The role of Santa Casa in the Brazilian public health system: a historical survey of a philanthropic institution

O papel da Santa Casa no sistema público de saúde brasileiro: o levantamento histórico de uma instituição filantrópica

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Abstract

This article[1] aims at analyzing the evolution of the interaction between the Santas Casas and the Brazilian Public Health stemmed from the historical research of the Santa Casa de Mogi Mirim. This qualitative research was based on data collected by means of documentary research on the historical survey of the Santa Casa and the Brazilian health system, identifying the level of interaction between the institution and hospital care. The result of this comparative historical analysis demonstrated the intensification of the relationship between Santa Casa and the public health system, starting from a null interaction in the beginning of the 19th century that turns into a codependency with numerous disputes and very subtle limits in the beginning of the 21st century.

Keywords: Santas Casas; health System; SUS

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1 This research derives from the data collection carried out for the doctoral thesis entitled "The Transformation of a Field and its control conceptions: the case of a Santa Casa", developed by André Luiz Mendes Oliveira and defended at the Production Engineering Graduate Program of the Universidade Federal de São Paulo.

Resumo

O artigo tem por objetivo analisar a evolução da interação entre Santas Casas e o Sistema de Saúde Público brasileiro por meio do levantamento histórico da Santa Casa de Mogi Mirim. Os procedimentos metodológicos foram de abordagem qualitativa e basearam-se em uma coleta de dados por pesquisa documental do levantamento histórico da Santa Casa em questão e do histórico dos principais marcos do sistema de saúde brasileiro. Os dados obtidos foram analisados para identificar o nível de interação entre a Santa Casa e a assistência hospitalar do sistema de saúde em vigor. O resultado desta análise histórico-comparativa demonstrou a intensificação da relação entre a Santa Casa e o sistema público de saúde, partindo de uma interação nula no início do século XIX que se transforma em uma codependência cercada de disputas e com limites muitos tênues no início do século XXI.

Palavras-chave: Santas Casas; Sistema de Saúde; SUS.

Introduction

The creation of the 1988 Brazilian Federal Constitution culminated in an innovation for the Brazilian Public Health System: the creation of the Brazilian National Health System (SUS). The System was considered innovative due to its two guiding axes: comprehensiveness and universality, characteristics which were absent at the previous health systems.

During the development of the SUS, the government lacked of a structure to grant full-fledged hospital care to the population, and ensured, yet in the 1988 Constitution, the possibility of hiring private health services to complement the care network, prioritizing services from philanthropic and non-profit entities. This category included the Santas Casas, often centennial institutions whose original activities were philanthropic and charitable, and which began to play the role of service providers paid by the government.

Just over 30 years after the establishment of the SUS, health care researchers have been debating about the reasons that caused the mitigation of the pristine functioning of the health system, such as the management decentralization at the city level (Miranda; Mendes; Silva, 2017; Santos, 2012) and a health care "entrepreneurship" (Viana; Miranda; Silva, 2015). On the other hand, the charitable health segment shows a chaotic picture (CMB, 1992): a sector debt that reached a sum of R$15 billion (15 billion reais) and the shutdown of the largest emergency and urgent care hospital in Latin America, the Santa Casa of São Paulo, on July 22, 2014 for 28 hours due to a lack of materials and medicine.

When searching for the term "Santa Casa" in the **Web of Science** and **SciELO** databases, the authors retrieved, respectively, 43 and 26 academic papers (considering the ones published between 2011 and 2020 and excluding those describing surgical techniques). The papers adopting a historical approach to a specific Santa Casa were restricted only to a certain period of its history and, thus, an opportunity to discuss the relationship between the Santas Casas and the Brazilian health system emerged. Considering the different interaction levels in the relationship between Brazilian health policies, hospital care and the Santas Casas throughout history, this study aims at presenting the evolution – or absorption – of the role

of the Santas Casas within the hospital care network during the development of the Brazilian Public Health System based on a historical survey of the Santa Casa de Misericórdia of Mogi Mirim (SP).

This research stems from data obtained for a PhD thesis which analyzed a Santa Casa as a Strategic Action Field. The qualitative methodology used here was developed utilizing documentary research based on: (1) scientific publications from the **Web of Science** and **SciELO** databases concerning the Brazilian health system throughout history; and (2) the historical documentation center archives of Mogi Mirim. At the end of data collection, the main events related to health care were selected as study period delimiters of the health system, adding the historical report of the Santa Casa of Mogi Mirim and its interaction with the aforementioned system to the analysis.

Origin of the Santa Casa of Mogi Mirim

The oldest Santas Casas were installed in the first villages created on the Brazilian coast, such as Salvador, Santos and Rio de Janeiro; soon after the discovery of Brazil. Due to this, the initial hospital care focus of these Santas Casas was to avoid the diseases brought by sailors arriving at Brazilian harbors - the main "public health" concern at the time.

According to Baptista (2007), the arrival of the royal family in Brazil at the beginning of the nineteenth century contributed directly to the emergence of the first public health actions. These practices sought to ensure that the available workforce was kept healthy, in order to continue on developing the business implemented by the Royal Family in their colony.

This logic of city sanitation and combat against diseases - which lasted until the First Republic - gave doctors the space to charge those who could afford. Meanwhile, the Santas Casas aided the indigent and the poor[2], which, in turn, were assisted by a small group of volunteer doctors.

The Irmandade da Santa Casa de Misericórdia of Mogi Mirim was founded on April 6, 1867 on the initiative of Father Luiz José de Brito, Dr. Delfino Pinheiro de Ulhôa Cintra, José Costa Rangel, Albano Leite da Cunha Canto and José Alves dos Santos, following the pledge approved on August 30, 1867 by Don Sebastião Pinto do Rego, diocesan bishop of São Paulo, and by Dr. José Tavares Bastos, president of the province of São Paulo.

In 1882, 15 years after the foundation of the Irmandade, the funds raised were still insufficient for building the hospital. In that year, the Provincial Government allocated the proceeds of the 48th province lottery, an amount of 12:000$000 (twelve contos de réis, the operating Brazilian currency at that time), to the institution and appointed a commission to manage the construction of the hospital, with LTC José Batista da Luz as its president. The first meeting took place in May, 1882 and the commission decided to accept the donation of a plot of land offered by the commission chairman himself for building the structure.

The foundation stone was laid on July 6, 1883 and the people of Mogi Mirim sought to raise funds to pay for the construction of the hospital with kermesses, shows, auctions and charity parties.

The inauguration took place on June 3, 1888, 21 years after the foundation of the Irmandade and almost five years after the foundation stone was laid, serving the poor and indigent until 1895 when it closed its doors due to an internal reorganization. On February 7, 1897 the Santa Casa de Misericórdia of Mogi Mirim reopened, with Captain Miguel Antunes Pereira Lima as its ombudsman and counting on the volunteer work of four doctors who lived in the city: Dr. Carlos Augusto Fernandes de

2 Historical data define the profile of those served in the Santa Casa of Mogi Mirim, in the late nineteenth and early twentieth centuries, as black people, aged 60 or older, widowed and without occupation. However, this profile cannot and should not be generalized to all Santas Casas. In *The Santa Casa de Misericórdia of Bahia and the Patient Hospital Care in the Nineteenth Century*, Barreto (2011) highlights that, throughout the nineteenth century, most of the patients treated at the São Cristóvão Hospital in Salvador, ran by the Santa Casa de Misericórdia of Bahia, were white foreigners and with a defined occupation, even though it also assisted the poor and the indigent. The distinct characteristics between the patients in Mogi Mirim and Salvador demonstrate that it is fundamental to discuss the profiles of those assisted by the Santas Casas when studying them, since the results may vary depending on the geographical and/or temporal cut-out applied to the research.

Castro, Dr. Tertullian César Gomide, Dr. Matheus Chaves de Mattos and Dr. Pedro de Souto Mayor.

From July 5, 1899, Colonel João Leite do Canto – capitalist, great coffee producer and great city benefactor – assumed the position as ombudsman and held the position for 17 and a half years. In July, 1900, 14 patients had already been treated in the hospital: a modest flow when considering modern standards.

The end of slavery increased the number of settlers in rural properties, the main ongoing city income source, and it consequently intensified the hospital patient flow. In November, 1916, the city doctors started the "Movement of Interest for the Santa Casa", a list of renewals which were necessary to improve the medical care carried out by the Santa Casa, not only concerning the poor and indigent, but also to "pensioners",[3] a category which was included in the Irmandade's reports to indicate patients who could afford hospital care.

This movement ends the phase of coffee producers assuming the position of ombudsman in the institution. In 1917, the position was taken over by one of the doctors of the Santa Casa: Dr. Altino Joaquim de Almeida. The need to adapt the physical structure due to service growth resulted in the increase on the number of brothers (volunteers) to enable the necessary renewals. In November, 1919, after a generous donation from Colonel João Leite, former ombudsman of the Santa Casa, the Colonel João Leite Hall was inaugurated in order to assist tuberculosis patients.

The Pension Funds and the Retirement and Pension Institutes

On January 24, 1923, based on a proposal developed by Chief of Police Eloy Chaves, the decree No. 4,628 – later known as the Eloy Chaves law – came into effect to regulate an existing care practice in some companies: the Retirement and Pension Funds (CAPs) (Baptista, 2007).

These funds were a benefit offered by large companies, in which the worker contributed with part of their salary and the company with part of its income, in order to guarantee that the participating worker and their entire family had access to medical aid and medicines, retirement money and pensions for their heirs. The CAPs were controlled by the companies themselves and their workers, and acted as some kind of insurance: the worker could seek a registered practitioner for assistance and the amount spent by the worker/policyholder was refunded later. The role of the State was to mediate possible conflicts between the workers and the company, not being responsible for financing or supervising the CAPs.

The renewals carried out in the Santa Casa of Mogi Mirim between 1918 and 1919, as well as the construction of a surgery room in the mid-1920s, enabled the improvement of the hospital care, but the building still required several emergency structural interventions in most of its components: walls, floors and ceilings. In this period, the main hospital care focus continued to be on the poor and the indigent, but there was also a small number of private patients.

In 1933, the State developed the Retirement and Pension Institutes (IAPs) and it took over the financial and administrative control of the system. While the CAPs represented a single company, the IAPs represented categories of workers, regardless of the company in which they worked. The Retirement and Pension Institutes created were:

(1) IAPTEC, for workers in transport and cargo;
(2) IAPC, for commercial workers;
(3) IAPI, for industrial workers;
(4) IAPB, for bank workers;
(5) IAPM, for seafarer and harbor workers;
(6) IPASE, for public workers.

The IAPs expanded the assistance, but not in a universal way, since the Institute benefits were restricted to those who had an employment relationship in one of the aforementioned categories defined by the government. This resulted in a segregation of the other categories of workers, such as rural workers, liberal

3 The word "pensioner" in this historical moment derives from the term used to describe a paying guest at a pension, someone who could afford the services offered on site, such as lodging, food, bath etc. It did not describe a beneficiary of the Pension Funds or the Retirement and Pension Institutes yet, but those who could pay for hospital care, carried out in a different way and in facilities other than those intended for the poor and indigent.

professionals, among others. But discrimination occurred also among the Institutes themselves, since the independent management of each IPA prevented the standardization of the offered benefits. In other words, Institutes of categories with greater economic power, such as bank and industrial workers for example, offered broader and better assistance than the other Institutes. Precisely due to this difference in fund-raising capacity, not all IAPs offered medical care to its members. Besides, the construction of institute hospitals was feasible only in some locations, such as the IAPM hospital in Rio de Janeiro – currently known as Hospital Geral do Andaraí.

From 1935, with the election of Dr. Lúcio Cintra do Prado, the district judge, for the ombudsman position at the Santa Casa of Mogi Mirim, a new wave of renewals began, along with the adaptation of a maternity hospital with 10 beds in the Colonel João Leite Hall at the end of 1940.

In May, 1943, the precarious structural conditions of the hospital building led to the idealization of a new building for the Irmandade on a plot of land close to the old one, whose foundation stone was laid on August 2, 1945. The people of Mogi Mirim had, again, a large share of contribution to the construction of the new hospital: in addition to the donations made by several prominent figures of the society, several charitable events were organized. Due to the collapsing risks the old building, the inauguration ceremony of the new, although unfinished, building was held in August, 1953. However, it was not only until the late 1950s that the building was finished when the Irmandade received a financial contribution through government grants.

The National Institute of Social Security and the National Institute of Social Security Medical Assistance

During the Jânio Quadros administration the 1960s, the debate around a proposal to standardize the benefits provided by the IAPs culminated, in September, 1966, in the unification of the several institutes into a single one: the National Institute of Social Security (INPS). In addition to the benefits standardization as expected by its creators, the unification also brought a series of complaints from taxpayers who priorly had access to more benefits, after all the assistance of the Institutes of greater economic power also was now accessible for other taxpayers who contributed with lower taxes and whose care network lacked of the same quality. This migration of taxpayers searching for care in other institutes caused the overcrowding of some hospitals, generated queues, delay in medical care and other problems that resulted in a general dissatisfaction of taxpayers.

In an attempt to meet the newly generated demand, the State began to hire services through accreditation of private hospitals to complement the available hospital care network, forming the structure that was known as the medical-business complex (Cordeiro, 1984).

Also in the 1960s, after a new building had been completely built, the Santa Casa of Mogi Mirim signed the agreement to assist the taxpayers of the National Institute of Social Security (INPS). The arrival of INPS users increased the patient flow and the directors board, Including Mr. José Martinelli as ombudsman, decided to hire, in June, 1968, a team of specialized architects to design a master plan – approved in September of that year – that took into account the expansion of the hospital considering the unused land area. The master plan began to be implemented in 1969, with Dr. Gastão de Oliveira Delafina as ombudsman of the Irmandade, starting with the adoption of administrative and operational practices indicated by the suggested plan. The implementation of these practices resulted in some changes, such as: replacing the voluntary role of the Mordomo (Butler)[4] for the paid Manager position, the adoption of hospital accounting, the creation of a human resources sector responsible for overseeing the recruitment and selection of employees, as well as hiring a trained nurse as the head of department.[5]

4 A Mordomo (Butler), in the Santa Casa of Mogi Mirim, was responsible for inspecting the hospital facilities and authorizing the payment of the bills related to the hospital costs. The creation of a paid position would ensure full and professional dedication to the hospital.

5 The nursing functions had been performed since 1935 by a group of nuns from the congregation of the Irmãs Franciscanas do Coração de Maria, assisted by people who often lacked of an academic education in the field of Health Sciences.

The expansion included in the master plan began in January, 1974 with the construction of a new laundry room and the installation of a Radiology Center where the old laundry room was. The Intensive Care Unit was built in the following year and, in 1976, the outbuildings which were used as enclosure by the charity Sisters were transformed into apartments for private patients. The construction of new facilities for the cafeteria/kitchen was executed from 1978 on, as a result of a new government grant, with a specific purpose, which also allowed the expansion of the emergency room and the development of the Maternity and the Pediatrics wards.

At the end of the 1970s, one of the first actions adopted by the State to mitigate the effects of the crisis of the social security system was to increase control over the resources applied in medical-hospital care. Thus, the National Institute of Social Security Medical Assistance (INAMPS), responsible for coordinating all health actions at the medical-care level of social security, was created in 1977.

In the early 1980s, however, the first signs of economic recession and the financial pension crisis announced a process that deepened at the end of that decade with the

> [...] progressive demise of the National Institute of Social Security Medical Assistance (INAMPS) as financier and provider of medical care for workers, due to the reduction in the quality of services caused by the crushing prices paid to the hired private sector and the extinction of the agreements INAMPS/company and INAMPS/Labor Union. (Medici, 1992, p. 9)

The collapse of the amount of money paid by INAMPS due to the inflation of the period allowed a unilateral break of several agreements and contracts by the hospitals. In summary, in the mid-1980s, the deterioration of Social Security Services generated an increase in the demand for special medical services, especially by skilled workers, wage-earners, executives and liberal professionals, while on the supply side there was a state favor through the systematic presence of government incentives to the private health system intended to assist those inserted in the formal labor market.

Brazilian National Health System (SUS)

Even with the creation of INAMPS, the social security sector crisis extended to the health care sector affecting the Santas Casas which stopped receiving the financial resources transfer, either due to contingency of the Institute, or to the review of the care reports presented.

In 1981, the Advisory Council for Social Security Health Administration (CONASP) established a specific working group focused on identifying the causes of the sector crisis. Its diagnosis pointed towards a set of distortions that bolster the health movement arguments in behalf of a health system reformulation in Brazil:

(1) services that did not match the reality;

(2) insufficient integration of the different providers;

(3) insufficient financial resources and unforeseen estimations;

(4) discredit of their own services;

(5) overproduction of hired services.

The Ministry of Health summoned, in 1986, the 8th National Health Conference (VIII CNS), in which the medical community and technicians took part in the discussions for the first time. In addition to its role as an instrument of political pressure, the VIII CNS report was also accepted as a reference material by the Constituent Assembly in 1987/1988. The 1988 Constitution legalized the VIII CNS report by creating the SUS based on four principles:

(1) universality of health care actions and services;

(2) comprehensiveness of the health assistance;

(3) decentralization with a single system direction;

(4) social participation.

The health care universality caused an overcrowding of the in-place capacity at the public service and, therefore, the SUS allowed the accreditation of private hospitals to the health care network in an attempt to meet the generated demand.

With the creation of the SUS, the category "SUS user" was observed in the service reports of the Santa Casa of Mogi Mirim, unifying the service categories "the taxpayer" and "the indigent" or "free". The decentralization of resources also allowed the Santas Casas to make agreements directly with the city and state realms for the SUS's service provision.

In January, 1991, the ombudsman, Lúcio Ratz, informed the Mogi Mirim City Hall that the hospital was in a financial crisis that had been aggravated by the salary adjustments granted to the employees of the hospital and that the management bureau was willing to hand over the hospital to the city. After a committee of councilors was created to analyze the issue, some alternatives were presented to the public authorities and they opted for subsidizing the hospital costs, an action that had already been done in July, 1990. However, in January, 1992, new salary negotiations culminated in a three-hour stoppage of 70% of the operational framework in the hospital and the agreement to resume activities pointed towards a new financial crisis in the following months.

The Management Bureau of the Santa Casa and the Executive Power met again in search of a solution to the situation of the hospital and, in 1992, the "agreement of technical and management cooperation of the health care in Santa Casa" was born, an agreement between the City Hall, the State Department of Health (SES) and the Santa Casa of Mogi Mirim, which became known among the parties as Co-management.

The Co-management allowed the hospital to have access to other levels of financial resources through government grants, but the administrative board became 50% of its composition, elected by the Municipal Health Council and appointed by the Municipal Mayor. In addition to the mixed membership, the agreement implemented a relay system between the positions in the Co-Management Board and the Supervisory Board, in order to ensure fairness between members of the Irmandade and members appointed by the Public Power during the tenures.

Over the time, the government grants provided through Co-management were transformed into contracts for the provision of complementary services to the SUS, resulting in a new model of hospital management that allowed to monitor the meeting of the contracted targets. This new model brought with it several private partnerships that performed renewals at the hospital.

The membership composition of the Co-Management Board by means of a relay between members of the Irmandade and the public authorities lasted until 2003, because a new bylaw approved in January, 2004 defined that the hospital would be led by a board composed of members of the Irmandade and that, if agreements were made with the public authorities, representatives of the other party could be invited to take part in the board. This new statute did not strain the relationship between the Santa Casa and the public power, given that in 2005 the City Hall inaugurated an annex to the Santa Casa, built with public resources, to house the Unscheduled Care Unit (UANA), responsible for assisting medium complexity cases which had been so far carried out in Center of Medical Specialties (CEM) of Mogi Mirim. The Santa Casa was responsible for the management and operation of the UANA until the end of 2017, when the parties did not agree in renewing the contract.

In this period, other complementary agreements with the SUS were signed, in order to ensure a minimum number of elective surgeries within the city, remote duties of some specialties for emergency care, orthopedic ambulatory service, among others.

In 2010, the Irmandade adopted an expansion plan that included:

(1) the diversification of the number of insurances covered by the hospital through the accreditation of new ones and ending the service exclusivity of the Unimed health insurance;

(2) the attainment of a loan for the construction of 40 new inpatient beds for the private health insurances users, and for the purchase of a land plot adjacent to the hospital where the administrative center of the Santa Casa was installed;

(3) the implementation of outpatient clinics – the so-called medical centers – outside the hospital, one in Itapira/SP in 2011 and another in Mogi Mirim in 2012 for the new private health insurance users.

With the near end of the complementary care agreements with the SUS in 2011, the negotiation for the contract renewal with the City Hall assumed a confronting character due to the values claimed by the hospital and, after the mediation of the Public Prosecution Office, the agreements were renewed totaling an increase of 31.25% of the funds received by the Santa Casa. It should be noted that these values were not intended for investments, but were limited to the costs of the services supplied to the SUS.

However, the expansion strategy and the stance toughening during the renewal negotiations of the public and private insurance contracts resulted in the interruption of the assistance of Unimed users in the Santa Casa in mid-2012, causing a decrease of about 30% of the its revenue. Subsequently, the medical committee announced that the health assistance to SUS users would be interrupted due to the recurring delays in the money transfers related to SUS contracts.

Considering that Santa Casa was the only licensed hospital in the city to serve SUS users, the city council requested judicial intervention from the Public Prosecution Office, claiming that (1) the Santa Casa had received the whole amount of money related to the contracts with SUS, (2) did not inform the values to the medical committee and (3) did not deliver the accountability reports several times throughout that year. Although the Public Prosecution Office did not comply with the request for judicial intervention, the city council made an interdiction, in August, 2012, through a municipal decree that dismissed the Board of Directors and rendered the Statute and the internal rules of the hospital ineffective. The intervention was extended until November, 2012.

In 2019, with allegations of misuse of public money, non-payment of medical fees, suspension of assistance at the orthopedic outpatient clinic and the Neonatal ICU, the Public Prosecution Office determined a new partial intervention at the hospital: the City Council became responsible only for the assistance of the SUS insurance users. Shortly after the intervention, the city mayor informed the people of Mogi Mirim that the Santa Casa was no longer able to assist SUS users and announced the construction of a City Hospital that would meet the demand of all the users in the city.

However, this announcement catalyzed great political turbulence, since the construction of a City Hospital would depend on the approval of a bill that could amend the annexes of the multi-annual city plan. Even though the allies of the executive power in the city council constituted the majority of the councilors, doubts regarding the issue caused the bill poll to be postponed twice. During this period of postponement, two major events took place in May, 2019: a technical meeting with the Regional Health Board (DRS) of São João da Boa Vista organized by one of the councilors, and a public hearing summoned by the vice-president of the chamber in an attempt to clarify and better detail the City Hospital project.

The main goal of the technical meeting with DRS was to sign an agreement so the project would be framed as a regional hospital and, thus, obtaining funding from the state realm. But despite that, the regional director argued that in addition to the lack of significant evasion of patients from that DRS to others – indicating a demand higher than the supply of offered medical services – there was no program planned for the accreditation of new regional hospitals.

The public hearing which was proposed to explain and detail the hospital project also did not have the expected effects: the executive power first tier servers presented contradictory speeches, demonstrating the absence of an executive project, or an action plan, or even an estimated budget for the construction and operation of the City Hospital. Another argumentation line adopted by these servers addressed the fact that the Santa Casa was a private hospital and that there was a risk of the SUS insurances not being renewed with the Irmandade.

Of the 17 councilors, 16 were present at the public hearing and a considerable number indicated, in their pronouncements, the concern with the increase in public expenses – some presented figures from the neighboring city, demonstrating that the cost to maintain a City Hospital would be much higher than the values of the agreements with the Santa Casa. Other aspects highlighted by the councilors were the likely consequences agreement closure with the Santa Casa: the possible shutdown of a centenary institution in the city and the clamping of more than 200 jobs linked to the hospital operation.

There was a free pulpit at last part of the public hearing in which some representatives of the citizens of Mogi Mirim took the floor. The positions presented at this part can be summarized in three axes: (1) the resources that would be used to build a City Hospital could be invested to improve the infrastructure of the community health centers in the city; (2) the costs of a philanthropic private

hospital are lower than those of a public hospital; and (3) the awful experience in the installation of a City Hospital in a neighboring city that resulted in an obsolete and idle structure.

The absence of a viable project, the lack of political articulation with the state realm and with the chamber, as well as the popular pressure – either for investments in primary health care, or in defense of the Santa Casa – could not have a different outcome: at the beginning of June, 2019, the City Council ran the bill poll to amend the annexes of the multi-annual city plan and the project was rejected by 14 votes against 2.

Final considerations

Analyzing the interactions between the hospital care of the Brazilian health system and the Santas Casas from the historical perspective of the Santa Casa of Mogi Mirim allowed us to visualize how this relationship intensifies over the years.

During the nineteenth and mid-twentieth centuries there was no public health system which could assist the entire Brazilian population. While the wealthiest could afford private health care, the poor and indigent depended on the charity and philanthropy of the Santas Casas.

Nevertheless, with the agricultural economy giving way to the industrial economy, the emergence of retirement and pension funds and, later, retirement and pension institutes, the Brazilian health system began to serve a portion of the economically active population and intensified the care of a new category in the Santas Casas: the private patients. In addition to the free health care for the indigent, the Santas Casas began profit from these private patients, which led them to improve their facilities in order to attract this audience to the health care performed in the municipality itself, ensuring that patients did not have make large trips in search of more complex medical treatments.

The creation of the INPS and the accreditation of the Santas Casas to serve the INPS partners placed the philanthropic hospitals definitively in the hospital backup of the public health system and assisting all categories: the INPS partners, the other categories of workers, the private patients, the poor and the indigent. This period also brought a large volume of financial resources injected by the public authorities in Santas Casas in order to improve the service structure for INPS partners.

The crisis of the INPS/INAMPS system and the creation of the SUS not only brought financial independence in the health resources management by the cities, but also made them directly responsible for ensuring the full and universal assistance of the population. This led to new models of contracting services and health management. It is no longer just a matter of remuneration for contracted services, but of ensuring that such services are available to the population. The episodes involving the interventions of 2012 and 2019 and the possibility of building a City Hospital are clear examples of the political competition between public and private realms indicated by Bahia (2018), in which not only there is a dispute over material resources, but for a symbolic capital which is extremely valued by the city mayor:[6] "who is in charge of Health?". The studied case indicates not only the tendency to a more regulatory posture at the expense of a directly executor (Goya et al, 2016), but the need to establish political positions with the Irmandade itself to ensure the hospital backup necessary to the city.

The aim of this article was to analyze how the interaction between the Santas Casas and the Brazilian health system originated from the hospital backup. After verifying two municipal interventions in the hospital of the Santa Casa of Mogi Mirim in a period of seven years, it is emphasized that it is not only an interaction, but a codependence of the two parties: the Santa Casa needs to assist SUS users in order to ensure its existence – in the case of the Santa Casa of Mogi Mirim, SUS services represent more than 80% of its current revenue – while the City Hall needs the Santa Casa to assist the users because it is the only hospital in the city with the capacity to do so, since it lacks of available resources for building and operating a City Hospital.

6 The interventions of 2012 and 2019 and the attempt to build a municipal hospital were demanded by the same mayor, but in different tenures (2009-2012 and 2017-2020).

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Authors' contributions

Oliveira was responsible for the conceptualizing and designing the research, writing the paper and reviewing it critically. Neto and Donadone were responsible for approving the version to be published.

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