

Reflections on the Unified Health System and the *Servizio Sanitario Nazionale*: the reform of the reform – the adoption of *Ticket Sanitario*¹

Reflexões sobre o Sistema Único de Saúde e o *Servizio Sanitario Nazionale*: a reforma da reforma – a adoção do *Ticket Sanitario*

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Abstract

From the comparison performed between the institutionalization of *Servizio Sanitario Nazionale* (SSN), in Italy, and the Unified Health System (SUS), in Brazil, both based on the philosophy of the right to health and under the aegis of the State, the article aims to analyze the reform implemented by SSN, which introduced the co-participation of the user in the cost of care, upon payment of the *Ticket Sanitario*. If on the one hand this reform aimed to tackle the fiscal crisis, on the other, it brought serious consequences to the life and health condition of the Italian population. Using also the methodology of comparison between health systems, the study draws attention to the adoption of reform proposals, now by the SUS. The proposals presented by the documents “Agenda Brasil” and “Uma ponte para o futuro”, targeting the selective charge for care, decharacterizes SUS when institutionalizing differentiated entrance gateways. This way, as happens with the Italians, the fiscal crisis imposes, now, on the Brazilians, the disrespect to the right to health. **Keywords:** Health Systems; Reform of the Health Systems; Right to Health.

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Resumo

A partir da comparação realizada entre a institucionalização do **Servizio Sanitario Nazionale** (SSN), na Itália e o Sistema Único de Saúde (SUS), no Brasil, ambos cunhados na filosofia do direito à saúde e sob a égide do Estado, o artigo objetiva analisar a reforma implementada pelo SSN, que introduziu a coparticipação do usuário no custo do cuidado, mediante pagamento do *Ticket Sanitario*. Se por um lado essa reforma visava combater a crise fiscal, por outro, trouxe graves consequências para a condição de vida e saúde da população italiana. Utilizando-se, ainda, da metodologia de comparação entre sistemas de saúde, o estudo alerta para a adoção de propostas reformistas, agora pelo SUS. As propostas apresentadas pelos documentos “Agenda Brasil” e “Uma ponte para o futuro”, visando a cobrança seletiva por atendimento, descaracteriza o SUS ao institucionalizar portas de entrada diferenciadas. Dessa forma, assim como os italianos, a crise fiscal impõe, agora, aos brasileiros, o desrespeito ao direito à saúde.

Palavras-chave: Sistemas de Saúde; Reforma dos Sistemas de Saúde; Direito à Saúde.

Introduction

When it comes to Health Systems, one could mention big bang and incremental type reforms. The so-called big bang reforms are those which introduce significant changes in the operationalization of systems; incremental reforms, on the other hand, are based on small successive adjustments (Viana; Dal Poz, 2005).

The establishment of the *Servizio Sanitario Nazionale* (SSN), in Italy, through Law No. 833 from 1978, is considered a big bang type reform. This law introduced a new operative systematics to perform not only curative and rehabilitation actions, but also preventive actions, in order to increase the individual and collective well-being. In its first article, the law, in a clear reference to article 32 of the Italian Constitution (Italy, 1947), appoints the Repubblica, i.e., the Italian State, as the one responsible for the protection of health - a fundamental right of the individual and of collective interest. The law also states that the protection of physical and mental health should respect the dignity and freedom of human beings (Italy, 1978). Berlinguer, Teixeira and Campos (1988) note that this law expressed the increasing demands of mobilization of the people and workers. According to the authors, with this law the real process of reform would not be complete, but only initiated.

In Brazil, the creation of the Unified Health System (SUS) is also considered a big bang type reform. The Federal Constitution of 1988 and the infra-constitutional standards that followed it, Laws No. 8,080 and 8,142, both from 1990, established a new national health system model, marked by the principles of universality, equity and comprehensiveness as well as under the organizational logic of regionalization and tiering, decentralization and community participation. For Fleury (1997), the material expression of the Health Reform was achieved in the search of the universal right to health and in the creation of a single system under the aegis of the State.

Dallari (2008) draws attention to the unprecedented phenomenon of significant popular participation, in the late 1980s, in the definition of the

most important constitutional objectives. During the 8th National Conference of Health, a new health policy is formulated, giving rise to a proposal for popular amendment which was submitted to the Constituent Assembly.

In fact, the Federal Constitution of 1988 recognized health as a fundamental right of the human being and bound its obtaining to social and economic policies, aiming at the reducing of the risk of diseases, and at the ensuring of universal and equal access to actions and health services geared not only towards its recovery, but also towards its protection and promotion.

The Italian Health Reform should be understood, according to Berlinguer, Teixeira and Campos (1988), as a reform for health, implying a deep transformation in social life. More than a privileged action field to provide better care to the Italians, it is an opportunity to unite them in a work of renewal. Cohn (2009), when reflecting on the contents of the Brazilian Health Reform, observes an emancipating national project. Thus, the fact of a resemblance between the reforms is confirmed, which is not random. As institutional expression of the Brazilian Health Reform, SUS, among other references, was inspired by the process of change in the Italian health system.

Methodology

Giovanella and Stegmüller (2014) note that the comparative analysis between countries is a classic resource of political science, being employed to study regimes and institutions. In public policies, comparison with operating purposes of structures and institutions and, more recently, for getting to know the determining factors of performances, is common. Thus, the analysis of the reforms implemented by the SSN, especially those geared towards the market, can serve as a warning to the SUS, in view of the serious consequences to systems which propose themselves as universal.

In recent decades, in light of the economic, demographic, epidemiological and political pressures, the health systems of European countries went

through repeated reforms. Particularly, during the 1990s, accompanied by neo-liberal economic policies, reforms were disseminated, introducing market mechanisms for the increase in competition in public health systems (Giovanella; Stegmüller, 2014, p. 8).

This article aims to analyze the incremental reform implemented by the SSN, which introduced the coparticipation of the user in the cost of care, upon payment of the *Ticket Sanitario*.

Results and discussions

In Italy, a *riordino* may be observed, i.e., a reordering in the SSN (Levaggi, 1999). This incremental reform modified the structure of the health system by separating the function of acquisition/purchase from the function of provision of services, also changing the funding of the system, which starts having the co-participation of the user in the cost of care, upon payment of the *Ticket Sanitario* (Levaggi, 1999).

Ticket Sanitario represents a share of direct participation of citizens in public spending, as a counterpart to the healthcare provided by the State. For Levaggi (1999), if on the one hand this change is interesting from the point of view of rationalization of expenditure, on the other, it causes some discomfort in what concerns the philosophy of a public system, inspired by solidarity and equal access to health care.

In a time of reducing of resources available for the financing of health expenses, in Italy, the adoption of the *Ticket* system was seen as a means to avoid the increase in expenses, avoiding the waste of public resources (Levaggi, 1999). Thus, the *Ticket* appears for the first time in the Government of Mita, in 1989, as a means by which the citizen must co-participate in the costs of medical services (Italy, 1989).

According to Balduzzi and Carpani (2013), the crisis in public finances, the fiscal crisis in the early 1990s, was responsible for determining a global reorganization in the Italian Welfare State, starting with health through the SSN. In this sense, Law No.

421 from 1992 and Decrees No. 502 from 1992 and No. 517 from 1993, which followed it, pointed to the need for regionalization of the system. Thus, Region becomes the center of the health care system.

The decrees also introduced the notion of levels of care, in order to delimit the benefit provided by the *Repubblica*, pursuant to art. 32, supported by the SSN, and those which are not provided by it and that, therefore, would be responsibility of the people seeking to benefit from them. The equation between care levels and volume of available resources was motivated by the need to maintain a relationship of compatibility between the expansion of demand and financing, within the framework of a programming oriented towards what is possible and not towards what is ideal (Poli, 2007).

However, Chieffi (2001) warns that the selection of priorities of access will lead, inexorably, to tragic choices, which will exclude certain services that are not considered essential, depriving a portion of the population of the required health care, contrary to the principles of the universal health systems.

The system of co-participation in health costs establishes that only citizens in special economic and health conditions will be entitled to free health care. Everyone else should share with the State the cost of health care on the basis of family income. Therefore, citizens were classified into three categories: exempt, partially exempt and non-exempt. Thus, the cost of care for the health system will depend not only on the needs, but also on the economic situation of the user (Levaggi, 1999).

Article 8 of Law No. 537 from 1993 presents general guidelines for the use of the *Ticket*, but over the years, several legislative measures have changed the nature and method of the use of the *Ticket* system. From 2001, the responsibility for the standardization of the use and payment of the *Ticket* was delegated to regional authorities, and therefore, vary from region to region (Atella et al., 2013). Thus, who is most affected by the reduction of public funding in the regional health systems is the citizen, in the regions where the budget deficit is higher (Collicelli, 2013).

Currently, the *Ticket* is intended for three types of health care: emergency care, white and green

codes (not classified as emergencies), with a base rate of 25 euros, some categories of medicines, specialized consultations and diagnostic exams (Tasse-fisco, 2015). It is worth mentioning that there are exemptions applied to pregnancy, chronic diseases, people with disabilities or who seek diagnosis in relation to the Human Immunodeficiency Virus (HIV) and cancer (Tasse-fisco, 2015).

Citizens over the age of 65 are also exempt from the payment of the *Ticket*, although there is a debate about the ceasing of the exemption, in view of the increase in the life expectancy of Italians (Il Messaggero, 2015). No wonder that, in what concerns well-being and health, apprehension is high. According to the *Censis*, disease is for 38.4% of Italians the most worrying problem for the future (Collicelli, 2013). After all, as observed by Giovanella and Stegmüller (2014), the co-payment system implies the transfer of responsibility of State funding to the families.

Within this context, Levaggi (1999) notes that those who pay the *Ticket*, in fact, realize the high cost of care, but are not convinced of having received a better service. On the other hand, Collicelli (2013) shows, based on data from *Monitor biomédico*, that about 18% of Italian citizens had to forgo, for economic reasons, dental consultations or those of specific nature. In this sense, Atella et al. (2013) report that the use of cost-sharing tools can result in major redistributive problems, with consequent deteriorating of the health of Italians.

If the *Ticket Sanitario* system was introduced to fix the increase in government expenditures on health, nowadays it represents a significant portion of the funding, and it tends to become even more important, with the result of the new incremental reforms that make it possible to resort to the *Ticket* even for obtaining hospital services (Levaggi, 1999).

Other European countries, such as England, Spain and Germany, in light of the strong financial pressure resulting from the economic crisis started in 2008, also adopted policies that followed the same prior strategies of “market-oriented reforms” and which deepen regulated competition, with separation of functions between funders/purchasers and providers of services in the national health systems (Giovanella; Stegmüller, 2014).

The SUS, in Brazil, has also been going through a lot of incremental reforms. The most recent one, Decree No. 7,508, from 28 June 2011, brings with it the paradox of wanting to regulate Law 8,080, enacted 21 years before, in 1990. In this sense, it rules over the organization of the SUS, health planning, health care and the federative coordination. The decree also deals with the establishing of health regions. It is in the health regions that the integrality of care should happen.

As a result, the decree introduces the Organizational Contract of Public Action in Health (COAP), which has as objective the organization and integration of actions and health services under the responsibility of federal entities in a Health Region, to ensure the integrality of the care to the user (Brasil, 2011). In this manner, as in Italy, a strong movement towards regionalization of health may be noted, although in Brazil this movement has not yet been put in practice.

Another possibility of incremental reform for the SUS was presented in August 2015. Renan Calheiros, president of the Senate, and the economic team of Dilma Rousseff's government have disclosed to the country "Agenda Brasil" (2015), a document divided into 4 axes: Improvements in the Business Environment, Fiscal Balance, Social Protection and Administrative and State Reform. In the Social Protection axis the following proposal is made:

Evaluate the possibility of differentiated charging for procedures of the SUS by income range. Consider the income ranges of the Declaration of Individual Income Tax.

It is interesting to note the similarity of the proposal presented with the *Ticket Sanitario* system, from Italy. Thus, the same crisis mentioned by Balduzzi and Carpani (2013) - the fiscal crisis - now imposes, on the Brazilians, the disrespect to the right to health. In this sense, health-related entities such as the Brazilian Association of Public Health (Abrasco), the Public Health Association of São Paulo (APSP), the Brazilian Center for Health Studies (Cebes), among others, presented the "Carta à Presidente Dilma Rousseff e à sociedade - Nota Pública Sobre o SUS e a Agenda Brasil" (Letter to

Dilma Rousseff and to society - Public Statement on the SUS and Agenda Brasil) (2015).

Through this letter, the entities questioned the proposal of dismantling of the SUS, in the name of the overcoming of the political and economic crises, but with serious consequences for the health of the Brazilian population. According to the letter, the selective charging for care decharacterizes the SUS when institutionalizing differentiated entrance gateways for the rich and the poor. The entities stressed that the institutions and the law should not structure the SUS only, but also protect the right to health. And that, when copayments are considered as stable sources of revenue, the debate on the appropriate funding for the health system is avoided. After these manifestations, this point of discussion ended up being removed from "Agenda Brasil".

However, the interests aimed at the destruction of the SUS as an emancipatory project (Cohn, 2009), as an universal, integral system with good quality, still persist. In this manner, the document "Uma ponte para o futuro" by the Brazilian Democratic Movement Party (PMDB), in October 2015, says: "O Brasil gasta muito com políticas públicas com resultados piores do que a maioria dos países relevantes" (PMDB, 2015, [n.p.]). (Brazil spends a lot with public policies with worse results than most relevant countries.)

Thus, the analysis and the proposals of the document presented by the PMDB to the country, in what concerns social policies, do not differ from what was presented by "Agenda Brasil". Once again, to face the tax issue and on behalf of a "real budget", it is proposed to disassociate the resources ensured in the current system from health financing (Marques, 2015). In this sense, the document suggests that health and education are not priorities in the range of values of the Brazilian state and that their access should be ensured more and more in light of the individual income of each citizen or family (Marques, 2015). Thus, through suffocating (sub)financing, the goal is to make the SUS a system of low quality, destined only to those who cannot pay.

This idea is based on the proposal of Universal Health Coverage, designed by the Rockefeller Foun-

dation and seized by the World Health Organization (WHO). It promises giving universal access to health services, but separating the rich from the poor according to how much they can pay. Those who are richer, and who can thus afford it, would have access to more services, while the middle class and the poor would have access to basic services only, which certainly will not cover their needs (Cebes, 2014).

Final considerations

Unfortunately, now, with the reality of Michel Temer's government, from the PMDB, the proposals presented by "Agenda Brasil" and "Uma ponte para o futuro" have greater chances of being put into practice. As in Italy, citizens will be the most affected, since such proposals interfere directly on the life and health condition of the population.

In countries that have acquired a robust social protection system, the proposal might be appropriate, but in countries that have failed to provide minimum social protection to its population, like Brazil, such a proposition is almost inhumane, especially having as parameter the search for the universal right to health. Thus, the proposed debate traverses several axes of discussion, such as, for example, the financing of the health system, universal system × universal coverage, the relationship between the public and the private, economic development × health protection.

Within this context, the following debate is proposed: should Brazil adopt the copayments system?

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Authors' contribution

Oliveira worked in the design, data collection and analysis and writing of the article. Dallari was the advisor, collaborating also with the critical review and approval of the version to be published.

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