

Single waiting list for hospital beds during the COVID-19 pandemic: performance of the Federal Legislative Branch in 2020

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Abstract *This study investigated legislative proposals on the single waiting list for hospitalizations and ICU beds within the scope of the Federal Legislative Branch in the first year of the pandemic (2020). This was an exploratory, qualitative, and document-based study, which analyzed bills analyzed in the Brazilian National Congress on the subject. The results were organized according to the authors' profile and qualitative content of the bills. There was a predominance of male parliamentarians, affiliated with left-wing parties and professional training in areas other than health. Most bills dealt with a general single waiting list, specifying hospital beds, the mixed management of hospital beds, and indemnity through the Brazilian Unified Health System's (SUS, in Portuguese) price table. The House of Representatives presented more bills, but no progress was made in their processing. Among the analyzed bills, only one was prioritized in the External Commission to Combat COVID-19. It was concluded that the Federal Legislative Branch once again missed the chance to legislate for the future and prepare the country with a normative framework capable of confronting health emergencies, which will demand much from health managers and SUS itself.*

Key words *Legislative Branch, Hospital bed capacity, Health law, COVID-19 pandemic*

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Introduction

In Brazil, the COVID-19 pandemic brought back the discussion on a chronic problem in public health: the scarcity of hospital beds, especially in intensive care units (ICUs). With the increased number of infected people, the violation of sanitary measures for virus containment and insufficient vaccine coverage, the country faced an unprecedented overcrowding of ICUs, be they in private or public hospitals during the three epidemic phases of COVID-19¹.

Surveys indicated that the Brazilian Unified Health System (SUS, in Portuguese) would face a challenge in terms of access to hospital beds during the pandemic^{2,3}, since even before the pandemic, Brazil had already been showing a reduction in numbers of places for hospitalization, in addition to the lack and the poor distribution of ICU beds.

In terms of available hospital beds (including available beds for surgery, clinical treatment, obstetric, pediatric, day care and other specialties)⁴, there was a reduction of more than 23,000 beds (SUS and others) between 2008 and 2018⁵. At a time when the World Health Organization (WHO) established the need for 30 to 50 hospital beds for each 10,000 inhabitants, in 2008, Brazil only had the equivalent of 24 beds/10,000 inhabitants, which had been reduced to 21 by 2018⁵.

Meanwhile, in terms of ICU beds, the WHO proposes a proportion of 1 to 3 beds/10,000 inhabitants, and Brazil had, by 2019, 2.2 ICU beds/10,000 inhabitants⁶, meeting the proportion defined by the WHO. However, the inequality in the distribution of these ICU beds resulted in a deficit in the North, Northeast, and Midwest regions of the country³⁻⁷. Another inequality to be considered is the availability of places provided by SUS when compared to the other hospitals, which, though with a higher supply, provide care for only 25% of the population⁷.

The COVID-19 pandemic worsened that chronic situation even further. Noronha *et al.*³ warned of the risk of a collapse in the health system in all the macro-regions of the country if the rate of transmissibility SARS-CoV-2 reached 1% per month.

Such an expectation became a reality as the ratio was overcome still in the early months of the pandemic⁸. Moreover, regardless of the creation of new ICU beds aimed at keeping up with the sanitary emergency, they were not sufficient to meet the demands of the population⁹. Moreover, the increase in the number of hospital beds

between December 2019 and April 2020 (14,220) benefited mostly the users of the supplementary health network, since the private sector was responsible for the creation of 11,115 beds¹⁰, thus increasing the iniquity among the users of the health system. According to the Committee on Economic, Social and Cultural Rights (CESCR) from the United Nations (UN)¹¹, availability and accessibility are some of the essential elements that should be observed by countries as far as health rights are concerned. A sufficient number of beds available to all, the equality of distribution, and access determined by a regulated order that reduces possible inequalities, are all criteria that must be considered, especially in a pandemic scenario. The waiting lists, therefore, should be considered as important indicators of the conditions of access to the health system and as indicators of the system's equity¹²⁻¹⁴.

During the pandemic, discussions arose in academia¹³ and social movements¹⁴ concerning the idea of a single waiting list for hospital beds, in face of the binomial scarcity-necessity of the resource.

However, the creation of a single waiting list for hospital beds is a competence of the National Congress, since it is a governmental action that creates expenses and changes the current legislation, thus demanding federal legislation to render it effective.

Considering the theme and its temporality, the current study is unprecedented in investigating the legislative proposals concerning the single waiting list for hospitalization and/or hospital beds, in the Federal Legislative sphere.

Methodology

This is an exploratory, qualitative, document-based study, using a secondary databank obtained from a research project on Congressional Bills at a time of sanitary crisis.

The original study obtained a total number of 2,835 bills classified as part of the public health-care sphere, from February 3rd to December 31st, 2020. The initial landmark of the database was the declaration of a Public Health Emergency of National Importance (ESPIN, in Portuguese) by the Brazilian Ministry of Health, and the end of the database corresponded to the end of the first year of the pandemic.

From the original survey, 27 documents were categorized as being about "hospital beds". After reading the entire content, 16 bills were excluded

for not dealing with the theme of a “single waiting list for hospital beds”, and some of the bills were withdrawn by the Congressional member/author.

The results were systematized in two groups: The first included information about the profile of the authors of the bills, including political party and ideology, gender and profession. We adopted, for the definition of ideological spectrum, the adaptation of the classifications done by Tarouco and Madeira¹⁵. To define the profession of the legislators, we looked up their biographies on the internet.

The second group covered the qualitative content of the bills, considering five variables: (i) kind of waiting list, considering as “general single waiting list” (GWL) the total of beds available in the realm of the public and private health systems, and considering as “partial waiting list” (PWL) the total number of beds in the public system plus a portion of beds provided by the private sector. In terms of “kind of bed”; (ii) we considered ICU and general hospitalization beds in terms of the criteria for prioritizing access; (iii) we considered “single criteria” or a combination of several kinds of criteria, such as order of request, clinical and/or epidemiological criteria (seriousness), and waiting list management; (iv) considering each member of the federation, individually or in association; and (v) financing, considering whether funding comes from the National Budget or not.

The study conforms to Resolution 510/2016 from the National Health Council (CNS, in Portuguese), which was therefore exempt from submission to the Research Ethics Committee.

Results and discussion

After applying the criteria of inclusion and exclusion, the final sample had 11 documents, 10 of which from the House of Representatives and one from the Senate. There were no bills from the Executive branch.

Among the authors, there were 88 Congress members, 82 of whom were State representatives and six senators. The high number of State representatives was due to many bills having a high number of signing legislators.

Concerning the modality of the bills, only legislative proposals were found.

We must mention that most of the bills were under analysis simultaneously, since article 142 from the Internal Regiment of the House of Rep-

resentatives defines that: “when having two or more bills of the same nature, regulating issues which are identical or correlated, it is legal to analyze them together”¹⁶.

Chart 1 shows that the first trimester of the pandemic was the initial point for presenting bills concerning hospital beds and a waiting list for them. Other studies proved that the beginning of each legislative session is the period when a higher number of bills of a social nature is introduced by legislators¹⁷, possibly in response to the voters’ demands.

Until the end of the legislative session, no information was obtained regarding the bills being ratified into laws.

Authors’ profile

The bills created by female legislators were clearly present, with 31 female legislators and 57 males, showing expressive female representation (35%), especially considering the overall proportion of women in Congress (15%)^{18,19}.

Bill 2,548/2020 was signed by 18 female legislators from left-wing and right-wing parties, all members of the House of Representatives Women’s Secretariat. Joint bills from legislators from opposing parties are common and even desirable, since heterogeneity strengthens the Legislative branch, enabling the habit of considering the legislators as being exclusively focused on their own class interests²⁰. Elias²¹ stated that an individual focused only on him/herself ends up denying belonging to a group and the interdependence between individuals and social groups, between foes and allies who define and face each other in the relationship which denies them, which has been denominated as *homo clausus*²¹.

This is common in parliamentary fronts, groups which unite position and incumbent representatives, in order to gain more weight in congressional voting, even more than the parties’ representation in Congress²⁰.

However, even though women are the majority of the Brazilian population (51.8%)²², they are still underrepresented in political life. This can be verified in the “ranking of female representativeness in Congress”, which ranks Brazil in 134th place among 193 countries, even behind countries such as Afghanistan (57th) and Saudi Arabia (109th)²³. The mismatch in representation may be attributed to factors such as the belief, still strongly present in the Brazilian culture, that women are not supposed to become involved in political and partisan activities, as well as the in-

Chart 1. Bills dealing with hospital beds and a single waiting list for hospitalization and ICU beds, in the Federal House of Representatives and the Senate, from February 3rd to December 31st, 2020.

Number of bills	Status	Date of presentation	Subject	Author
HB* 892/20	In process - CSSF (1)	March 24	Alters Law 8080, from September 19, 1990, to deal with the integration and unification of information regarding the quantity and availability of hospital beds and intensive care beds in the health system and authorizes the requisition of up to 20% of the beds in private facilities, by the managers of SUS, in cases of emergency.	José Guimaraes PT-CE
HB 1110/20	Added to Bill 753 (2)	March 26	Adds art. 4-J to Law 13,979, from February 6, 2020.	Marcelo Freixo PSOL-RJ e Túlio Gadêlha PDT/PE
HB 1254/20	In process - CSSF (1)	March 30	About the unification, in a single waiting list by the Federative State, so that all patients cared for by health services who have an indication for hospitalization may occupy the vacant hospital beds in strict observation of the order of arrival.	Arlindo Chinaglia - PT/SP, Enio Verri - PT/PR, Rubens Otoni - PT/GO, José Guimarães - PT/CE, Célio Moura - PT/TO, Pedro Uczai - PT/SC, José Ricardo - PT/AM, Rogério Correia - PT/MG, Nilto Tatto - PT/SP, Erika Kokay - PT/DF, Patrus Ananias - PT/MG, Airton Faleiro - PT/PA, Paulão - PT/AL, Maria do Rosário - PT/RS, Waldenor Pereira - PT/BA, Vicentinho - PT/SP, Marcon - PT/RS, Zé Carlos - PT/MA, Padre João - PT/MG, Professora Rosa Neide - PT/MT, Natália Bonavides - PT/RN, Frei Anastacio Ribeiro - PT/PB, Leonardo Monteiro - PT/MG, Margarida Salomão - PT/MG, Afonso Florence - PT/BA, Alexandre Padilha - PT/SP, Valmir Assunção - PT/BA, Carlos Veras - PT/PE, Alencar Santana Braga - PT/SP, Rui Falcão - PT/SP, Paulo Pimenta - PT/RS, Beto Faro - PT/PA, Benedita da Silva - PT/RJ, Vander Loubet - PT/MS, José Airton Félix Cirilo - PT/CE, Rejane Dias - PT/PI, Bohn Gass - PT/RS, Odair Cunha - PT/MG, Henrique Fontana - PT/RS, Helder Salomão - PT/ES, Paulo Teixeira - PT/SP, Luizianne Lins - PT/CE, Gleisi Hoffmann - PT/PR, Reginaldo Lopes - PT/MG, Jorge Solla - PT/BA, João Daniel - PT/SE, Assis Carvalho - PT/PI, Zé Neto - PT/BA, Zeca Dirceu - PT/PR, Carlos Zarattini - PT/SP, Joseildo Ramos - PT/BA, Paulo Guedes - PT/MG

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sufficient incentive from parties to have female candidates. Moreover, praxis demonstrates that at the level of the political parties, there is a higher chance of success for veteran candidates²⁴.

Concerning the legislators' profession, 15 of the 88 Congressional members were health pro-

fessionals, while the other 73 were from other areas, especially lawyers (Graph 1). This does not mean that legal professionals are interested in approaches of a medical and public health nature, but rather that most legislators - be they from the House of Representatives or from the Sen-

Chart 1. Bills dealing with hospital beds and a single waiting list for hospitalization and ICU beds, in the Federal House of Representatives and the Senate, from February 3rd to December 31st, 2020.

Number of bills	Status	Date of presentation	Subject	Author
HB 1316/20	Added to Bill 892/2020 (2)	March 31	Changes Law 8,080, from September 19, 1990, which defines the conditions for the promotion, protection, and recovery of health, the organization and performance of the corresponding services, among other provisions, to include the Sole Paragraph and items from Article 15 regulating the requisitions defined in Item XIII of the aforementioned provision.	Alexandre Padilha – PT/SP, Jorge Solla – PT/BA, Alencar Santana Braga – PT/SP, Nilto Tatto – PT/SP, Carmen Zanotto – CIDADANIA/SC, Pedro Uczai – PT/SC, Rubens Otoni – PT/GO, Rogério Correia – PT/MG, Margarida Salomão – PT/MG, José Guimarães – PT/CE, Helder Salomão – PT/ES, Carlos Veras – PT/PE, João Daniel – PT/SE, Patrus Ananias – PT/MG, Professora Rosa Neide – PT/MT, Paulo Pimenta – PT/RS, Patricia Ferraz – PODE/AP, José Airton Félix Cirilo – PT/CE, Marília Arraes – PT/PE, Perpétua Almeida – PCdoB/AC, Célio Moura – PT/TO, Frei Anastacio Ribeiro – PT/PB, José Ricardo – PT/AM
HB 2161/20	Added to Bill 1254/2020 (2)	April 24	Includes provisions in Law 13,979 from February 6, 2020, in order to guarantee access by SUS to ICU beds from the private health network.	Rubens Otoni PT-GO
HB 2176/20	Added to Bill 1254/2020 (2)	April 27	Creates a single waiting list for hospital beds in ICUs, unifying the regulation of access to ICU beds in private and public hospitals under the management of the SUS for as long as the effects of the pandemic last, among other provisions.	Orlando Silva PCdoB-SP
HB 2301/20	Added to Bill 1254/2020 (2)	April 29	Ensures to all patients severely affected by COVID-19, access to all ICU hospital beds, both public and private; establishes that the State and Municipal governments, together with that of the Federal District, will assume the regulation of ICU beds from the private hospitals under their jurisdiction for the duration of the State of Nationwide Public Health Emergency, according to what is established in Law 13,979 from February 6, 2020, among other provisions.	Daniel Almeida PCdoB-BA

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ate – are lawyers by profession. Moreover, bills in the health area always make the legislator stand up for his/her electorate^{17,26}, attracting legislators from a variety of backgrounds.

However, the presence of legislators with a background in the area in discussion is an important element in the political debate, since those legislators may be perceived as a source of

information by their peers, besides being able to act in the coordination of negotiations and/or being authors of the bills²⁶.

Regarding the analysis of party ideology, Tarouco and Madeira¹⁵ defined that, regardless of the lack of ideological consistency of Brazilian political parties, the left-right classification is recognized by both the politicians themselves

Chart 1. Bills dealing with hospital beds and a single waiting list for hospitalization and ICU beds, in the Federal House of Representatives and the Senate, from February 3rd to December 31st, 2020.

Number of bills	Status	Date of presentation	Subject	Author
HB 2333/20	Added to Bill 1254/2020 (2)	April 30	Deals with the creation of the Emergency Single Waiting List for the management of hospital beds, covering the private and public systems, in order to ensure that SUS is in charge of the use, control, and management of the entire hospital capacity available in the country, aimed at guaranteeing universal and egalitarian access to the hospital network in the scenario of the New Coronavirus pandemic.	Fernanda Melchionna – PSOL/RS, Sâmia Bomfim – PSOL/SP, Talíria Petrone – PSOL/RJ, Luiza Erundina – PSOL/SP, David Miranda – PSOL/RJ, Edmilson Rodrigues – PSOL/PA, Marcelo Freixo – PSOL/RJ, Ivan Valente – PSOL/SP, Glauber Braga – PSOL/RJ, Áurea Carolina – PSOL/MG
SB** 2324/20	In process – CSSF (1)	April 30	Changes Law 13,979, from February 6, 2020, to deal with the compulsory use of available private hospital beds, of any kind, by government institutions for the hospitalization of patients suffering from Severe Acute Respiratory Syndrome or those suspected of having COVID-19.	Senador Rogério Carvalho (PT/SE), Senador Paulo Rocha (PT/PA), Senadora Zenaide Maia (PROS/RN), Senador Jean Paul Prates (PT/RN), Senador Jaques Wagner (PT/BA), Senador Paulo Paim (PT/RS)
HB 2548/20	Added to Bill 1254/2020 (2)	May 11	Deal with the creation of a single waiting list for the occupation of ICU hospital beds from the public and private networks due to COVID-19.	Tereza Nelma – PSDB/AL, Professora Dorinha Seabra Rezende – DEM/TO, Dra. Soraya Marnato – PSL/ES, Rosana Valle – PSB/SP, Erika Kokay – PT/DF, Norma Ayub – DEM/ES, Rejane Dias – PT/PI, Talíria Petrone – PSOL/RJ, Dulce Miranda – MDB/TO, Leandre – PV/PR, Soraya Santos – PL/RJ, Patricia Ferraz – PODE/AP, Jéssica Sales – MDB/AC, Daniela do Waguinho – MDB/RJ, Carmen Zanotto – CIDADANIA/SC, Mariana Carvalho – PSDB/RO, Leda Sadala – AVANTE/AP, Maria do Rosário – PT/RS
HB 2674/20	Added to Bill 1254/2020 (2)	14/maio	Creation of a single waiting list of access to hospital beds from the public and private systems and its use and management by SUS.	Wilson Santiago PTB-PB

* HB – Bill from the House of Representatives. ** SB – Bill from the Federal Senate (1). Permanent Commission for Social Security and Family. (2). The bills which were added to another are processed as accessories of the main bill.

Source: Authors.

and by the analysts, and it is a valid instrument for studies on the effects of party ideology on different variables.

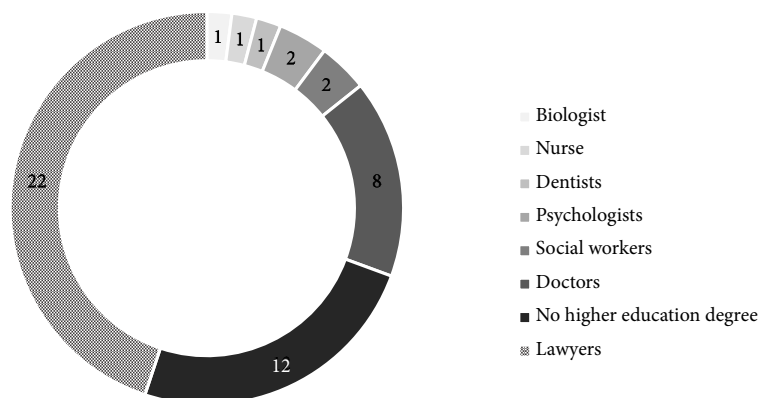
In this context, the results indicate a higher participation of legislators from parties within the left-wing ideological spectrum (Graph 2).

Other studies have already demonstrated that political parties with a progressive orientation have a major participation in proposing bills of a social nature¹⁵.

Content of the bills regarding a single waiting list for hospital beds

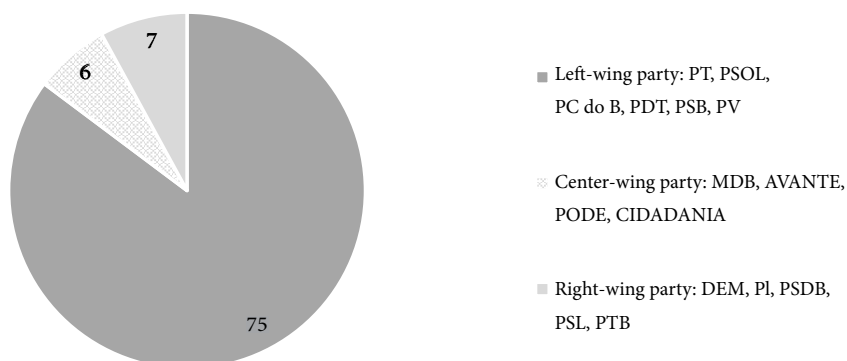
Most of the bills propose, explicitly, the compulsory requisition of hospital beds and facilities from the private sector by the public sector, during pandemic events (Chart 2).

Although based on social equality and on the governmental intervention, which is more evident during pandemics, requisition is something that should and ought to be used by the



Graph 1. Professional profile of the legislators who proposed bills about the waiting list for hospital beds, 2020.

Source: Authors.



Graph 2. Profile of legislators who made bills about a waiting list for hospital beds, organized by party ideology, 2020.

Source: Authors.

government in the case of emergencies or calamity; however, there is an administrative process, which should precede any form of intervention by SUS in private health facilities.

It is important to make it clear that requisition falls upon vacant hospital beds, and that the government is responsible for compensating the hospital for any damages to the requested resources. For cases of using private hospital services when there is no vacancy in the public hospitals, there must be remuneration, which the

bills define according to SUS cost table, always preceded by the administrative process.

Bill 1,254/2020 proposes one single waiting list for hospitalization in the private and public health systems, stratified by the states of the federation (SF), including all of the patients with a medical recommendation, exclusively for the duration of the COVID-19 pandemic.

The criterion of the waiting list is strictly chronological, according to the entry of the patient's name on the waiting list of the respec-

Chart 2. Variables which characterize the single waiting list bills.

Number of the bill	Kind of waiting list	Kind of beds	Prioritizing criteria	Management of waiting list	Financing
892/20	PSWL	Hospitalization	-	-	-
1110/20	GSWL	Hospitalization	-	Municipal	-
1254/20	GSWL	Hospitalization	-	State	Compensation by SUS cost table
1316/20	-	Hospitalization	-	-	Compensation by SUS cost table
2161/20	GSWL	Hospitalization	-	-	Compensation by SUS cost table
2176/20	GSWL	ICU	Combined	Mixed	Compensation by SUS cost table
2301/20	GSWL	ICU	Combined	Mixed	-
2333/20	GSWL	Hospitalization	Combined	Mixed	Compensation by SUS cost table
2324/20	PSWL	ICU	-	State	Compensation by SUS cost table
2548/20	GSWL	ICU	-	Mixed	Compensation by SUS cost table
2674/20	GSWL	Hospitalizations	-	State	Compensation by SUS cost table

GSWL – Considers the total number of available hospital beds in the realm of the public and supplementary/private healthcare system. PSWL - Considers the public hospital beds plus a portion of the hospital beds from the supplementary/private system.

Source: Authors.

tive State of the Federation (SF), after medical recommendation for hospitalization. However, the medical criteria are not considered for a later change of place in the waiting list, and the chronological criterion prevails as the only one.

The waiting list is managed at a state level, and the health managers of each SF are responsible for producing a list with all the patients who have a medical recommendation for hospitalization. The state lists should be constantly updated and published in official media so that they can be checked by anyone who is waiting to be hospitalized. The federal management is in charge of gathering the information from around the country and publishing it in the official media so as to ensure transparency and access to the entire population.

The costs of the occupation of private hospital beds by patients from the public health system will be refunded according to the table of cost procedures defined by SUS (no specification of which federal department will be responsible for the refund).

Bill 2,176/20, differs from the previous bill by dealing exclusively with the creation of a single waiting list for ICU beds in the private and public systems for the duration of the pandemic, with no provision regarding regular hospital beds.

That bill differs from the previous one as it bases the waiting list not solely on the order of arrival, but also on the seriousness of each patient's case, combining criteria for the organization of the list and for access to resources. It also propos-

es that the list should be managed by the SUS at the municipal and state levels, coordinating access to those beds.

The necessary resources to pay for the use of private hospital beds should come from the federal budget as compensation expenses after proof of use. However, Bill ,2176/20 does not refer to using the SUS cost table as a parameter for the payments.

Bill 2333/20 has a broader reach, it proposes a single waiting list to manage all of the hospital beds, from the private and public systems, at both the civilian and military spheres, for the duration of the emergency and calamity state, supported by Law 13,979/20 and by Legislative Decree 6/20.

In terms of access to hospital beds, the bill proposes that the criterion is combined and based on an evaluation of the individual and collective seriousness, as well as on the chronological criterion as well.

The management of the waiting list is of a mixed nature, the responsibility being of the State, the Federal District, and the municipalities to regulate access through an Emergency Single Waiting List for all serious cases of COVID-19.

As regards financing, the bill establishes that payment for the use of services, and resources should come from the Federal Budget, based on the reference values from the SUS cost table.

Data shows that nearly 72% of the bills propose a single waiting list (SWL) encompassing all the hospital beds, public and private. For Maranhão⁷, the adoption of a single waiting list address-

es the dimension of equity and the reduction of inequalities in access to hospital beds, and also brings positive results to the management process, such as centralizing the information and decisions, optimizing the resources, and facilitating the reallocation of patients between health units.

Adopting the SWL would create more egalitarian parameters²⁷ for access to ICU beds, providing the possibility of access to hospital beds for SUS patients who otherwise would not have this possibility.

Among the bills that defend a general single waiting list (GSWL), we highlight Bill 2,333/20, which has more constitutional elements, such as the universality of access and sanitary equity, besides the transparency of the information for social control, thereby reinforcing the importance of the issue, especially in situations of sanitary crisis.

On the other hand, bills which define only a partial single waiting list (PSWL) were few (Bill 892/20 and Bill 2,324/20). The first suggests the request of 20% of the beds from private hospitals in cases of sanitary emergencies, and the second proposes that requests of private ICU beds take place only when their rate of occupation is below 85%. The reference to a maximum occupation rate which allows for the request of private beds was not part of the initial text of PL 2,324/20. It originated in the Senate, but its final text had the addition of 20 amendments before being sent for approval by the House.

Marinho⁷ argues that in the case of the PSWL, the overcrowding that might eventually occur in the hospitals not run by SUS would exclude patients who are exclusively dependent on SUS, since private hospitals would primarily address the needs of their own patients.

The kinds of single waiting lists appear as alternatives to optimize access to healthcare services and to reduce the inequalities present in contexts of intense use of health services, as happens in the event of sanitary crises. However, the GSWL is more inclusive than the PSWL, and manages to achieve more social justice, since all the patients would have the same chances of access.

Considering that the bills were created in a context of sanitary crisis, guaranteeing access of the population to the scarce resource in an egalitarian manner is an important initiative that must be led by the Legislative branch²⁸, providing juridical safety for the managers of the health system to intervene in an efficient and responsible manner.

Most of the bills (63%), however, dealt with the theme of a single waiting list for hospital beds without specifying or prioritizing ICU beds. Those are actually the care resources, which is the most critical for the treatment of COVID-19 patients, and which were already scarce before the pandemic⁶. This indicates that the federal legislators missed an opportunity to advance in the discussion that could generate a better management of scarce resources, not only in the case of the COVID-19 pandemic, but also for future emergencies which can possibly happen²⁸.

It is important to note that nine bills (Bills 1,110/20, 1,254/20, 2,161/20, 2,176/20, 2,301/20, 2,333/20, 2,324/20, 2,548/20, and 2,674/20) reduced their reach to the context of the COVID-19 pandemic only, failing to considering future perspectives. Only PLs 892/20 and 1,316/20 proposed changes in Law 8,080/90, aimed at guaranteeing more efficiency for measures to be adopted in case of sanitary emergencies.

It is a well-known fact that the basic cycle of the legislative process requires considerable time for analyses and deliberations. Hence, actions to mobilize the Legislative structure in order to obtain temporary legislation, even though the legislators are aware of the gaps in the federal health legislation concerning epidemics and are also aware of the structural problems in the system, may be interpreted as inaction or a lack of commitment by the Brazilian Legislative Branch.

Some of the bills left important gaps regarding operationalizing the waiting lists and did not cover specific aspects, such as the prioritization criterion of access for a single waiting list, its management, and its financing.

The prioritization criterion is a fundamental variable to guarantee equalitarian access in the waiting list for hospital beds; however, that was the least discussed variable among the bills. Only four bills mentioned that variable, including Bill 1,254/20, which proposes an isolated criterion, considering only the chronological order of the patient in the waiting list.

To prioritize means to establish a hierarchy of the identified problems, ranking them according to relevance, efficiency and level of feasibility of the proposed interventions²⁹. Sousa et al.³⁰ considered that the process of selection of priorities is too subjective; hence, there is a need to clarify the adopted strategies in order to achieve a transparent process that is properly grounded and auditable.

Moreover, considering the imbalance between the health needs and the available resourc-

es, the use of prioritizing criteria for access to ICU beds may be an invaluable tool in the process of decision-making, based also on equity criteria.

The objective of the management of the waiting list is to make the healthcare resources available, based on scientific criteria to classify risks and prioritize the users, thus avoiding the worsening of the clinical situation. The delay in providing care significantly impacts the chances of cure and of incurring aftereffects on the patients, their families, and society¹².

Such criteria are somewhat similar to what is adopted for the management of the single waiting list for The National Transplant System. In this case, care is also provided by order of arrival, but criteria considering seriousness, urgency, and compatibility are also taken into account¹². It is important to remember that patients who are in the transplant waiting list, despite being serious medical cases, are usually chronic, which makes them differ from the demand for ICU beds caused by COVID-19, a case in which the patients need a quick response, since they have a serious and acute clinical situation⁷ that should demand more agility in revising the patients' health conditions and updating their place in the waiting list.

Combined criteria would enable a better evaluation of the patients, give priority to their hospitalization, and optimize the allocation of available resources.

Regarding the management of the waiting list, three bills suggested a state-run management, similarly to the model of the National Transplant System, with waiting lists managed by the states even though the patient list follows a national registry, and organs and patients may be transported from one state to another in order to reduce waiting time and optimize the allocation of the organs.

There is no bill suggesting federal management, which is consistent with the idea of decentralized and regionalized actions in such a way that the management of health services and public health actions are no longer concentrated on the hands of the Federal Government, as was the case before the 1988 Constitution³¹.

Concerning the financing criteria for the use of private ICU and regular hospital beds, 72% of the bills indicate financing from the Federal budget for the use of private beds of either kind, since it refers to a costly service, and its expansion and maintenance would be compromised if conducted only by state and municipal govern-

ments. Some of the bills (Bills 892/20, 1,110/20, and 2,301/20) did not mention this category.

Santos³², considers that many bills are not approved due to a lack of elements that would guarantee their implementation and execution, such as the scarcity of human and financial resources, and difficulties for social control and fiscalization. Reis (1999 apud SANTOS, 2011, p. 54)³² highlights that, in order for a bill to be commenced, it must undergo a prior evaluation of its viability and potential efficiency, considering coherence between the proposed solutions and the reality that it is supposed to change. Therefore, we can see that many of the bills take a long time for deliberation, as they lack elements that would guarantee viability and implementation, such as the indication of the source of financing.

Costa e Silva³³ pointed to the difficulties the legislators have in presenting bills which meet the criteria defined in the Constitution, Law of Fiscal Accountability, in the Budget Guidelines Law, and in the Internal Norms of the Commission for Financing and Taxation of the House of Representatives. In the study, 87% of the bills examined by the Commission were presented by legislators, but less than 12% were approved, since the rest did not meet the criteria required to make them compatible and adequate to planning and budgeting.

Taking into consideration the existence of a historical embarrassment regarding SUS financing, aggravated by the publication of EC/95³⁴, one can notice that the flaws in the processing of the bills occur by the lack of consideration to requirements established in the very legislative process, notably when analyzing bills regarding the increase in expenses with no indication of the source of financing. This shows the legislators' fragility and/or lack of knowledge about how to fulfill the prerogatives that the law requires.

Although there were several bills, with a greater or lesser degree of detail and coverage, the theme has had great progress in the Federal Legislature. Among the analyzed bills, only Bill 1,316/20 was prioritized in the External Committee Against COVID-19 (CEXCORVI in Portuguese) from the House of Representatives³⁵. That commission was created on February 11th, 2020 with the purpose of following up on the actions aimed at fighting the pandemic, and it became consolidated as a prime space for prioritizing and analyzing legislative proposals³⁶.

However, regardless of being prioritized, Bill 1,316/20 still awaits an opinion from the Commission on Social Security and Family from the House of Representatives.

A consultation conducted on 3/29/22 regarding the status of the 11 bills under analysis showed that all of them have been in the CSSF for more than 300 days awaiting a legislative opinion.

Bill 2,324/20, the only one that originated in the Senate, is the bill that is the farthest ahead, since it has already been sent to the House. But it has also been awaiting a legislative opinion since May 2021.

Gomes³¹, in a study which evaluated the processing of bills in the House from 1999 to 2006, noticed that the time for processing bills in the House, including those that were introduced and converted into laws, was 889 days. The author also highlighted that time for processing is a fundamental variable in the process of conversion, since bills from any of the merit commissions to which they were sent will be filed away at the end of the Legislative period, which does not happen to bills from the Senate and the Executive, for example³¹.

The delay in advancing this debate, especially during a pandemic, when the resource – hospital beds – is so important, is similar to what was found by Romero³⁷ when analyzing the way the Legislative Branch acted in another four epidemics, when the author observed that the National Congress had several bills introduced, but none ended up becoming a law.

Final considerations

Although this study has temporal limitations, since the data gathered refers only to the first year of the epidemic, we were able to examine Congress' actions in terms of legislative production in the healthcare area, capacitating the judicial system through the creation of legislation capable of providing more juridical security for interventions during episodes of sanitary crisis.

The federal legislature was responsible for presenting bills which proposed the regulation of the emergency single waiting list for hospital beds, or ICU beds, aiming at dealing with the scarcity of the resource, aggravated by the COVID-19 pandemic.

Although we found that the initiative of the bills came only from the legislators, with no participation of the Executive power (at least during the period studied), those bills were fragile and casuistic. They were also considered fragile, for not pushing forward the discussion concerning a general, single waiting list, integrating the resources from the private and public systems to deal with a sanitary crisis that spread throughout the country, perhaps ensuring more equity in access and a better use of the resources.

In the other aspects analyzed in this study, fragility is also expressed in the absence of the necessary clarity and required elements for the implementation of single waiting list bills – be they total or only partial lists – such as the management of the resources and the financing parameters for the use of hospital beds from the private sector.

Casuism is evident in the sense that the legislators were short sighted, creating laws exclusively for an episodic disease and not addressing the normative gaps concerning the customary lack of beds in SUS. It is also emphasize that the time for legislative production does not attend to the kind of disease, which demands urgent measures. The bills presented were not processed completely in the Legislative chambers where they originated, except for Senate Bill 2,324/2021, which is now in the House of Representatives, but still has no prospective of becoming a law. The bills should be filed away at the end of the legislative period in 2022, because the internal regulation of the House¹⁶ determines that, at the end of a legislative period, the bills which are not being processed regularly, should be filed away indefinitely. That, however, does not prevent them from being unfilled by the same legislator in case of re-election, or by anyone else who is interested in the matter, as long as the unfiling occurs within the first 180 days of the new legislature¹⁶.

It can thus be concluded that the federal legislative branch once again missed an invaluable opportunity to legislate for the future and to prepare the country with a normative substrate capable of dealing with sanitary emergencies that can possibly happen and that will certainly demand much from the managers of the healthcare system.

Collaborations

APN Rodrigues contributed to the writing, analysis and review of the data. SMC Alves contributed to the writing, analysis and review of the data. MC Delduque contributed to the analysis and final revision to the article.

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