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The importance of the Unified Health System for improving Public Health

The importance of the Unified Health System for the improvement of Public Health

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Summary
The article aims to rescue the relevance of the Unified Health System (SUS) as a Public Policy that underpins the promotion and prevention of collective health. The methodology used was an integrative literature review based on the search for articles in Lilacs, MedLine and Scielo, using the descriptors: SUS, Public and Public Health and Health History. The descriptors were crossed to elucidate the implications of actions of health promotion and prevention to improve collective health.
Key words: Unified Health System, Public health, Community health planning, Total quality management.

Abstract
This article aims to rescue the relevance of the Unified Health System (SUS) as a PublicPolicy that underpins the promotion and prevention of collective health. The methodology used was an integrative literature review from the search for articles in Lilacs, MedLine and Scielo databases, using the descriptors: SUS, Collective and Public Health, History of Health. The descriptors were crossed to elucidate the implications of actions with promotion and prevention for the improvement of collective health.

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INTRODUCTION

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being and not just the absence of illnesses and diseases.[1]. A social right, inherent to the condition of citizenship, which must be ensured without distinction of race, religion, gender identity, political ideology or socioeconomic condition, health is thus presented as a collective value, a good for all. It is an expanded conceptualization that encompasses collective health.

Sanitarian Sérgio Arouca was one of the main theorists and leaders of the Health Movement, giving new meaning to Brazilian public health and constituting one of the pillars of health as a right to universal access present in the 1988 Constitution.[two]. Quoting Escorel[3], for Arouca, collective health was a process of social determination of health and illness, founding the conceptual bases of collective health in contrast to preventive medicine, which, at the time, was an educational activity, focusing on individuals, to the detriment of the community .

lime[4]explains that the Brazilian sanitation movement, launched during the First Republic (1889- 1930), explained the precarious health conditions of rural populations as being impediments to the civilizing development as a nation. The origin and trajectory of movement are related to the emergence of American trypanosomiasis or Chagas disease, discovered by the doctor and researcher at the Oswaldo Cruz Institute, Carlos Chagas, in Lassance (MG), in 1909. In line with Kropf[5], in October 1916, Carlos Chagas and the Brazilian delegation, upon returning from a medical congress in Buenos Aires (Argentina), were welcomed and honored by the medical profession as recognition for the representation of national science abroad, in addition to the discovery of trypanosomiasis, a disease that affected the population.

For Paim[6]The study of the Brazilian Health Reform (RSB), within the scope of health sciences, is essential for understanding the history of public and collective health. According to Nunes[7], the history of Public Health in Brazil can be divided into three periods. The first, called the pre-

- Public Health, was from 1955 to 1970, and was marked by a preventive project. The second, in the 1970s, it was called the social medicine phase. The third began in the late 1970s and is referred to as Public Health itself. With the advent of the health emergency caused by the new coronavirus at the end of 2019, actions and debates about measures to contain the spread of the disease and, to this end, the implementation of procedures aimed at collective health became pertinent. According to Ocké-Reis[8], on 03/11/2020, the WHO declared the acute respiratory infection caused by the SARS-CoV-2 virus, responsible for Covid-19, as a pandemic. As the disease progressed in Brazil, measures were adopted to mitigate the spread of the disease, such as isolation and restriction of non-essential activities. Thus, in addition to the health crisis, the population began to suffer from the economic collapse. The drop in income and unemployment, combined with the resurgence of the pandemic, further burdened demand for the public health system.

Therefore, strategies for implementing health care measures in the face of an underfunded public system that is constantly demanded on a large scale, required a reorganization of activities aimed at promotion and prevention - use of masks, respiratory etiquette, social distancing, mass immunization - less expensive, reversing the hospital-centric logic, more expensive for public coffers and less efficient for the population's health. In this way, the pandemic evoked the importance of collective health as an appropriate procedure for health care for the community.

The importance of SUS for improving collective health

The history of health in Brazil began with activities carried out by philanthropy, of a religious and charitable nature. The population was assisted by philanthropic institutions and doctors. At the same time, the government carried out specific actions in the face of epidemics, such as vaccination and basic sanitation. At the end of the 19th century and beginning of the 20th century, a smallpox vaccination campaign took place. The State also intervened in neglected diseases such as mental health, leprosy, tuberculosis, among others. Later, we started providing emergency services and general hospitalizations.

Braga compliant[9], traditional, campaign-based public health was organized by limited programs in view of the population's health needs, reduced financial capacity and the high cost resulting from the adopted technical requirements, using a centralizing, vertical logic, and in addition to standardization that produced harmful effects of disarticulation with state services.

With the Elói Chaves Law of 1923, workers' health linked to social security became part of a system for workers. Initially, the pension funds, then the institutes and, finally, the National Social Security Institute (INPS). The Special Public Health Services (SESP), later transformed into the SESP Foundation, served rubber and manganese extraction workers. It was the most complete health care program associated with sanitation in the country. Its structure included a multidisciplinary team, based on mixed units where basic care, first care, urgent and emergency care and hospital admissions were provided.[10].

It is worth highlighting the milestone represented by the 3rd National Health Conference in 1963, which encompassed several studies to create a health system for all (health as a right) and organized decentrally (protagonism of the municipality). From the perspective of Teixeira et al.[11], the health movement has a socializing perspective on the problems highlighted by the crisis of commodified medicine, as well as its inefficiency.

However, the military dictatorship that began in 1964 buried the proposal a few months later, with some privatization projects such as Vale Consulta and, for the most vulnerable regions, it implemented a reissue of the SESP Foundation, the Health Actions and Services Interiorization Program (PIASS).). In a clandestine way, organizations such as popular movements, universities, political parties, among other protagonists, outlined the pillars of a comprehensive and universal public health system.

In the 1980s/90s, health surveillance materialized as an alternative care model to the hegemonic medical-welfare and health-campaignist models, by proposing restructuring practices

health through the incorporation of interdisciplinarity, articulating knowledge of epidemiology, planning, communication and education, policy and management, geography and organization of services [12].

In 1973, the National Immunization Program (PNI) was created, which represented the outcome of a series of initiatives by the Ministry of Health in the area of disease control, influenced by the creation of the Medicines Center (CEME), two years earlier, in 1971. , responsible for implementing pharmaceutical assistance policy in the country. Before that, the administration of immunobiologicals was carried out in different ways, with greater or lesser participation from the federal government, since, in 1941, the administrative reform had assigned control of some communicable diseases to federal policy and vaccination against these diseases became a priority. managed by autonomous bodies, which were committed to the production, technical standardization and use of products. BCG and yellow fever vaccines were the responsibility of the national tuberculosis and yellow fever services. Other vaccines, not linked to national services, were under the responsibility of the network of health centers, generally administered by state governments, although there were also autonomous networks, such as the SESP Foundation, present in all states. The federal government technically cooperated and supported the supply of vaccines, but insufficiently and irregularly. The possibility of expanding vaccination coverage depended on the initiative of state governments. Federal action was episodic, driven by international commitments, such as the control of smallpox or the emergence of new vaccines, such as those for polio and measles, as early as the 1960s. The Smallpox Eradication Campaign (CEV) and the National Plan of Poliomyelitis Control (PNCP) had as their basic strategy the extensive vaccination of the population and required close collaboration from the health services network, in this case, organized and directed by technicians from the SESP Foundation. In the case of smallpox, an epidemiological surveillance system for the disease was organized from 1969 onwards. But as the campaign came to an end, there was concern about maintaining routine vaccination, to ensure that coverage remained high. The PNCP was conceived in 1971 and was greatly influenced by the experience of the CEV, having sought to improve the mass vaccination strategy, with integrated institutional and social mobilization efforts in the states[13].

The Brazilian public health system arose after decades of struggle by a collective called the Health Reform Movement and culminated in the creation of the SUS in 1990. It was established by the Federal Constitution (CF) of 1988 and consolidated by Laws nº 8,080 and nº 8,142[14.15]. It is stated in the CF, in art. 196 that "health is a right for everyone and a duty of the State, guaranteed through equal access to actions and services for its promotion, protection and recovery"[16], and, in art. 198, "comprehensive care with priority for preventive activities, without prejudice to assistance services"[16].

Furthermore, Risi[13], reiterates the valuable work of immunization programs as they allow the appropriation of Brazilian demographic reality, sizing different geographic territories and expressing the performance of public health. This process was more successful in combating the vectors of yellow fever and malaria and had international cooperation, especially from the Rockefeller Foundation.

The expansion of criticism of the project of preventive and community medicine and the offer of ideas around social medicine made it possible for, in the 1970s, new training projects to be proposed, triggering the expansion of the political-social debate. In 1976, the Brazilian Center for Health Studies (CEBES) was created, and, in 1978-1979, the Brazilian Association of Postgraduate Studies in Public Health (ABRASCO) was organized, institutions articulated and engaged in the health debate, with the the first focused on political articulation, and the second, dedicated to the academic-training project. The debates proposed a socializing project for the State[17]. In 1979, CEBES produced the 1st National Health Policy Symposium, indicating the "right to health as a universal and inalienable right" and approving it as a principle[18].

According to Carvalho[10], the social security crisis in the 1980s caused the need to create a more robust association between the National Institute of Medical Assistance for Social Security (INAMPS) and public health services. Thus, the Integrated Health Actions (AIS) were conceived, which consisted of a partnership between social security and municipal and state public health; provision of care, mainly primary outpatient care; transfer of social security resources so that these actions could be carried out by States and municipalities. From 1987 onwards, the AIS were improved with the so-called Unified and Decentralized Health System (SUDS), which lasted until 1991 when it gave rise to the SUS. The Health Reform Project culminated, in 1986, with the holding of the 8th National Health Conference, in Brasília, which was attended by around

of five thousand people from all over Brazil, some of which are users. The proposal endorsed by the population and workers was delivered to the constituents who added the majority of recommendations to define the Social Order and, within it, Social Security.

According to Freitas[19], Health Surveillance as a care model, acts in the intervention of health problems, emphasis on those that require continuous attention and monitoring, operationalization of the concept of risk, articulation between promotion, prevention and assistance actions, with intersectoral action and over a territory; Therefore, it values the regionalization and hierarchization of services, operating under the principle of integrality. Paim[20]points out that the surveillance system must have information structures to support decision-making, planning and constant evaluation of interventions carried out on local health problems.

Paraphrasing Brito[21], the conception of the SUS, driven by the promulgation of the Magna Carta, in 1988, and established with the publication of the Organic Health Laws, in 1990, was an important achievement for social rights in Brazil. However, it revealed the complexity of the country's epidemiological situation, characterized by the triple burden of diseases in the population: persistence of acute diseases; increase in the relative weight of chronic conditions; and external causes. The SUS also constitutes a major social policy, the result of the struggle for the resumption of the so-called Democratic State of Law[22].

Public Health emerged from the need to create and apply actions aimed at controlling and preventing diseases that annihilated urban populations during the Industrial Revolution. While cities expanded haphazardly, communities were affected by infectious diseases, along with the absence of basic sanitation. With this scenario, the conduct of practices aimed at preventing diseases were relevant for public and industrial managers as they directly affected the population's production and economic development rates.[23].

Despite the robustness of the SUS structure, with a view to universal and equal access, the guarantee of health equity is still less than desired[24]. In this way, it is clear that it is utopian to detach public policy from effectiveness, because its purpose is not limited to effectiveness, but rather to efficiency in serving society.[25].

Guimarães et al.[26]explain that the activities contained within the scope of collective health consider the analysis of the health situation and living conditions and the territorial basis for proportions about the problems and needs identified. The territory brings together an articulated and inseparable set of objects and actions that allows them to understand the dynamics and constant movements, and, consequently, as a process in permanent construction/ reconstruction. Health policy priorities in Brazil are based on the morbidity and mortality profile of the country's various states and municipalities, with wide variations between regions. With data such as estimates of incident cases, epidemiological information can be provided that is fundamental for planning health promotion, early detection and diagnosis actions at all levels, in order to recognize regional inequalities caused by differences in development, being crucial to decentralize actions so that they become more effective and targeted.

FINAL CONSIDERATIONS

The conception and implementation of the SUS arose from historical struggles between different social segments. In addition to a health and assistance system, it was structured as a public policy, capable of providing health care in a universal, egalitarian, equitable, comprehensive manner and through popular participation.

Making efforts to adequately finance the SUS through collective actions that aim to maintain the health and quality of life of the population constitutes an elementary measure as a public policy. The State's responsibility for providing health as an inalienable right is based on the 1988 Citizen Constitution.

Undoubtedly, ensuring health promotion, prevention, recovery and rehabilitation activities are procedures that enable basic public health care. Furthermore, knowing and recognizing social determinants in different health territories favors the organization of programmatic, specific and targeted operations for health care in different Brazilian communities, promoting collective health. However, it is imperative to assert that investments

in public policies that ensure access to health, education, food, housing, work and income, transportation, safety and basic sanitation for the population, which constitute elements that directly affect the complex definition of health proposed by the WHO.

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