Rev Saúde Pública 2006;40(5)

Nivaldo Carneiro Junior[I]

Paulo Eduardo Mangeon Elias[II]

Public control and equity of access to hospitals under non-State public administration

ABSTRACT

OBJECTIVE: To analyze social health organizations in the light of public control and the guarantee of equity of access to health services.

METHODS: Utilizing the case study technique, two social health organizations in the metropolitan region of São Paulo were selected. The analytical categories were equity of access and public control, and these were based on interviews with key informants and technical-administrative reports.

RESULTS: It was observed that the overall funding and administrative control of the social health organizations are functions of the state administrator. The presence of a local administrator is important for ensuring equity of access. Public control is expressed through supervisory actions, by means of accounting and financial procedures.

CONCLUSIONS: Equity of access and public control are not taken into consideration in the administration of these organizations. The central question lies in the capacity of the public authorities to have a presence in implementing this model at the local level, thereby ensuring equity of access and taking public control into consideration.

KEYWORDS: Social organization. Health management. Health policy. Health planning guidelines. Public health administration, trends. Health care reform. Equity in health. Equity in access. Qualitative research.

[I] Departamento de Medicina Social. Faculdade de Ciências Médicas. Santa Casa de São Paulo. São Paulo, SP, Brasil

[II] Departamento de Medicina Preventiva. Faculdade de Medicina. Universidade de São Paulo. São Paulo, SP, Brasil

Correspondence:
Nivaldo Carneiro Junior
Departamento de Medicina Social
Faculdade de Ciências Médicas da
Santa Casa de São Paulo
Rua Dr. Cesário Motta Junior, 61 6º andar
01221-020 São Paulo, SP, Brasil
E-mail: nicarneirojr@uol.com.br

Received: 12/4/2004 Reviewed: 5/17/2006
Approved: 7/12/2006

INTRODUCTION

There is a need to understand how new management methods fit into the scenario of transformations in the relationship between the State and contemporary society, in the light of technological advances in the production of goods and social wealth and complex demands from society that are characterized by social group heterogeneity and marked social inequality.

The dominant thinking that has arisen within this context identifies the State as a factor holding back economic development. The State intervenes in the market and carries out productive functions and service provision with less competence than do private agents, thereby favoring the appropriation of company policies. This causes strangulation of production and is detrimental to social wealth, with resultant harm to the population. Within this perspective, it is sought to move beyond the social welfare state model that predominated from the Second World War onwards.

At the end of the 1970s, movements for reforming the State emerged with a variety of concepts and implementation methods. These originated from the countries at the center of capitalism and were based on neoliberal concepts as the principal response to this crisis in the State's role regarding social development.

In the 1990s, a new current of thought emerged within the reform movement, and this was identified with new concepts of the relationship between the State and society that resulted from criticisms of the neoliberal policies that had been implemented.[5] The positions defended by these new movements attributed a prominent role to non-state institutions with regard to social development. However, these movements also called for the State to follow up the process of encouraging partnerships with non-state institutions by means of incentives, coordination and, fundamentally, its capacity for public/private regulation, in relation to the production of goods and services aimed towards the population. From this viewpoint, concern for the poorest social segments would be the State's responsibility, so that these segments could be assured of minimum access to the social assets denied by the market.[6]

Countries on the periphery of capitalism went along with the hegemonic concepts of this movement for state reform. Through this, they absorbed at a local level the questions relating to the countries at the center of capitalism without having experienced the welfare state. The reform patterns outlined on the periphery took the form of decentralization, privatization and focus. The provision of services was delegated to subnational levels of government and/or non-for-profit entities. Privatization of economic production sectors within the state-owned sphere was promoted, and public policy was directed towards economically disadvantaged population groups, while always from the perspective of increasing the efficiency of state action.[3]

The Brazilian government put these presuppositions into effect from 1995 onwards, when it presented its conception for reforming the state apparatus, with the proposal to change from a pattern of bureaucratic public administration to one of managerial administration.[11,13]

The reformist ideals of the central countries took on new shape in the political and social realities of the peripheral countries. These characteristics marked out qualitative differences in relation to the reform of the Brazilian State.

Public policies should be efficacious, with a state bureaucracy that is dynamic, free of pressure from special interest groups and capable of devising efficient managerial mechanisms, establishing targets and verifying the results. They should also favor coparticipation by social agents in public actions to benefit social development.

Nonetheless, these presuppositions come up against the concrete realities. In the case of Brazil, there is a very unequal relationship between the State and society. The State is authoritarian and dominated by social forces connected with the interests of capital, thereby resulting in strong emphasis on private action.

Therefore, the delegation by the state to non-state institutions gains prominence as a matter to be analyzed from the point of view of equity of access to services and public control over the formulation of health policy.

This perspective can be qualified through analysis of the recent health policies of the State of São Paulo, which has prioritized its offer of medical-hospital services for the population by means of passing over public resources to social health organizations.

Thus, the objective of this paper was to present the results from a study on the social health organization model, from the perspective of increasing the public control and equity in providing services. The possibilities and limits of social organizations and instruments for state regulation for the health sector were analyzed.

The social organization model

In proposals for reforming the Brazilian state apparatus, social organizations are considered to be an instrument for strategic management of the changes to the pattern of public administration that are needed, with the possibility of entering into management contracts between the parties. Such contracts would allow assessment and control of the agreed targets, which is one of the fundamental requirements for managerial reform.[12]

The qualification of institutions within civil society as social organizations comes through a law within the power of the executive authorities. This makes it possible to pass over state equipment and the corresponding finance for maintaining services.

Complementary Law n. 846/98 guarantees powers for the state executive to qualify entities as social organizations. Moreover, the hospitals passed over belong to the state and therefore there is nothing in this process that could contradict the legitimacy with which the São Paulo State Health Department (SES-SP) has moved forward with this policy of transferring state equipment to the private sector.

In the State of São Paulo, this management model was implemented in the middle of 1998. With the law in force, SES-SP adopted management by social organizations as its hospital care policy, and passed over the administration of new hospitals that were conceived within the Metropolitan Health Plan for the Greater São Paulo region, to private agents qualified as social health organizations. Thus, this represented a radical change in the role hitherto played by the State in the provision of health services, since the production of services ceased to be the direct responsibility of the State.

The legislation of the State of São Paulo differs from the federal legislation in three important respects: inclusion of an evaluation committee (composed of representatives of the Legislature, Executive and State Health Council); restriction of service production solely to the National Health System (*Sistema Único de Saúde* - SUS); and adoption of the new management model only for new health equipment. As a result of this, SES-SP underwent structural reorganization to create a central technical group linked to the Health Secretary's office, with the aims of monitoring the implementation of the new model and promoting improvement in the management contract, particularly with regard to funding and assessment indicators.*

Today, the State of São Paulo has around 20 hospitals with secondary-level technical and care profiles that are managed by social health organizations of different institutional origins. These include religious organizations (*Casa de Saúde* Santa Marcelina), universities (Universidade de Santo Amaro), community organizations (*Sanatorinhos*), and employers' associations (Social Service for Civil Construction of the State of São Paulo - SECONCI), among others.

METHODS

The starting point was the hypothesis that the way in which the Brazilian State had delegated health care to private agents – through the intermediation of social organizations – did not take into account putting public control into effect or the equity of access to services.

Access was an important category for analyzing the health systems. Because this involves the offer, the service organization and the population's acceptance, it reveals the dimensions of social and political nature that are necessarily present in formulations and implementations of health policies.[8]

Equity is understood as a strategy for organizing health actions and services that are distinct and directed towards population groups that are socially unequal, with strong traces of "positive discrimination" to guide the formulation and implementation of a given action.[2]

Public control is understood as participation by organized civil society at different levels, with the aim of exercising control over the State, with regard to policy supervision and formulation, among other matters. The types of control instituted by the contemporaneous State can be divided into two spheres:[7,14]

a) horizontal, undertaken among sectors of the state bureaucracy: administrative control (exercised within the sector), legislative control (policy control by the executive power), accounting control (a technical dimension that gives backing for legislative) and judicial control (to avoid abuses in exercising power);
b) vertical, undertaken by society in relation to the government and bodies of the State.

Two social health organizations were analyzed: one linked to a philanthropic entity that manages a hospital in the eastern zone of the municipality of São Paulo (HZL) and the other linked to an employers' association that is responsible for a hospital located in a municipality in the Greater São Paulo region (HGSP).

*São Paulo. Novo modelo de contrato de gestão. Diário Oficial do Estado de São Paulo. 13 dez 2001;Seção I:49-50.

The criteria that guided the selection of these hospitals were as follows. HZL is in a region of high population density and low socioeconomic indicators, with significant presence of participation by a health movement for the people. This entity that has been qualified as a social health organization is known for providing health services of public nature in the region. HGSP is a reference hospital for four municipalities within a small geographical area, which also presents low socioeconomic indicators. There is a local tradition of social agents in the health reform movement, and the entity managing the hospital has extensive experience of outpatient services of self-managed type.

The qualitative case study approach was utilized, for a variety of reasons: it was the investigative tool that was most appropriate for the problem under examination, and for situations in which the research does not have any control over the subject; it met the need for understanding the internal dynamics of the subject; and it is recommended for studies on contemporaneous phenomena.[1,10]

The analytical categories chosen were equity of access to health services and public control.

The empirical material was collected by means of interviews with key informants,[15] taking into consideration the interviewee's position in the administrative hierarchy of the social health organization, his technical-administrative role in the organization, his implementation of care, his utilization of the services and his participation in spaces for exercising public control. Fourteen interviews were conducted, covering directors, managers, health professionals, users, health councilors, members of the state parliament, health secretaries and central-level technicians in SES-SP.

The secondary data utilized included legal documents (ordinances and laws relating to the creation and implementation of social health organizations, and minutes of health council meetings) and institutional information covering service production and human resources, among other information.

The material was analyzed by exhaustively reading it to search for elements connected with the analysis categories.

ANALYSIS OF RESULTS

Analysis of policy relationships for the managerial model

With regard to policy formulation for the managerial model for social health organizations, it was observed that the state executive has a central role, represented by the central level of SES-SP. It is at this level that entities with the criteria for qualifying as social organizations are defined, and the targets for service production to be reached, assessment indicators and routine follow-up of management contracts are established.

The technical-administrative management of social health organizations participates in defining targets, implementation time periods, technical administrative monitoring stages and the amount of funding destined for enabling management contracts:

"*...we are the ones who define what the activity types are, the types of service in the light of the epidemiological realities in the region where it* [the hospital] *is located*" (central-level technician in SES-SP);

"*...they* [SES-SP] *close a budget x; through this budget we will be working within the framework that the Government establishes (...) If we feel there is repressed demand, we are fully prepared to sit down with the group* [SES-SP] *and negotiate an expansion of the funding*" (social health organization manager).

In the experience at HGSP, it was observed that the technical-care model ensured equity of access, as a result of the active participation of the local public authorities in formulating the health system for the region. Thus type of management implied negotiation between the hospital board and the health secretaries in the municipalities covered by the hospital, which resulted in creating a hierarchy of access to services according to local needs and effective linkage between the municipal public services and the hospital:

"*...the four municipalities got together (...). We had assemblies of the Municipal Health Councils (...), at which the general hospital topic was discussed a lot by the councilors: how and in what way they wanted this hospital to exist (...). All the negotiation and the agreement to open the wings was conducted together with the municipalities*" (municipal health secretary).

Analysis of the equity of service provision and public control

The analysis of the situation in HZL revealed features that were the opposite of those in HGSP, in relation to guaranteed access. The public authority did not act effectively in organizing health care and consequently it was seen that there were no linkages within the public health service network or with the hospital. This also contributed towards the fact that

the hospital organized its attendance in a non-referred manner, a manner commonly named "open door".

"*...there is a lack of organization in the referral and counter-referral system and, perhaps most importantly, with regard to user confidence. Users know that if they go to health care center A, B, C or D they are not going to be seen there. They may have to queue here, but they get seen*" (social health organization manager).

On the one hand, this type of health care organization, which is oriented towards dealing with complaints, consists of an offer of services meeting the population's demands. On the other hand, the equity of access is impaired, since there is no guarantee of attendance for those who really need it. The attendance is determined by the order of arrival at the emergency services, which are transformed into the "entry door" of the institution, with the exception of urgent and emergency cases that are defined technically. This is not a characteristic exclusive to this hospital. This has generally been the model utilized in facilities at secondary and tertiary healthcare levels that are linked to SUS.

In the two social health organizations analyzed in relation to equity of access to health services, the way in which access was implemented was highlighted. Active participation in the organization of the health system by the public sphere, on the basis of hierarchy creation and regionalization, constituted a differentiating element.

Access is basically understood as an attribution of a technical nature, i.e. the doctor's professional competence to determine that a given user can enter the service. As such, assessments made using exclusively technical parameters are given preference, and other variables of a social nature are disconsidered, particularly income and social needs.

The hegemony of this technical conception generates significant tension in the relations with users. Systems that operate using "open doors" logic, like HZL, are more prone to such conflicts, because there is no local backing for dealing with these needs within arenas for policy and technical care provision, such as health councils and technical chambers. The case of HGSP illustrates this possibility well, since this institution has the backing of the local public authorities for promoting effective linkage between public services, involving the municipal health councils and segments of the population, with the aim of putting into effect a system creating a healthcare hierarchy in which the social health organization is important. According to the testimony of a representative of the local public authority, there is a need for "(...) *a monthly run-in with the Health Council and with the district councils. We never tire of explaining this model; we've managed to get politicians and the mayor to go along with it* (...)" (municipal health secretary).

With regard to public control, the policy of transferring state assets to private entities presents other questions. This matter generated tensions in the debate in the legislature for approving Complementary Law No. 846/98 that resulted in the control mechanisms expressed in this law. These mechanisms have, however, been seen to be insufficient, and this has kept up the criticism of how the state executive has dealt with this question:

"*...the law provides for sending a report there* [to the committee that assesses how the management contract is being conducted] *every three months, but they* [SES-SP] *don't do this*" (member of the state parliament).

From a legal-bureaucratic point of view, the control is exercised by means of legally established procedures. Thus, the State of São Paulo Accounts Tribunal exercises accounting-financial control that is restricted solely to financial and tax matters.

SES-SP was the government level identified by the managers of these organizations as the preferred one for accounts declarations, taking into consideration the information from the results achieved, for the purposes of releasing funds:

"*...we have a committee that we call the follow-up committee, which has members from hospitals, from the territorial levels of the Department and from the central level* [SES-SP], *and which holds meetings once a month*" (central-level technician in SES-SP);

"*...we have two means of public control: one that is more constant, more present and closer to us, which is the State Health Department (...), and the other is the State Accounts Tribunal*" (director of a social health organization).

The precedence of this policy in public administration must be emphasized, since it is within this sphere that the regulation of interests takes place. It is important to signal this, because it is often said that it is enough to incorporate clear managerial mechanisms, with well-established targets and defined assessment indicators, so that the efficiency with which services are produced and the population's needs are met can be established.

The ideal of managerial reform of the State is perme-

ated by the concept that social organizations are one of its strategies.

Analysis of the management of social health organizations

Nevertheless, in analyzing management by social health organizations, it is seen that the type of service provision contract that exists is not strictly a management contract. This is because, strictly speaking, the management continues under the aegis of the state public authorities, in that it exercises the functions of health policy formulator and social health organization fund-provider. Consequently, the social health organizations are led towards becoming organized in such a way that they can negotiate matters that are of interest to them. In this, they resemble private providers for SUS:

"*...we have a meeting that is just for us, the social health organizations. The state* [SES-SP] *doesn't come into it. It's not that it's prohibited, but we discuss a series of strategic situations, and even so that we can take them to the state* [SES-SP]. *So, we don't agree actions*..." (director of a social health organization).

Also with regard to public control, it was noted that there was no expanded participation by the State Health Council, considering that this council does not take part in formulating and following up this policy, as can be gathered from reading the minutes of the council's meetings and from the interviews with key informants (councilors and members of the state parliament). However, it was seen from the two social health organizations that the council's participation is characterized by actions to inspect the accounts and finances: the same ones performed by the State of São Paulo Accounts Tribunal:

"*...we have accounts declarations. We have this every year: what came in, what went out, how much was spent*..." (health councilor).

Two other questions deserve highlighting: one regarding the differentiated way of funding these social health organizations in relation to other providers for SUS, whether to these themselves or to contractors. The other relates to the management of human resources.

With regard to passing over financial resources for funding health service provision, Elias[4] drew attention to the fact that the funding models generally determine the technical care provision models. Thus, in SUS, payment per procedure and for the production achieved, to private and public health care agents, imprints a particular attendance type that is oriented towards offering services, with preference for acts of greater complexity, because these are better remunerated.

The overall budget for social health organizations is agreed with SES-SP, with monthly fund transfers, and there is the possibility of negotiating increases on the strength of proven deficits. This means of financing is desirable both for the social health organizations and for the state administrator itself, since together with the managerial autonomy in using these resources, the targets established can be fulfilled with an effective guarantee of funding. Thus, another logic can be imprinted on the attendance, through a concern to absorb the demand without selecting the procedures according to their remuneration (high or low), since the contract implies a "closed package" for supplying the care activities.

Moreover, in linking the administrative and financial autonomy of social health organizations, this type of funding establishes differences in relation to the government bodies themselves. In government bodies, the destination of expenditure is linked to budget items, with small margins for reallocation, which compromises the managerial autonomy for meeting the routine needs of the service, or the possibility of implementing actions that are closer to the sociodemographic and health realities of the population attended. This limitation is frequently indicated as a limit on state action, to explain the inefficiency of this apparatus in responding to the population's health needs.[9]

One marked characteristic indicated by the managerial and technical-professional staff as a factor in the efficacy of implementing health actions in these social health organizations relates to the managerial autonomy for hiring and firing human resources. In public administration of bureaucratic type, hierarchical authority prevails and is backed by the powers and competencies of positions that are characterized by functional stability and subject to political influence from the people holding the reins of government. In managerial public administration, work contracts are established following the same logic as in private companies, in which efficacy and technical-administrative competence predominate, thereby facilitating the firing of those who do not meet the criteria of productivity and quality established by the company:

"*...I think this flexibility of Human Resources is fundamental (...), because you can fire people who are not doing anything. If someone doesn't adapt to the team, you can't keep this person*" (director of a social health organization).

This managerial characteristic is important for organ-

izing health services, particularly hospital services, which require speed in hiring human resources, both in qualitative and in quantitative terms, in order to meet the population's health needs more efficiently.

FINAL CONSIDERATIONS

The investigation that was carried out has made it possible to validate the general hypothesis that guided it, i.e. that guaranteed access to health services and putting public control into effect do not appear centrally within the management of these social health organizations. The public-private agenda for this new management model for health services is qualified by responsibility within the public sphere for formulating and controlling policies, while the private sphere has the responsibility for organizing the work process and managing human resources. This enables human resources management logic in which direct control over workers and the work.

Thus, management by social health organizations is characterized by devolution of services to the non-state sphere. Furthermore, this model makes it possible for the public authorities to expand services while respecting the limits on hiring personnel established by the Fiscal Responsibility Law.

This investigation has made it possible to infer that the management model for social health organizations does not constitute a limiting factor on the development of public health policies, in that it favors linkage between the public authorities and civil society, as in the case of HGSP. Nonetheless, the central question lies in the capacity of the public authorities to make themselves present in implementing this management model at local level, while retaining and expanding the arena for policy formulation and thereby ensuring equity of access to health services and taking public control into consideration, so as to give due regard to defending social justice as a priority target in their actions.

REFERENCES

1. André MEDA. Etnografia da prática escolar. 2ª ed. Campinas: Papirus; 1998.

2. Carneiro Junior N, Andrade MC, Mazziero M, Pinheiro RC, Souza ND, Silva SM, et al. Construção da equidade no acesso às políticas públicas: uma experiência de articulação intersetorial e interinstitucional na área central do município de São Paulo. *Rev Adm Pública*. 2000;34(6):95-104.

3. Draibe SM. A política social na América Latina: o que ensinam as experiências recentes de reformas. In: Diniz E, Azevedo S, editores. Reforma de Estado e democracia no Brasil. Brasília (DF): Universidade de Brasília; 1997. p. 213-58.

4. Elias PEM. Estrutura e organização da atenção à saúde no Brasil. In: Cohn A, Elias PEM. Saúde no Brasil: políticas e organização de serviços. São Paulo: Cortez/CEDEC; 1996. p. 57-117.

5. Evans P. O Estado como problema e solução. *Lua Nova*. 1992;(28-29):107-56.

6. Ferlie E, Asburner L, Fitzgerald L, Pettigrew A. A nova administração pública em ação. Brasília (DF): Universidade de Brasília/ENAP; 1999.

7. Fonseca F, Sanchez O. Controle da corrupção e reforma do Estado (o Governo Covas, 1995-2000). *Lua Nova*. 2001;(52):93-119.

8. Hortale VA, Pedroza M, Rosa MLG. Operacionalizando as categorias acesso e descentralização na análise de sistemas de saúde. *Cad Saúde Pública*. 2000;16:231-9.

9. Junqueira LAP, Inojosa RM. Gestão dos serviços públicos de saúde: em busca de uma lógica da eficácia. *Rev Adm Pública*. 1992;26:20-31.

10. Lüdke M, André MEDA. Pesquisa em educação: abordagens qualitativas. São Paulo: EPU; 1986.

11. Ministério da Administração Federal e Reforma do Estado. A reforma do Estado no Brasil. Brasília (DF); 1998.

12. Ministério da Administração Federal e Reforma do Estado. Emenda Constitucional n. 19, de 4 de junho de 1998: reforma administrativa. Brasília (DF); 1998.

13. Pereira LCB. Do Estado patrimonial ao gerencial. In: Sachs I, Wilheim J, Pinheiro OS, editores. Brasil: um século de transformações. São Paulo: Companhia das Letras; 2001. p. 223-59.

14. Przeworski A. O Estado e o cidadão. In: Pereira LCB, Wilheim J, Sola L, editores. Sociedade e Estado em transformação. São Paulo: UNESP; 1999. p. 323-59.

15. Thiollent M. Crítica metodológica, investigação social e enquête operária. 5ª ed. São Paulo: Polis; 1987.

Based on doctoral thesis presented to the Faculdade de Medicina of the Universidade de São Paulo, in 2002.