its challenge tending to the health needs of 120 million inhabitants. Firstly, a history of the Brazilian sanitary reform is done, informing on the ideological conception or strategic intention of SUS. It is an exploratory and descriptive study, based on the analysis of system documents and some statements from management executives of the health field. On the researched literature there were not found any prior studies with these same objectives, what became a greater challenge for comparison of affirmations and conclusions originated from the work. A summary of the governance mechanisms used by SUS and a critic of the absence of performance indicators may be considered the main conclusive points of this case study. However, the texts studied were extremely useful on the concept descriptions, both those related to strategic planning and those specific to the health field. The weight of the implanted governance suggests the need to implant a performance system in the management of this organization, one so important to the Brazilian population.

**Keywords:** governance, Brazil, management executives

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### 1. Introduction

By creating the Unified Health System (SUS), the Federal Constitution of 1988 took a great step in the democratization of Brazilian health care, opening the due space for debates that culminated with the system's regulation in 1990. Once the institutional battle was won, a movement of agents interested in the concretion of the sanitary reform was initiated. Since then and until today, many advances were obtained on the resources organization, in management and financing policies, among them, the regulation of health plans, institution of health councils, decentralization of the actions and services, creation of sanitary districts and inter-municipal consortiums, citywide decision taking, resource transferences fund to fund, ambulatory and hospital attention and diagnostic and therapeutic support without formal barriers, creation of the Family Health (Saúde da Família) and Communitarian Health Agents (Agentes Comunitários de Saúde) and creation of the Basic Welfare Floor (Piso Assistencial Básico).

Nevertheless, the path to be taken on the concretion of the sanitary reform is yet a long one. There is a need to consolidate implemented actions, establish those that were not given priority yet and

create new ones, in the direction of reaching optimal quality and assistance levels, comparable to first world countries, why not? Gonçalves (2004) affirms that, in order to achieve the desired changes, it is necessary that the governance system of that organization is constantly analyzing the external and internal environment on which it is inserted, be it on a rational, systematic manner or intuitive and aleatory. This investigative posture is of great notoriety on the opinion formers of the health field, specially on the matter of SUS' decentralization, where we may perceive strong movements on the direction of revising the current concept. The decentralization of the decisions and actions up to the municipal sphere was promulgated by the law 8.080/90, which brought indisputable benefits to the system, but without refraining from generating serious problems that may not continue existing anymore. "It is needed to recognize that the decentralization manner, by citywide focus, done by SUS, through an autarchic citywide paradigm, is depleted and needs to be rethought." (Pestana & Mendes, 2004). It is confirmed, then, the need to improve increasingly the critical sense of the system.

According to Serra *et al.* (2004) strategic planning may be considered the process to determine

the organization's objectives and adopting actions and allocating resources to achieve these. Its practice is, therefore, a decision of valor and great significance in the present and future positioning of any organization. Strategic planning foresees competition, whenever on the markets logic, suppliers, customers, on logics of alternative products, competition among companies or even on the ideologies logic, in which the competition's objective is associated with collective resource distribution (Gonçalves, 2004). The challenge for the SUS organization is huge – its clientele is almost the size of the Brazilian population – and it needs a structure on par with this challenge. The SUS-dependent people (do not have health plans) are 70% of the population or 120 million people. In this way, a study of SUS on a strategic planning perspective becomes relevant as far as it is the organization responsible for the health, on an amplified meaning, of Brazilian population, which is avid for better results on assistance and quality of services.

This case study has the objective to confront some specific topics from the literature related to Enterprise Strategic Administration with the context of the Unified Health System, in an attempt to give conclusions over the consistency of the model facing the new managerial technologies. Specifically it will be observed the mechanisms of *Corporate Governance* and the *Organizational Structure*. The mechanisms of corporate governance and the organizational structure of SUS are appropriate to the global and hyper-concurrent market? Are they aligned with its doctrinarian principles? Are they effective for the concretion of the Brazilian Sanitary Reform? These are the three basic questions that we aim to answer on this text.

## 2. Methodology

For the achievement of the objectives of this paper there were necessary exploratory literature studies on strategic planning and the Brazilian health model. Various document types were consulted, like books, laws, Health Ministry Ordinances dissertations, thesis and academic works, and further official publications from various municipal and state health secretaries. It may be considered as an essentially descriptive study, once that it did not demand a field research. For enrichment of the topic of discussions and conclusions interviews were done with SUS managers – people that occupy confidence positions in the municipal and state spheres of the health system structure – that contributed much to delineate critical factors of SUS, on a strategic view.

## 3. The Unified Health System (SUS) and its principles

The current Brazilian public health system is a fruit of a series of political and ideological clashes, which its trajectory began in the 1920 decade, time of the

appearance of Social Security, culminating in the year of 1986 with the creation of the Unified Health System (SUS), approved by the Federal Constitution of 1988, which recognizes health as a right assured by the State. Interlined by the principles of universality, equity and integrality and organized in a decentralized, hierarchized and socially supportive manner, SUS is today one of the greatest public health models of the world, granting full and free care to all the population, including people with Aids, cancer and chronic kidney patients, which demand high cost treatments (Based in CUNHA & CUNHA, 1998).

### 3.1. History

The hegemonic health model, in the decade of 1970, was characterized by a high centrality of resources and decision in the federal sphere, from a division of responsibilities between the Health Ministry (MS) and Social Security Ministry (MPAS), through the Inamps (National medical care institute of the social security), in which the first took care of preventive health actions, and the second took care of the curative diagnostic actions, of treatment and rehabilitation, these actions being planned, controlled and evaluated by the federal sphere (Viana, w/o date.).

Another characteristic of this policy was its private focus because the offer of curative services was guaranteed by contracts with private institutions. The payments done by Inamps to the private sector were based on the quantity of medical acts done by each kind of service (ambulatory, hospital e laboratorial). The degree of regulation and control of the actions bought from the private sector were basically inexistent, it being almost like writing a “blank check” to the provider (Viana, w/o date.).

The management of Inamps may be considered excluding, because the benefited clientele were only the those held by Social Security, in other words, workers from the formal labor market. Whoever contributed monthly with part of their salary had assured his medical care. The rest were treated as indigents. The health actions developed by the other public organs (Health Ministry and state and city health secretaries) were in almost exclusive dependency to the federal, state and city budgets. This way, the public health actions of a hygiene and primary care type were almost all the time compromised in terms of public health indicators and assistance quality results.

From the law of National Health System (1975), the states and cities would receive technical and financial incentives from the Union to organize their services, having as attribution the maintenance of the Emergency Room services and the actions of epidemiologic vigilance. This model was supported by the private sector linked to the public sector and organized by associations like the Brazilian Hospital Federation (FBH), Confederation of Mercies of Brazil (CMB) and others. From the creation of FAS (Fund for Social Care) there was stimulation to the

amplification of the private hospital network in Brazil, mainly on the second half of the seventies. This emergent “market” of goods and services ordered by the public sector was widely supported by the State representatives on the sector. However, the type of this model’s political interaction among the private and public actors is notorious. Politics indicated people to occupy the key posts in the bureaucratic apparatus of Inamps, and thus tended to claims from private suppliers, forming bureaucratic rings, whose objective was to beneficiate public, political (parliamentary) and public (Inamps bureaucracy) segments. The political segments received financial support for campaigns and the bureaucracy received favors, gifts and diverse easiness (Viana, w/o date.).

The 1980/83 period is considered the outbreak of three crises: the ideological, the financial and the political-institutional crisis. The process of re-democratization that was beginning, the high levels of inflation and the break in the internal cohesion of the regimen contributed to the rise of the need of restructuration in the health field. Inspired in the determinations of OMS (World Health Organization), stated on the Alma-Ata Conference, that all the member countries should obtain “health for all in the year 2000”, workers, users and service providers initiated various movements in the direction of proposing changes in the sector.

On 1986 it is held in Brasília the VIII National Health Conference (CNS), with wide support of professionals from the sector. Preceded by municipal and state conferences, the VII CNS meant a mark in the formulation of change propositions, consolidated in the Brazilian Sanitary Reform. Rises the concept of health as: *“resulting of the feeding, habitation, education, income, environment, work, sport, employment, leisure, freedom, access and hold of land and access to health service conditions. It is, thus, before anything, the result of the forms of social organization of the production, which may generate imbalance on the levels of life”* (CUNHA & CUNHA, 1998). Thus, the Federal Constitution of 1988 approved the creation of SUS, regulated afterwards through the 8080/90 (Organic Health Law) and 8142/90 laws. These laws define the attributions of the different government levels; establish responsibilities in the areas of sanitary, epidemiologic and worker health areas; regulate the financing and the spaces of popular participation, formalize the understanding of health as area of public relevance and the relationship between the public authority and private entities, among other various principles. Of operational character, the Basic Operational Rules (NOBs), published by the Health Ministry, are important devices for the exercise of the system’s activities.

### 3.2. Concept

Beyond the amplified concept of health, SUS brings other two important concepts, of *system* and the idea

of *unity*. The notion of system means that we are not talking of a now service or public organ, but of a group of various institutions, of the three levels of the government and of the contracted and convened private sector, all following the same principles and the same rules of the public service. Unity comes from unified doctrine and same form of organization in all the country, however, with due respect to the cultural, economical and social diversity of the different Brazilian states (CUNHA & CUNHA, 1998).

### 3.3. Doctrinarian Principles

*Universalization* – Health is a citizenship right of all people and it is the State’s role the guarantee this right. Access to the actions and services must be assured to all people, regardless of gender, race, income, occupation or other social or personal characteristics. Before SUS those who had the right for health care in Brazil were only workers insured by INSS and INAMPS. (Based on CUNHA & CUNHA, 1998).

*Equity* – Despite all having right to the services, people are not equal and, for that, have different needs. Equity means to treat unequally the unequal, investing more where the need is greater. Equity is a social justice principle and is not the same as equality (CUNHA & CUNHA, 1998).

*Integrity* – This principle considers the person as a whole, tending to all their needs, including the health promotion, disease prevention, treatment and rehabilitation. It assumes the articulation between health and other public policies, as a way to assure an inter-sector acting among the different areas associated to quality of life (CUNHA & CUNHA, 1998).

### 3.4. Organizational principles

*Regionalization and Hierarchy* – The services must be organized in crescent levels of complexity (primary attention, secondary attention and tertiary attention) circumscribed to a determined geographical area, planned based on epidemiologic criteria, and with definition and knowledge of the clientele to be tended to. Regionalization is a process of articulation among the existing services, seeking unified command of those. Hierarchy, beyond differencing the attention levels, assures means of access to them due to the complexity of each case, inside the resources limits in a given region (CUNHA & CUNHA, 1998).

*Decentralization (citywide application) and Unified Command* – To decentralize is to distribute power and responsibility among the three levels of government (federal, state, and city). Each government sphere is gifted autonomy and dominion on their decisions and activities, being the city’s role the responsibility for the health of their citizens. The sanitary authority is exercised by the health system managers: in the Union

by the minister of health, in the states by the state secretary of health and in the cities by the city secretaries or health department chiefs. Decentralization is a fundamental strategy to guarantee integral access of the population to promotion, protection and recuperation of health (CUNHA & CUNHA, 1998).

*Popular participation* – Society's participation must be present on the daily activities of the system through Health Councils and Conferences, which have as role to formulate strategies, control and evaluate the execution of the health policy. The Health Councils are deliberative organs, of permanent character, and must exist in the three levels of government. Its composition must be egalitarian, with half of its members representing users and the other half, government, health workers and private providers. The Health Conferences are forums with representation of various social segments which regularly reunions with the same purposes as the Councils. Must be organized on all levels of government (CUNHA & CUNHA, 1998).

*Complementary nature of the private sector* – In case the public sector is unable to tend to a programmed demand, the private sector must be contracted, however, following the determinations of the public system, in terms of functioning rules, organization and articulation with the rest of the network (BRASIL. Law number 8.080).

#### 4. Discussions over Governance Mechanisms and Organizational Structure

*The main component for competitiveness on global markets is the development and implantation of an effective strategy. Thus, the current and future Brazilian administrators must learn more on the necessary actions for building and maintaining a competitive advantage, both in the internal and global markets. With this knowledge, the administrators will be prepared to develop effective strategies, which, when implemented, generate aggregate value to all shareholders (HITT et al., 2003 [free translation<sup>85</sup>]).*

Evidently the author is referring to private companies that are in the globalized and hyper-concurrent market, what may seem as something completely out of the public administration scope, that is the focus of this study. However, the administration concepts are universal, if different in context. It is up to us to understand, adapt and use them to generate value to the individuals and groups that, in one way or another, affect and are affected by the organization at issue.

##### 4.1. Stakeholders

According to Hitt et al (2003), any organization is a system of primary groups of *stakeholders* with which

it establishes and manages its relations. They are the individuals and groups capable of affecting and be affected by the achieved strategic resources and which have applicable and valid claims regarding the performance of the organization. In general they are subdivided into three groups: shareholders and main sources of capital; customers, suppliers, community and syndicates; and employees (managers and non-managers). The identification of SUS' *stakeholders* and their respective interests is vital to a more accurate evaluation of the efficiency of the Brazilian sanitary reform.

##### 4.2. Corporate Governance

Represents the relationship between the investors that is used to determine and control the strategic direction and performance of organizations. Corporate governance preoccupies with identification of manners to assure that the strategic decisions are taken efficiently. Involves supervision on areas in which the proprietors, managers and members of the Administration Council may have interest conflicts. These areas include the election of directors, general supervision of CEO (Chief Executive Officer) payments – the highest executive position in the corporation – and director payments, etc. The most used governance mechanisms currently used by capitalist companies are: *propriety concentration*, *administration council*, *executive payment and multi-divisional structure* (HITT et al, 2003).

*Propriety concentration* – concentrating propriety means accumulating a expressive percentage of shares of the corporation, which, consequentially makes the proprietary more active in his exigencies to the administrative decisions, influencing in the resource allocation decisions, aiming to obtain returns superior to the market average. Differently from essentially capitalist organizations, the “shareholder” of the SUS corporation – composed by various institutions of the three levels of government and of the convened and contracted private sector – is the society, which sends us back to the concept of *diffuse propriety* (a great number of shareholders with a small number of shares). Diffuse propriety, according to Hitt et al (2003), produces low monitoring of the administrative decisions, as also making the efficient coordination of actions difficult.

*Administration Council* – Still according to Hitt et al (2003), it is a group of elected and contracted people, whose main responsibility is acting on the interest of the proprietors monitoring and controlling formally the high level executives of the corporation. It is an effective mechanism inasmuch as protects the proprietors from the executives opportunism, but demands an intermediation relationship between the parties. They may be composed by *insiders* (high level managers, active in the corporation), *related outsiders* (individuals with some relation – contract or not – with the organization, but not involved in daily operations) and *outsiders* (individuals independent

<sup>85</sup> All quote translations are free translations.

from the organization in terms of daily operations and other relations). This governance mechanism is widely used in the SUS corporation, but under the name of *Conselhos de Saúde* (Health Councils), organs of SUS control by the society on the city, state and federal spheres. Evidently there are countless differences in the manner of conducting the activities of the administration councils and the health councils of SUS, for instance, in the autonomy to contract and dismiss a high level manager, but it may be clearly perceived that the objectives are convergent in the search for control and efficiency.

*Executive payment* – it is a governance mechanism which seeks to align the managers and proprietors' interests through salaries, bonuses and long term incentive rewards, as, for instance, options of share buying. Still according to Hitt (2003), a recent study suggests that the performance of an internal director improves if he has participation in the social capital. The announcement of an internal director which holds less than 5% of the shares diminishes the wealth of the shareholders, but one *insider* who holds between 5% and 25% of the shares improves the wealth of the shareholders. On the other hand, these payment plans isolated are imperfect in their capacity to monitor and control the managers, because the measuring of the effects of strategic decisions is complex and difficult to link with the payment. Executive payment as a governance mechanism, though not impossible, would be of difficult application on public institutions due to the concerning legislations. However, it is of public knowledge the practice of alternative illegal mechanisms, true payment "schemes", involving executives and non-executives in various Brazilian public organizations.

*Organizational structure* – this is the configuration of the formal role, proceedings, direction and control mechanisms and processes of authority and decision taking of an organization. Strategic competitiveness - and here the concept of competitiveness may be understood in a wide manner, not only from the viewpoint of obtainment of above average profits, but, for instance, of aggregating greater value to the customer – may be obtained only when the chosen structure of a company is congruent with its formulated strategy. Inasmuch as the organizations evolve and modify their strategy, structuring needs to be rethought. There are three basic types of structure: Simple, Functional and Multi-divisional, each one with its variations due to the formulated strategy and business characteristics. The evolution from a simple structure to a functional and from a functional to a multi-divisional occurs due to coordination and control problems, caused by the increase in product of service demand. Because of SUS dimensions, it is important to concept only the functional and multi-divisional structures, for the simple structure applies only to small companies with a single product line.

*Functional structure* – consists of a CEO and a limited corporate staff, with functional line managers in predominant organizational areas as, for instance,

production, accounting, marketing, research and development (P&D), engineering and human resources (HITT *et al*, 2003).

*Multi-divisional structure* – the multi-divisional structure (M form) is a form of organization composed of operational divisions, each one representing a business of separate profit center, in which the higher corporate authority delegates responsibilities for daily operations and the strategy of that business unit to the division managers. This type of structure is commonly used in organizations with a high level of product diversity, because it makes easier monitoring the individual performance of the business unit. According to Alfred Chandler (1994), quoted by Hitt *et al* (2003): "the M form became existing when the senior managers, which operate through centralized structures, functionally departmentalized..., perceived that they did not had time, nor necessary information, to coordinate and monitor the daily operations, or idealizing and implementing long term plans for the various product lines. The administrative overcharge simply became too much". The adoption of an M form structure in a diversified organization is also a corporate governance mechanism, once it allows to evidence those division managers with low performance, limiting possible opportunist behavior. On the other hand, this mechanism is not so effective for corporate executives, which have a tendency to diversify increasingly the product portfolio as a way of reducing the risk of losing their jobs (if one business fails the high executive level stays employed). The organizational structure of SUS deserves special attention, once it has great potential of influencing the strategic mission and intention of the organization. It is necessary to study the "product" portfolio of SUS, as also as the coordination and control forms to then conclude over its adequacy.

*Cooperative networks* – a cooperative network (or alliances network) is a group of identifiable and competitively relevant links between two or more relatively comparable firms. The performance of a cooperative network may be increased in consequence of the mutual commitment that the partners assume when a network is created and due to the mutual dependence that the commitment creates, making the partners work together in tending to the common interests of all parties. The reasons to use cooperative networks as a basis for a network cooperative strategy are various, among which we highlight: a) sharing complementary resources, capabilities and essential competences; b) remaining on par with emergent technologies; c) sharing the risk and the costs of capital spending. The cooperative strategies are not devoid of risk and the choice of partners is the main point. For the success of the cooperative network it is necessary to know deeply the intent that propels the firm's interest in the alliance, which requires countless interpersonal actions in the search for confidence. This aspect might be the most efficient mechanism in the administration of a cooperative

network. Another important point for risk reduction in cooperative networks is the definition of a central strategic firm to manage the relations network. These firms must have essential capabilities and competences which allow it to dislocate important activities to other network members, creating value when these are more capable of performing these activities (Hitt *et al.*, 2003). The structuring form in cooperative networks is also present in SUS through the Inter-municipal Health Consortiums, juridical entities under private law, organized by municipal initiative, whose objective is rationalize the use of resources to tend to a determined region (BRASIL, Ministério da Saúde (Ministry of Health), 2005).

## 5. Description of the SUS “business”

### 5.1. Objectives and attributions of SUS

According to the Basic SUS Legislation (BRASIL, Law no. 8.080/90), the objectives of SUS are: (I) identification and disclosure of the conditioning and determinant health factors; (II) formulation of a health policy destined to promote, on the social and economical fields, the reduction of disease risks and other aggravations and establish conditions to assure the universal and egalitarian access to the actions and services to its promotion, protection and recuperation; (III) the assistance to people through medium of health promotion, protection and recuperation actions, with integrated execution of the care actions and preventive activities.

Are included in the field of action of SUS: (I) execution of actions of sanitary vigilance; of epidemiologic vigilance; of worker health; and of full therapeutic care, including pharmaceutical; (II) participation in the formulation of the policy and in the execution of basic sanitation actions; (III) ordination on the formation of human resources on the health area; (IV) nutritional vigilance and alimentary orientation; (V) collaboration on the protection of the environment; (VI) formulation of the policies for medicaments, immunological equipment and other inputs of interest for health and participation on its production; (VII) control and inspection of services, products and substances of interest to health; (VIII) inspection of food, water and drinks, for human consumption; (IX) participation on the control and inspection of the production, transport, storage and utilization of psychoactive, toxic and radioactive substances and products; (X) the increment, in its area of acting, of scientific and technologic development; (XI) the formulation and execution of the policy for blood and its derivatives.

### 5.2. Models of attention to health

The model legitimated by SUS implicates the hierarchies, decentralized and organizational systems, already stated above, but also a change of concepts related to health-disease and the link between the

services and the users. Health is seen no longer as absence of disease, but as quality of life. In this view, the model of attention proposes the combination of three axis of action: health promotion, infirmity and accident prevention and curative attention. Thus, the system is organized by points of attention to health: primary, secondary and tertiary (MINAS GERAIS, Secretaria de Estado da Saúde (State Secretary of Health)).

*APS (Primary Health Attention)* – actions under city responsibility related to promotion and prevention of health like the Family Health Program (Programa de Saúde da Família), epidemiologic vigilance, etc.

*ASS (Secondary Health Attention)* – assistance activities on basic specialties (pediatric, medical clinic and obstetric) and services of ambulatory and hospital urgency and emergency, occurring on micro-regional depth.

*ATS (Tertiary Health Attention)* – organized in macro-regional poles, include high complexity ambulatory and hospital services.

### 5.3. Products supplied on APS (Primary Health Attention)

The actions paid with resources destined to basic care are: (I) medical consults on basic specialties; (II) basic dental care; (III) basic care by other tertiary education professionals; (IV) visit/domiciliary ambulatory care by members of the family health staff; (V) vaccination; (VI) educational activities to community groups; (VII) prenatal assistance and family planning activities; (VIII) small surgeries; (IX) basic care by secondary education professionals; (X) activities of the community health agents; (XI) nutritional and alimentary ambulatory and communitarian orientation; (XII) domiciliary childbirth assistance by medic from the Family Health Program; (XIII) E.R. services. (BRASIL, Law no. 8.080/90).

## 6. SUS Governance Mechanisms

### 6.1. SUS Stakeholders

It is possible to classify the *stakeholders* of the Unified Health System on three groups: financiers, network integrants and collaborators.

*Financiers* – they are entities who invest financial resources on the organization with expectations to obtaining feedback from the investment, not in terms of profit – SUS is not ruled by private initiative laws – but feedback related to the highest quality of services by adequate use of resources. The main financier agent of SUS is the *community* itself, represented by the *Federal Treasure*, which passes resources on to the states and cities, *State Treasure*, which also contributes to the cities and to those priority programs on its sphere, and *Municipal Treasure*, which assigns part of its income to health.

*Network Integrants* – it is the group formed by the *final users*, *health professionals*, *private institutions*

of services complementation, suppliers, professional and superior teaching institutions, philanthropic entities and those with no profit ends, public foundations, autarchies and syndicates. All the integrants of this group are important for they form SUS' operational network, specially the final user, whose satisfaction is determinant for measuring the success on the strategic implementation.

*Collaborators* – the organization employees hope that it provides a dynamic, stimulating and gratifying work environment, with well-defined career policies and opportunities for everyone. This is the group formed by the *public employees of SUS, managers and non-managers*, including those in confidence positions.

## 6.2. Health conferences

The health conferences are one of SUS' governance mechanisms. Convoked by the Executive Power, they are institutional spaces destined to analyze the advances and regressions of SUS, reuniting representatives of the users, government, health professionals, service providers and parliamentarians, which propose directives for formulation and revision of the city, states and country health policies. They are vital for the exercise of social control, because establish directives for the actions of the Health Councils on the three spheres of government (BRASIL, Ministério da Saúde (Health Ministry), 2005). The National Health Conferences must occur once every four years, after the municipal and state conferences have been held. It was the report of the 1986 VII National Health Conference that served as the basis for elaboration of the chapter on health of the Federal Constitution of 1988, which created SUS.

## 6.3. Health councils

The health councils are collegiate, deliberative and permanent organs of the Unified Health System (SUS), existing on each government sphere and integrants of the basic structure of the Ministry of Health and of the State, Federal District and City Secretaries of Health, with composition, organization and competence prescribed by the Law no. 8.142/90. They act on the formulation and proposal of strategies and in the control of the execution of the health policies, including their financial and economical aspects. The rules for the composition of the Health Councils are, also, established on the legal text, having to include representatives of the government, service providers, health workers and users, being the user representation equal (50%) to the group of other segments. Since the edition of the Organic Health Laws (8.080/90 and 8.142/90) the existence and functioning of the health councils are requisites demanded in order for the habilitation and receiving of federal resources passed "fund to fund" to the cities (BRASIL, Ministério da Saúde [Health Ministry], 2005).

## 6.4. Collegiate instances

There are other collegiate instances responsible for managing SUS, appreciating, among other issues, the pacts and schedules between managers, seeking for integration between the governmental spheres. They are: *Tripartite Inter-manager Commission (CIT)*, *Bipartite Inter-manager Commission (CIB)*, *National Council of City Health Secretaries (Conasems)* and *National Council of Health Secretaries (Conass)*.

*Tripartite Inter-manager Commission (CIT)* – linked to the national direction of SUS, it is an articulation and pact instance on the federal sphere, integrated by SUS managers from the three government spheres (five representatives from the Ministry of Health, five from Conass and five from Conasems). The states and cities representation on this Commission is regional, being one representative for each of the five regions of the country. In this space decisions are taken by consensus and not voting (BRASIL, Ministério da Saúde [Health Ministry], 2005).

*Bipartite Inter-manager Commission (CIB)* – state sphere spaces of political pacts and articulation that aims to orient, regulate and evaluate the operational aspects of the decentralization process of the health actions. They are constitutes, equally, by representatives of the state government – indicated by the State Secretary of Health – and the city health secretaries – indicated by the representation organ of the collection of cities in the state, usually Conasems. They are also instances of political articulation among city health managers (BRASIL, Ministério da Saúde [Health Ministry], 2005).

*National Council of City Health Secretaries (Conasems)* – non-governmental entity, with no profitable ends, created with the objective to represent the state health secretaries. Its importance on the political scenario is due to the ascertainment that it is fit, primarily, to the city the provision of health services, with technical and financial cooperation of the states and the Union. Acts, among other fronts, on the formulation of inter-sector public policies, important on the propagation of the principles of universality, equity and integrality of health (BRASIL, Ministério da Saúde [Health Ministry], 2005).

*National Council of Health Secretaries (Conass)* – it is an organ which congregates the health secretaries of the states and of the Federal Districts and their legal substitutes, having as finality operating the exchange of experience and information among its members, assuring the implementation of the constitutional and Brazilian health complementary legislation principles and directives, in the implementation of health actions and services. Among other attributions, orients and promotes congresses, conferences, seminars and other encounters for improvement of the sector activities and maintains an exchange with national and foreign entities of interest for the health sector (BRASIL, Ministério da Saúde [Health Ministry], 2005).

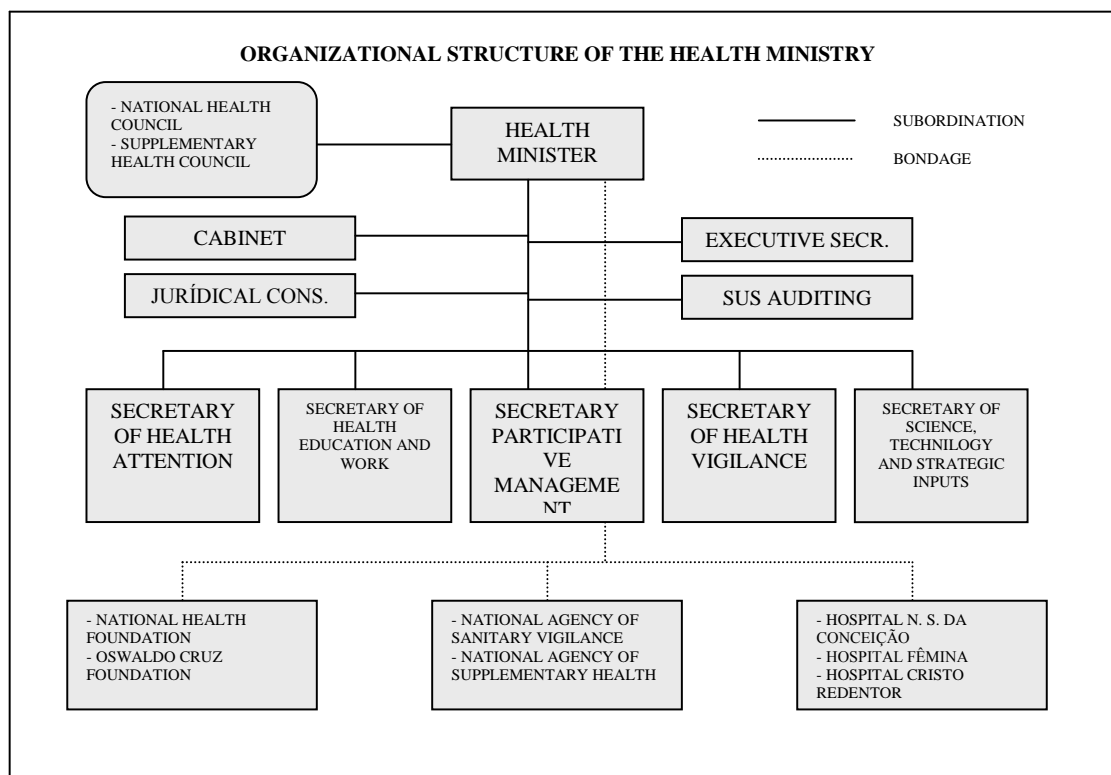
### 6.5. Inter-municipal health consortiums

These are juridical entities under private Law, with autonomous management structure and its own budgets, built and paid by the city managers, and, in some cases, also by the state managers, that combine themselves to solve specific demands or health problems that cannot be solved isolated, on each city. The inter-municipal health consortiums allows to rationalize the use of resources destined to equipment, human resources, and hospital installation, as well as creating specialization centers that would be expensive and idle to tend to only one city, becoming viable when reunite users from various cities. The organization of the consortiums must be initiative of the cities, which elaborate and approve a commitment device, explicating, among other aspects, the

headquarter city of the consortium (BRASIL, Ministério da Saúde [Health Ministry], 2005).

### 7. Organizational Structure of SUS

The highest executive position in SUS is occupied by the minister of health, as shown in figure 7.1, having a relatively numerous staff, composed of collegiate organs, advisory bodies and corporate functional secretaries. We may also observe the presence of links with public foundations, autarchies and mixed economy societies. This structure allows the existence of functional specialization, making, thus, easier the information sharing and idea development. The main task of the CEO is integrating the actions and decisions of the individual business functions to benefit the whole corporation.



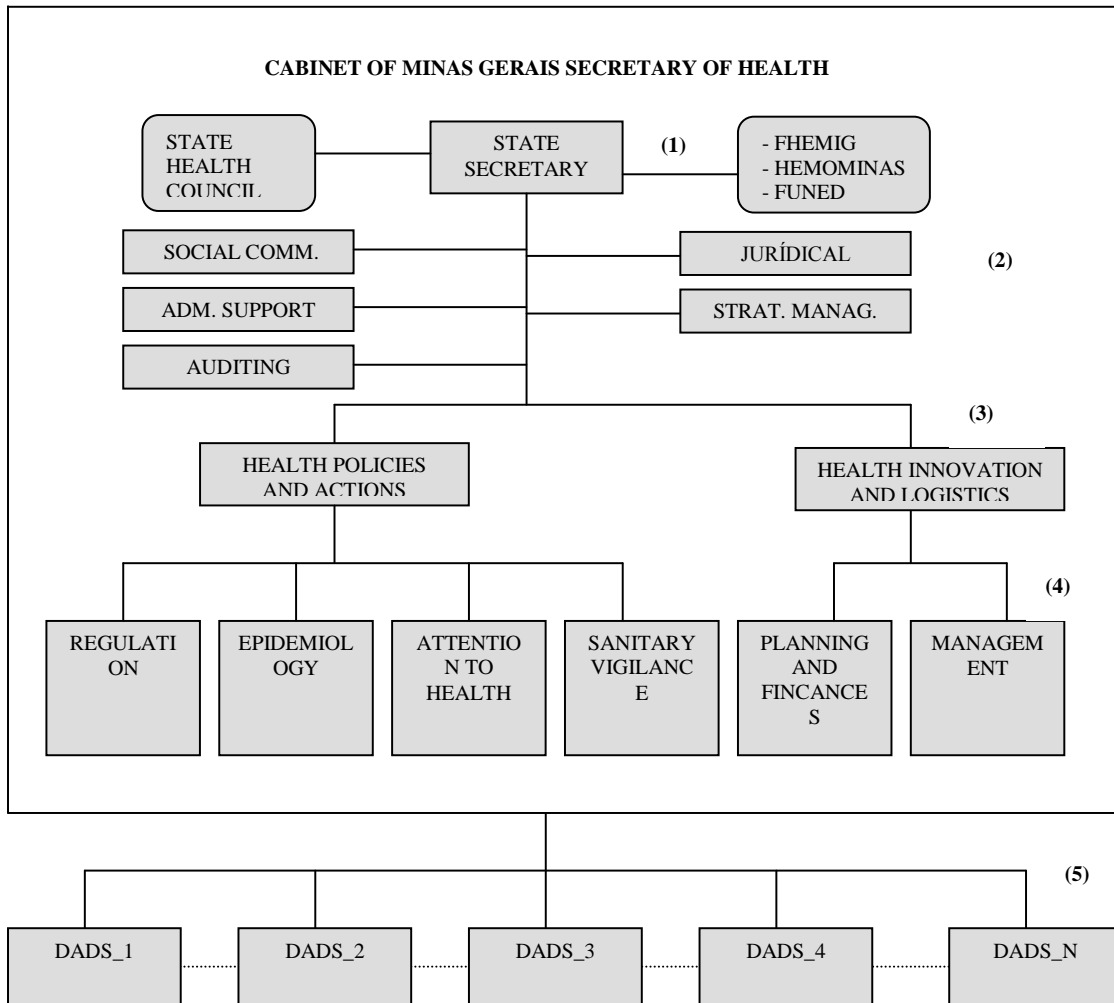
**Figure 7.1.** Organizational Structure of the Health Ministry (BRASIL, Ministério da Saúde, 2005).

On the state sphere, structurally shown in figure 7.2, we may also find a relatively numerous corporate staff, composed by advisory bodies, State Health Councils, sub-secretaries and superintendence, also observing the link with public foundations. The structure also counts with Directories of Decentralized Health Actions (DADS), which function as branches of the Secretaries. Though they remind a structure of business units, the DADS role is essentially bureaucratic, with no focus on results. The highest position on this structure is the State Secretary of Health, whose attribution is to exercise SUS management on state depth, incentive the cities to assume the health management, integrate and

modernize the municipal systems and participate on the financing of SUS.

On the municipal depth, as in the figure 7.3, we may observe a large corporate staff, composed of advisory bodies and administrative superintendence, technical coordination and the City Health Council. It may be noted an emphasis on the administration, auditing, management and strategic planning and health vigilance functions. The highest position on this structure is of City Secretary of Health, whose attribution is exercising SUS management on the municipal depth, with focus on basic health attention, planning and control, health vigilance and financing on local depth.



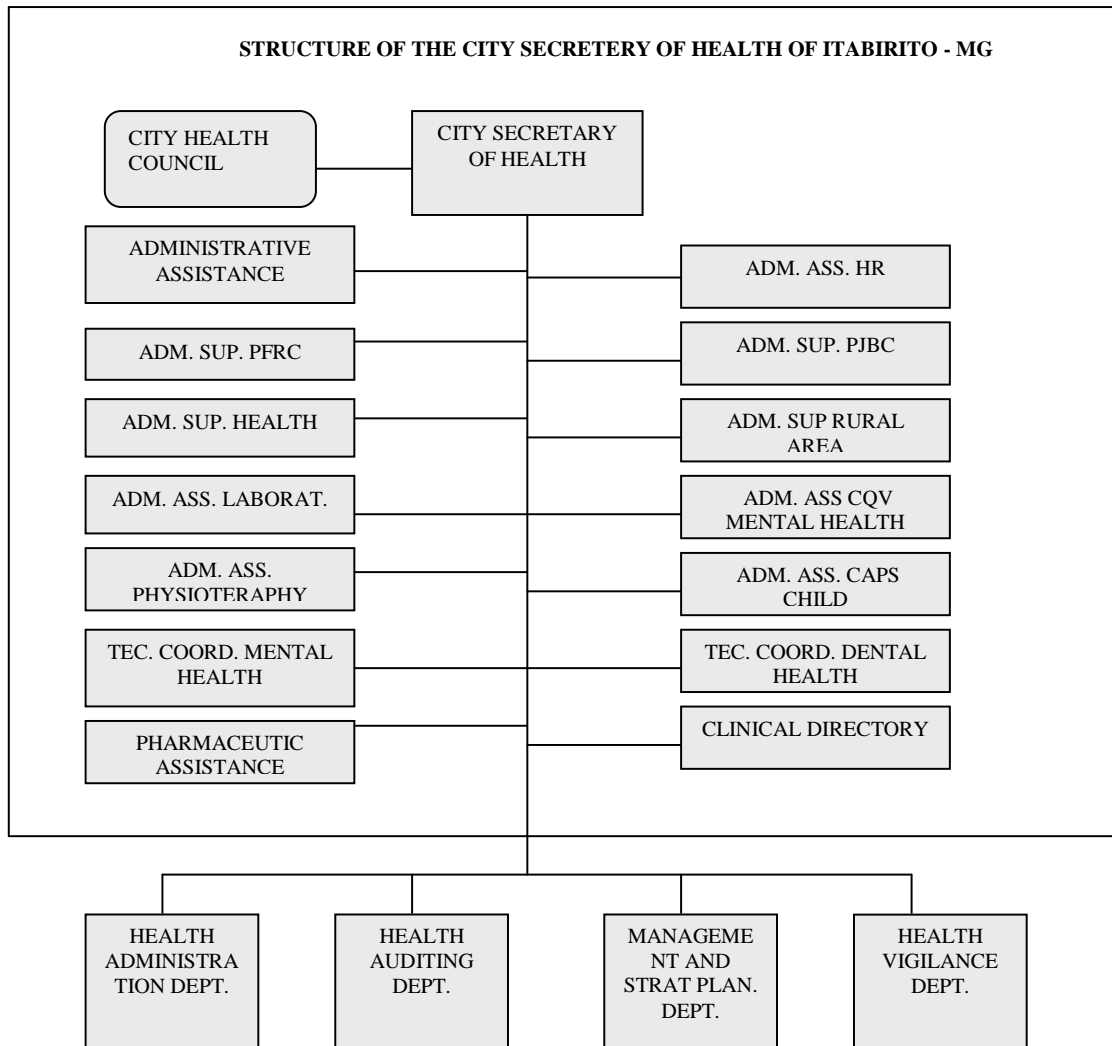


CAPTION:  
 STATE SECRETARY OF HEALTH  
 ADVISORY BODY  
 SUB-SECRETARIES  
 SUPERINTENDENCE  
 DIRETORIES OF DECENTRALIZED HEALTH ACTIONS

**Figure 7.2.** Organizational structure of the Minas Gerais Secretary of Health (MINAS GERAIS. Secretaria de Estado da Saúde).

One part of the city structure which is not on the organizational chart, perhaps for being still incipient, but that deserve special attention, are the Family Health Basic Units (UBASF). The PSF (Family Health Program) is considered the main mechanism of action for improvement of the primary health attention and consists in the forming of multi-professional family care teams, acting on the

promotion of change of habits on community locations. By determination of the World Health Organization each team must act on one UBASF and must be responsible for, minimum, 2,400 people. The structure formed by the UBASF also remind the formation of business units that, at principle, could be individually evaluated.



**Figure 7.3.** Structure of the City Secretary of Health of Itabirito/MG (BARBOSA e VALERIA, 2005)

## 8. Discussions and conclusions

As described on the introduction, the SUS organization has one great challenge, for it intends on attending, fully, the health needs of around 120 million people. Thus, it is hoped for SUS an advanced and daring project, on par with the importance of the theme. By confronting the governance model of SUS – inside the defined analysis scope – with the traditional models used on marked companies, it is observed the presence of almost all modern management mechanisms. The chart 8.1 presents, in a concise manner, the analyzed themes and its focuses on the market and Unified Health System contexts.

According to the investigated documentation, we may perceive that, in terms of governance structure, the control system of SUS could be considered comparable to those systems used by market companies, except for not allowing propriety concentration, which is justified by the concept of diffuse propriety associated to the ideological dimension of resource distribution to the collective. In other words, propriety of SUS is public and does not

allow share negotiation. Nevertheless, it prescribes mechanisms for control of the organization performance, on an attempt to anticipate conflicts of interest among the *stakeholders* and assure the alignment of strategic decisions with the corporation objectives. The conception of the governance model of SUS is, thus, adequate, advanced and deserving of compliment, not leaving anything to desire from a project point of view.

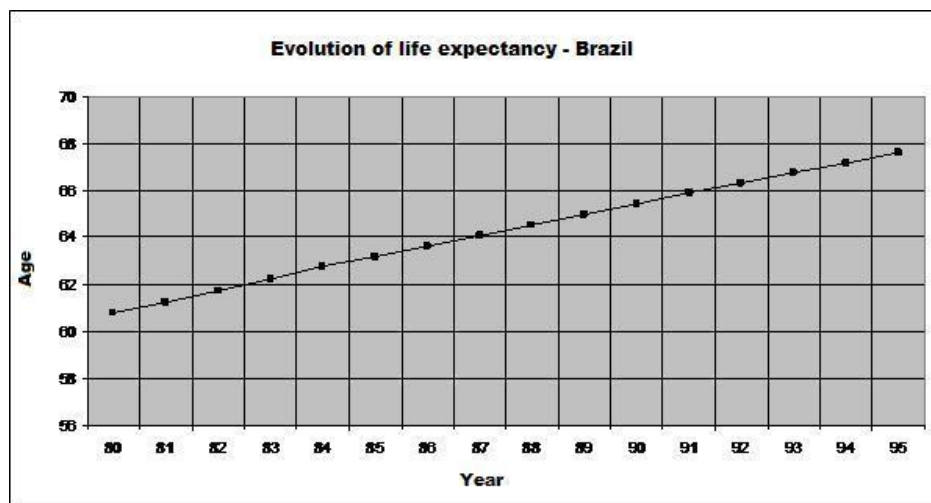
In evaluating efficiency, the most direct and transparent form would be through performance measures. According to Campos (2001), *control items (performance indicators) are numerical characteristics over which it is necessary to exercise control or management ... only what is measured is managed. What is not measured is adrift.* Going from this principle, which is widely spread on companies that seek quality management, it is fit to try to identify indicators that reflect performance on its essence, in other words, that measure the real effects of the strategically planned actions.

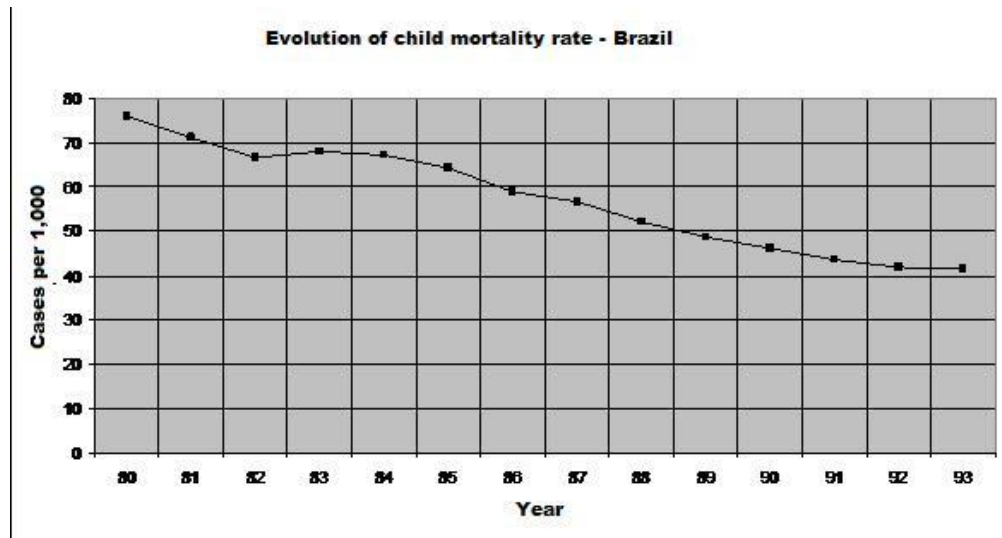
**Chart 8.1.** Focus differences of governance mechanisms on market companies and on the Unified Health System

Governance Mechanism	Market Company	SUS
Propriety concentration	Share accumulation to influence resource allocation and obtain greater feedbacks.	Non-existent resource. Diffuse propriety (corporation) with no possibility of share negotiation.
Administration council	Hiring of people to control the high level executives, protecting the shareholders from possible opportunisms. Autonomy to substitute executives according to their performance.	Permanent and deliberative health councils on the city, state and federal spheres. They act on the control of the execution of health policy. Do not possess autonomy to substitute executives.
Executive payment	Concession of salaries, bonuses and rewards for the executives, aiming to align their interests with those of the proprietors.	Application of the IVR (result appreciation index) as incentive by means of additional budgets to states and cities which implement health programs, ex. Family Health, School Health, etc. Openness for special payment to members of the family health teams.
Organizational structure	Adequacy of the structure for attainment of the established strategy of always that there are control problems due to increase in the demands. Multi-divisional structure (M form) used as means to monitor manager performance.	Application of the multi-divisional structure on the state sphere, but with bureaucratic character and not of business units. Possibility of application on municipal depth with the PSF (Family Health Program).
Alliances and corporate networks	Contracts among comparable firms to share resources, competences, risks and expenses. Utilization of a central firm for network control.	Inter-municipal consortiums constituted and financed by city managers to rationalize the use of equipments, human resources and hospital installations, inside micro-regions and macro-regions. Existence of pole cities.

One would think, then, that SUS managers have indicators which reflect the *strategic intention* of the organization and that they use them to exercise the management by objectives, referenced by Campos (2001). Through internet searches various indicators in the health area were found, available for the public. Among them the SUS database ([www.datasus.gov.br](http://www.datasus.gov.br): access at 09/09/2006) and the Ministry of Health portal ([www.saude.gov.br](http://www.saude.gov.br): access at 09/09/2005), on which the citizen has access to numbers relative to health care, care network, morbidity, vital statistic epidemiologic information, financial resources and demographic and social-economical information, allowing researches of various forms and periods. Though the system has already organized itself in order to maintain this wide database (the budget passes are done only after the data for that month is

sent by the cities), there were not observed specific indicators on the alignment of the governance model on its doctrinarian principles of *universality, equity and integrality*. We do not know, for instance, how far we are from the announced integrality. Only from measuring these principles, on the different government spheres, that the manager may truly manage the system, allowing the population to infer on the efficacy of the model. Any attempt to perform this evaluation through traditional demographic indicators such as *mortality rate and life expectancy* becomes innocuous (graphs 8.1 and 8.2) once these had already been presenting improvements along time, long before implementation of SUS, dated 1990. Therefore, there cannot be established cause and effect associations between the system reforms and the results obtained on these two indicators.

**Graph 8.1.** Evolution of life expectancy in Brazil (IBGE *apud* BARROS, w/o date.)



**Graph 8.2.** Evolution of child mortality rate (IBGE *apud* BARROS, w/o date.)

Due to the absence of these performance indicators, efficacy analysis should be restricted, at least until now, to qualitative evaluations obtained from the opinions of people involved on the day-to-day of health management. The interviewed managers revealed vulnerable points which it is worthwhile to state:

- Low capability of the population representatives on the city health councils, jeopardizing the action control and the elaboration of the city health plan;
- Deficiencies on the articulations of inter-sector policies on the collegiate instances CIB (Bipartite Inter-manager Commission), CIT (Tripartite Inter-manager Commission), Conass and Conasems, making difficult the implementation of PSF (Family Health Program);
- Low capability of health secretaries from small cities, causing a bad application of the resources passed through by the Union and the states, apart from the risk of opportunisms;
- Incipency of the Family Health Program due to various restrictive factors, such as high turnover rate of professionals; lack of knowledge by the population of the model conception; difficulties on inter-sector decision taking and lack of a special payment plan for the PSF teams;
- System fragmentation by the autarchic citywide application of SUS, in other words, the city sees only inside itself, generating hospital operations on a scaled "miseconomy".

Though we do not know of its intensity, for the lack of numbers, we may conclude that there are deficiencies on the management model of SUS, as to its alignment with the conceived doctrinarian principles. It is such true that there are various health community movements on the direction of approving reforms to the model, which among them the main ones are:

- Sanitary Responsibility Law, which establishes obligations and penalties for federal, state and city managers which do not comply to goals and commitments to the health area, like the example of the fiscal responsibility Law. ([www.saude.gov.br](http://www.saude.gov.br) date 08/09/2006);
- Management Pact, which aims to remodel the decentralization of the actions of attention to population, from the current autarchic citywide application to a cooperative regionalization (MINAS GERAIS, State Secretary of Health, 2004).

## 9. Suggestions and recommendations

A concept which is very important on the management by objectives is that of *goal*. Still according to Campos (2001), a goal is composed of three components: objective, value and deadline, for instance, *increasing the availability of medical-dental equipment from 75% to 90%, until December 2005*. In this case the objective is increasing the equipment availability; the value is 90% and the deadline December 2005. Establishing goals in this format means starting from the ends, from the desired results, and then identifying which are the better actions in order to achieve them. On some analyzed documents, differently, references to goals were found without the necessary components and, also, expressing actions as if they were goals. Now, *creating a system of preventive maintenance for the medical-dental equipment* is a possible action that aims to achieve the goal in our example, and not the goal itself.

All documents researched presented essentially qualitative analysis, including the announced improvement goals. In all improvement efforts the qualitative analysis is very important, for it is the first step on the search for the problem causes. But it should not stop there; it is necessary to always develop methods of quantification of the presented

causes, proving its effect on the results which we seek to achieve.

These observations indicate that the health managers are still lacking basic management principles, like those stated above, fundamental for a management by objectives. Increasing their knowledge on these issues is certainly a good start for the improvement of the system efficacy.

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