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Social health organizations: an analysis of the specialties and exams contracted by the State of São Paulo, Brazil

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Abstract *Social Health Organizations (SHOs) are private entities that receive resources from governments for the management of public healthcare services. With the history of market interest in public health and the high volume of resources transferred to SHOs, one must question if the market logic continues to be inserted in this management model. The understanding of the dynamics of providing healthcare services to the population in the different contracts may help to understand how possible changes in the contracted services may have an influence. This is a descriptive-exploratory study using quantitative and qualitative approaches. Documental research was conducted through the collection of data from management contracts and amendments. The State of São Paulo was chosen because of its economic representativeness and for being the pioneer state in the implementation of SUS services managed by SHO. Medical specialties were included in 184 renegotiations (6.14%) and excluded in 187 (6.24%), whereas non-medical services were included in 26 renegotiations (2.97%) and excluded in 144 (16.44%). Regarding examinations, 101 renegotiations (18.07%) had their goals increased and 60 (10.73%) reduced, while 6 renegotiations (1.07%) included exams and 12 (2.14%) excluded them.*

Key words *Social organization, Unified Health System, Management of health services*

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Introduction

Social Organizations are non-profit private entities that receive public financial funding from governments for the management of activities which would otherwise be a direct responsibility of the State, given that those activities are related to individual rights set forth in the 1988 Federal Constitution, such as the right to Health[1]. However, private enterprises working in the area, which, until the creation of the Unified Health System (SUS), were accustomed to selling hospital beds, services, and inputs for the government – which at that time had no structured health network – guaranteed their participation in the system in the constitutional process in a complementary manner.

As soon as SUS was created, still in the 1990's, the Directive Plan for the Reform of the State Apparatus (*Plano Diretor da Reforma do Aparelho do Estado* – PDRAE) was instituted. That reform proposed the process of *publicization*, or the transfer to the Third Sector (non-profit private entities) of the execution of services which are not exclusive to the State, such as scientific research, education, culture and health, emphasizing the managerial administration models as a solution. The document refers to the alleged inability of bureaucratic, public administration in coping with the overload of demands, and criticizes this manner of administration as being too strict and inefficient[2].

Considering the history of market-oriented interests of private enterprises in public health and the transfer of considerable resources to Social Health Organizations (SHOs) over many years[3], we pondered if the market logic was still a part of the management model of those institutions. The increasing growth in participation of SHOs in managing SUS services has taken place with no clear in-depth studies, which could indicate effectiveness in results of this kind of management[4]. Therefore, there is a need for further studies that seek to reveal the effects of those partnerships upon the health services offered to the population.

The renegotiations between SHOs and governments are, or at least should be, clearly defined and accessible in contractual documents, known as management contracts (MC) and contract amendments (CA). Understanding the dynamics of providing services to the population throughout the negotiations between the SHOs and the Departments of Health may help us understand how those partnerships function in terms of possible alterations in the contracted services. There is a need for control and transparency in the manner in which private entities, such as the SHOs, execute public management, since it is possible for market interests to play a role in the complex administration of SUS services.

The state of São Paulo (SP), besides its economic importance as the most representative state in the Southeast Region and in Brazil as a whole[5], was the first, in 1998, to implement legislation regulating SHOs[6]. The state also has the largest number of contracts and contract amendments negotiated with SHOs when compared to other Brazilian states, and has the largest SHO in operation in Brazil[7]. Many of the studies in literature which refer to this theme are with reference to the state of São Paulo, since it is the place which holds the longest running partnerships with the third sector. For this reason, we expected that the most representative data regarding SHOs would be from this state. Therefore, this study is focused on the contracts and contract amendments negotiated with the State Department of Health from the state of São Paulo (SES/SP).

In this context, the objective of this study is to analyze the specialties and exams negotiated in the MC and CA established between SHOs and the SES/SP, including the analysis of the dynamics included in providing those services throughout the negotiations. Data concerning specialties and diagnostic exams were available in the contractual documentation in the Internet websites of the state of São Paulo, and were chosen as the object of this study because, during the fluctuating reading[8] of the sampling universe of contracts and contract amendments signed between 2013 and 2017, we realized that the majority of the contracts dealt with the management of Medical Specialty Outpatient Clinics and hospitals which offer outpatient services, in addition to exams (as well as the management of other facilities, such as the Regulation Center and the State Center for Storage and Distribution of Health Inputs). Moreover, significant changes we found in the quality and quantity of the contracted services, which led us to investigate what changes had been made.

It is important to mention that this study, in a national scope, integrated the research project entitled "Industrial Economic Complex of Health (CEIS, in Portuguese) Innovation and Capitalist Dynamics: Structural Challenges for the Construction of a Universal System in Brazil" ("*Complexo Econômico Industrial da Saúde (CEIS), Inovação e Dinâmica Capitalista: Desafios*

Estruturais para a Construção do Sistema Universal no Brasil" (CNPq sob nº 405077/2013-0).

Methodology

This is a descriptive and exploratory study with qualitative and quantitative approaches. Document research was conducted for the collection of data regarding MC and CA negotiated between SHOs and the SES/SP. The reading and analysis of the contractual information was facilitated by the fact that the documents required for this study were available in the Transparency Portal of the respective Department. As it is information of public interest, its collection is supported by Law 12,527, 2011[9], known as the Access to Information Law, which defines the access to this kind of information as a constitutional right.

For this study, contracts and contract amendments from the state of SP were selected, which presented data on negotiations for hiring specialties and/or exams with contracts established between 2013 and 2017, referring to the following facilities which directly provide health care to the population: Medical Specialty Outpatient Clinics (*Ambulatórios Médicos de Especialidades* – AME), Reference Centers for the Elderly (*Centros de Referência do Idoso* – CRI), and Maternity and General Hospitals. CA were not included when, although signed in the period considered, were related to MC prior to 2013, as well as CAs and MCs with dates of signature within the scope, but validity only up to 2018. Although this study had a limitation regarding the sample, which did not include the CA related to MS prior to 2013, we emphasize that the totality of the medium and high complexity health units from the State of São Paulo were analyzed, and no change was found in the population base of this study.

For data analysis, first the contract amendments were categorized according to what was specified in the contracts. Next, the analytical units of interest were tabulated in a spreadsheet created with the *Microsoft Office Excel* program. All of the contracted medical and non-medical specialties, as well as the diagnostic exams offered, were inserted, and their changes were mapped.

Analysis of specialties

In this analysis, we verified which medical and non-medical specialties were negotiated with facilities that provide healthcare services, together with a ranking of the most and the least contracted services. A contracted specialty, according to the given health facility, was defined as those which appeared at least once in the contractual documents throughout the studied period.

The total number of renegotiations with possibilities of causing changes in specialties, was verified as well. This total was obtained with the purpose of calculating the percentage of inclusions and exclusions of specialties in the renegotiations in the "continuous" CA or MC – those which grant continuity to the last contract and its amendments. A given specialty was deemed as "included" every time it showed up in continuous CA or MC, after not having been contracted in the first studied MC. By contrast, a specialty was deemed as "excluded" every time it disappeared from continuous CA or MC, after having been identified in the first negotiation.

To obtain the percentages shown in this analysis, a renegotiation unit was considered to be each possibility of (re/de)negotiation of a specialty, given the characteristics of the contractual document and if it contains relevant data. The denominator applied was the sum of the negotiations only from documents which mention the specialties, otherwise the percentage calculation of inclusions and exclusions would not represent a real value, but would rather be underestimated, since some renegotiations do not have data on specialties. Therefore, the following formula was used to generate the real percentage of specialties included and excluded: the division of the total continuous CA and MC (renegotiations), which include or exclude specialties (numerator) by the total number of renegotiations prone to have those changes (denominator), multiplied by 100. The calculation was conducted both for each specialty and for all of them together. Another ranking was then established: medical and non-medical specialties which are most often included and excluded.

Analysis of the external therapeutic and diagnostic support services

In terms of exams offered by External Therapeutic and Diagnostic Support Services (*Serviços de Apoio Diagnóstico e Terapêutico Externo* – External SADT), these refer, according to the contractual documents in Technical Annex I (Description of Services), to exams offered to patients who are external in relation to the health facility in question, or "those patients who were sent to have SADT activities conducted by other

healthcare services, obeying the flow established by the State Department of Health".

The present study analyzed the total number of facilities where exams were offered was verified, and a ranking was created, showing the most and the least contracted exams. Moreover, the exams with the greatest expansion in services rendered (considering the increases in quantity of exams contracted and the inclusion of new exams) and the highest reduction of services rendered (through the reduction in terms of quantity of contracted exams or by exclusion of exams), considering the studied health facilities.

It is important to remember that the types and quantities of exams predicted in CA with renegotiations for the following calendar year, as well as in the continuous MC, were compared to the contractual documents referring to the previous period so as to establish inclusion/exclusion or increase/decrease in exam services. The remaining CA were compared to the negotiations predicted in the "renegotiation" MC and CA referring to the same contractual term. Regarding the total of contracted exams, a limitation in this analysis should be mentioned, since it took into consideration only cases when renegotiation increased or decreases the exams offered by the health service, without quantifying how much had in fact been altered.

Results

In the SES/SP site, 101 MC and 518 CA were identified, corresponding to the period from 2013 to 2017, considering that the cut-off of this study only included the contracts and contract amendments of the facilities that offer healthcare services, including care services and diagnostic exams. The results are shown according to the phases proposed in the methodology, including different cut-offs.

In terms of the contractual objects of the amendments, nine categories were identified: 1) Renegotiation for the Subsequent Term (RST); 2) Expansion/Inclusion of Services; 3) Suppression/Exclusion of Services; 4) Special Project/Joint Effort; 5) Readequation/Goal Adjustment (with or without financial adjustment); 6) Investment Resources; 7) Cost Discounts for Unmet Targets; 8) Other Reti/ratifications; and 9) Rectification Articles. For the present study, only categories 1, 2, 3, and 5 were taken into consideration, since the relevant changes in negotiations were present only in these categories.

The medical and non-medical specialties appeared in negotiations in 73 healthcare facilities (48 AME, 1 CRI, and 24 General Hospitals). Our analysis did not consider the two maternity hospitals identified in this study, given the differentiated nature of the specialties contracted, which could result in cut-off distortions. A total of 47 medical and 9 non-medical contracted specialties were identified. Of those, 44 medical and 9 non-medical specialties showed changes throughout the contracts (three of the contracted medical specialties did not present changes, since they had no renegotiations). Chart 1 shows the ranking of medical specialties that had been contracted the most and the least; the non-medical specialties that had been contracted the most and the least; as well as the number of facilities where they appear.

Regarding the total number of inclusions, 30 (68.18%) out of a total of 44 medical specialties and 4 (44.44%) out of a total of 9 non-medical specialties were included by means of CA signed with facilities that had not been contracted initially. In terms of exclusions, 37 (84.09%) medical specialties and 9 (100.00%) non-medical specialties were excluded at least once throughout the contracts. The results of the total number of renegotiations prone to alterations by the CA category, as well as the percentages of inclusions and exclusions of medical and non-medical specialties, taking into consideration all of the CA categories studied, are described in Table 1.

Besides the higher variety of excluded medical specialties (37) in relation to included medical specialties (30), the total number of exclusions in renegotiations was also higher (187) when compared to the inclusions (184). The same occurred with non-medical specialties, but with a larger gap between total inclusions and total exclusions: only 4 types of specialties were included, and all of the nine non-medical specialties were excluded at least once throughout the studied renegotiations. Moreover, there were nearly 5.5 times more exclusions (144) than inclusions (26) of non-medical specialties in the possible renegotiations. Chart 2 shows the ranking of the most included and excluded medical and non-medical specialties, as well as the total number of exclusions and inclusions.

Renegotiation of the External SADT was verified in the 75 health facilities studied, and 11 different types of contracted exams were identified. The ranking of the three most and least contracted exams, and the exams which had their the most and the least expanded offer, is shown in Chart 3.

Chart 1. Ranking of the most contracted and the least contracted medical and non-medical specialties in 73 health facilities in the State of São Paulo (2013 to 2017).

	Most contracted specialties	Number of facilities	Least contracted specialties	Number of facilities
Medical specialties	1st Cardiology 1st Orthopedics Traumatology	66	1st Neonatal ophthalmology 1st Gynecologic oncology 1st Children's urology 1st Oncologic surgery 1st Occupational medicine	1
	2nd Vascular surgery	64	2nd Angiology 2nd Children's orthopedics	2
	3rd General surgery	63	3rd Digestive endoscopy 3rd Pediatria 3rd General medical practice	3
	4th Urology	61	4th Oncology	6
	5th Dermatology 5th Ophthalmology	60	5th Cardiovascular surgery	9
Non-medical specialties[1]	1st Nursing	71	1st Social assistance	15
	2nd Nutrition	68	2nd Odontology	20
	3rd Psychology	61	3rd Occupational therapy	30
	4th Speech therapy	60	4th Pharmacy	37
	5th Physical therapy	58		

[1] In total, nine contracted non-medical specialties were found.

Source: Authors.

Table 1. Total number of renegotiations that can be altered, according to the CA category, and the percentage of inclusions and exclusions of contracted medical and non-medical specialities in 73 health facilities in the state of São Paulo (2013 to 2017).

CA categories	Total possible renegotiations	
	Medical specialties	Non-medical specialties
Renegotiations for the subsequent term	2770	818
Expansion/inclusion of services	0	0
Suppression/exclusion of services	19	6
Readequation/adjustment of targets	207	52
Total possible renegotiations (%)	**2996 (100%)**	**876 (100%)**
Total inclusions (%)	**184 (6.14%)**	**26 (2.97%)**
Total exclusions (%)	**187 (6.24%)**	**144 (16.44%)**

Fonte: Authors.

In terms of the exams, 101 of 559 possible renegotiations (18.07%) increased their targets, 6 renegotiations (1.07%) included exams, and increases in targets were verified in 7 of 11 types of exams. Five CA in the category "Renegotiations for the Subsequent Term" stood out, as did one in the "Re-adequation/Target Adjustment" category, which referred to four types of exams throughout the contracts in three health facilities. Meanwhile two CAs from the "Expansion/Inclusion of Services" category expanded the healthcare service of "Diagnostic Methods in Specialties", one because of a proposal of expansion of healthcare activities for a hospital, and the other, resulting from the implementation of a "Specialized Oftalmo-Retina Service" at a Medical Specialties Outpatient Clinic (MSOC).

Regarding the reduction in the providing of exams, 60 of 559 renegotiations (10.73%) reduced care targets, and 12 renegotiations (2.14%) excluded exams. There was a decrease in the providing of services in 8 out of 11 types of exams. In

Chart 2. Ranking of the most included and excluded medical and non-medical specialties in 73 health facilities in the State of São Paulo (2013 to 2017).

	Most included specialties	Total inclusions	Most excluded specialties	Total exclusions
Medical specialties	1st Anesthesiology	26	1st General surgery	14
	2nd Nefrology	20	2nd Obstetrics	13
	3rd Children's endocrinology 3rd Children's pneumatology	18	3rd Vascular surgery 3rd Digestive endoscopy 3rd Proctology	12
	4th Gynecology 4th Infectology 4th Proctology 4th Urology	8	4th Rheumatology	11
	5th Gastroenterology 5th Ophthalmology	7	5th Thoracic surgery	10
Non-medical specialties[1]	1st Pharmacy	12	1st Social assistance	42
	2nd Nutrition	6	2nd Psychology	18
	3rd Speech therapy 3rd Occupational therapy	4	3rd Nutrition 3rd Physical therapy	15
			4th Pharmacy 4th Speech therapy	14
			5th Occupational therapy	11

[1] Only three of nine non-medical specialties were included.

Source: Authors.

Chart 3. Ranking of the diagnostic exams which were the most contracted and the least contracted, and with more expansion and more reduction of services rendered in 75 health facilities in the state of São Paulo (2013 to 2017).

More contracted exams	Total facilities	Less contracted exams	Total facilities
1st Ultrasound	68	1st Mammography 1st Bone densitometry 1st Pathologic anatomy/cytopathology	1
2nd Endoscopy	61	2nd Clinical laboratorial diagnosis	2
3rd Specialties diagnostic methods	60	3rd *In vivo* nuclear medicine	4
Exams with more expansion of offer	**Total expansions/ inclusions**	**Exams with more reduction of offer**	**Total**
1st Ultrasound	35	1st Specialties diagnostic methods	26
2nd Endoscopy	25	2nd Radiology 2nd Ultrasound	14
3rd Specialties diagnostic methods	24	3rd Endoscopy	10

Source: Authors.

the total number of exclusions, 12 CA from the "Renegotiation for the Subsequent Term" category excluded the offer of 7 out of 11 kinds of exams in six healthcare facilities.

Discussion

The data on medical specialties indicates a lack of commitment with the health needs of the pop-

ulation, since the rearrangement of specialties takes place indiscriminately, as if those were only occasionally needed for the health of the population, and making them appear as if they were part of a market game, in which they are put in place and removed according to the convenience of the Public Powers and SHOs.

Considering the non-medical specialties, the fact that the total number of types of specialties excluded was higher than the number of included ones, and the manner in which they disappear from contracts more often than they are included, indicates that little priority is given to multidisciplinarity, with emphasis on the reduction and exclusion of the providing of non-medical professional services, which are nonetheless essential for the integrality of health care.

Regarding the relationship between inclusions and exclusions of specialties in MC and CA established between SHO and the SES/SP over time, and the rendering of services to the population, we should mention that even rearrangements may cause difficulties to the users, who are accustomed to having a certain specialty available at a given health facility, and the exclusion of any service at that facility will cause difficulty in access.

However, considering that the totality of health facilities was analyzed, an exclusion of services was clearly identified. Moreover, even if previous MC and CA had not been analyzed, by studying the given contractual documents, one could identify that the exclusions of those services occurred more often than did inclusions, particularly in the case of non-medical specialties.

According to the market logic, medical specialties are often deemed as unnecessary (law of supply and demand), which is actually predicted in contracts when they allow for the readjustments of targets according to indicators of prior productivity. However, even if the service is not used as often, it is still part of the user's right to have access to integral care. This type of partnership establishes (and is also a responsibility of government management, which proposes this kind of contract) that, if a service becomes more required or less required, a negotiation takes place in order to provide more or less of a given service, often leading to its exclusion, thereby causing a lack of health care provided to the segment of the population who might actually need the referred service.

This game of 'negotiation", "renegotiation", "de-negotiation" was also observed in terms of the providing of diagnostic exams. Although renegotiations have presented more increases than decreases in targets, the current study has not accounted for the totality of exams that are offered, nor which ones were offered and the dynamics of it, in other words, how many times the targets increased or decreases, and how many times the different types of exams were excluded and included. Therefore, there is a need for further investigation in order to verify exactly how much the targets increased or decreased, since there is the possibility that targets were increased in less quantity than they were decreased.

In an analysis similar to taht in the present study, Castro[10] (p. 124) indicates that 80% of the services analyzed in the state of São Paulo between 2013 and 2017 had, in the majority of their Renegotiations for Subsequent Terms, increases in monthly targets as compared to the previous term, considering that only 20% mostly showed decreases. Therefore,

an increase in most services was expected as well [...], but that did not happen: only 40% of the services had their actual offer expanded in comparison to the offer in the first negotiations, while 60% had their targets reduced in relation to the estimated total, demonstrating that reductions in offer are camouflaged as supposed expansions in services. If on the one hand there is an increase in the monthly targets [...], on the other hand, those same targets are more sharply reduced [...], indicating that those increases are lower than the reductions.

Although the experience in São Paulo indicates an excessive rearrangement in essential healthcare services and a lack of commitment to the integrality of health care, which is a guiding principle of the SUS, Sano and Abrucio[11] (p. 77-78), when evaluating the implementation of the so-called New Public Management in different states of Brazil, found that the SHO model in Brazil "shows the São Paulo case as the most successful one". However, they go on to explain that this is caused, partially, by the "precariousness of the model and of its implementation in other states and in the country as a whole". They also affirm that only the legislations from Curitiba, Bahia, and São Paulo make the integral publication of management contracts mandatory, defining those documents as part of the mechanisms to control results.

Besides the lack of commitment to the integrality of health care by the state government, which has been identified in this study, many authors refer to a lack of adjustment in terms of SHO management. André[12] (p. 46) points out

that the State is still not ready for the management through targets and management contracts, and defines that there is a lack of political will, and that the structure is inadequate, the technical competences are not sufficient and that "it is essential for management to be supervised by the State, or by whatever representatives of society may be, and that the implementation of management contracts is based on an efficient system of performance evaluation"[12] (p. 43).

Pinto and Amaral[13] (p. 145), when discussing the processes of accountability of Management Contracts in towns in the state of São Paulo and in the SES/SP in 2017, found, in these documents, fragility in management operationalization and the execution of healthcare activities and services. The authors recommend verification, by the State and the municipalities, of some points which will function as "actual harmful matter for the analysis of suitability and regularity of the adjustments, as well as of their contractual execution"[13] (p. 175).

The SHO, together with the private entities that work in the healthcare market, have constructed an agenda, defining rules for SUS and offering themselves as the solution for the problems faced by society in terms of access to quality public services. Even so, they do not indicate data which supports their greater efficiency and quality. The fact that the information regarding healthcare services offered throughout the contracts is dispersed in contractual documentation, demanding a deeper analysis for the understanding of that dynamic, also indicates the difficulty for social control.

The arguments in favor of the SHO management are not unanimous, but rather questionable and questioned. First, there is the fact that the contracting and the processes involving the SHO clash with the constitutional principles of impersonality, legality (Law 8,666/1993), and the principle of public tenders. Moreover, concepts such as autonomy and social control are not naturally practiced in a context in which the decisions are not participative or discussed but are instead decided arbitrarily by the governments[14] (p. 44).

In the management of public health services by SHO in Brazil, one can notice a clear market-oriented direction in the execution of essential services provided by SUS. Sestelo[15] (p. 148-149) places the SHO as models of third sector companies and defines the term *entrepeneurship*, a "neologism" which refers to the transformation of economic processes, which used to happen according to other forms of institutional organization, into business activities. Braga[16] agrees with this idea:

[...] the political-entrepreneuring forces present in the healthcare area, taking advantage of the culture of crisis, found space for a cooperation pact with social forces to defend values, ideas, and practices instituted by the Health Movement. In the final analysis, this process causes the weakening of SUS as a public health system that is universal and regulated by social control. It also weakens the wider idea of the Health Reform proposal, which refers to democratization of healthcare by intersectionality and by changing the medical and technological culture centered around entrepreneuring interests[16] (p. 168).

Even though the state of São Paulo may have the mechanisms to control the results and quality predicted in the MC, the SHO are receiving more and more resources and show insufficient results in terms of the providing of services to the population, since there is no assurance that services that are usually available continue to be available at healthcare facilities. It is important to mention the high number of exclusions of non-medical specialties, particularly Social Service, Psychology, and Nutrition, which together, were excluded in 75 renegotiations. That indicates a lack of commitment by both the Public Powers and the SHO when they exclude services that are essential to the quality of integral care provided to the population if we consider health as "a state of complete physical, mental, and social wellbeing, and not simply the absence of diseases or infirmities", as defined by the World Health Organization. Looking into this aspect, it is important to consider the change in the healthcare paradigm taking place since the 1960's, in which

[t]he frustration with the results of biomedicine, increasingly dependent on the industrial medical complex, and itself responsible for risks and damages, resulted in the development [...] in many parts of the Western world, of critical thinking in terms of a model which seeks to revalue the core social and cultural dimensions in the health-infirmity process, going beyond the exclusive focus on fighting diseases only after they are present[17] (p. 131).

SHOs, however, do not seem to take this new paradigm into consideration, since they exclude services that are directly related to determining and conditioning health factors[17], as in the cases of Social Services and Psychology. Using the unproven argument of being more effective and efficient, and of being more competent in the use of public resources, SHOs still enjoy great flexibility

in terms of purchasing equipment, materials, and inputs, as well as in terms of hiring professionals. This may expedite administrative processes in the management of public services, but it may also weaken the rules of public administration and the constitutional principles of impersonality, legality, and compulsory public tenders.

The autonomy of the SHO in the use of public resources should be questioned and monitored more rigorously. Considering the evidence found in this study, there is a need to improve the studies concerning the management of public healthcare services by those entities in terms of quality and quantity.

Delegating the execution of public services that promote the right to health to SHOs may result in drawbacks in the proposals to change the paradigms in the health sector, which were the goals of the important movement of Healthcare Reform in Brazil.

Collaborations

All co-authors participated in the full review of the article, adding pertinent notes or providing suggestions to the article, so that the entire article was written collectively.

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