

The fragmentation of the universal healthcare systems and the hospitals as its agents and outcomes

A fragmentação dos sistemas universais de saúde e os hospitais como seus agentes e produtos

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DOI: 10.1590/0103-110420195508

ABSTRACT This essay is aimed at producing a critical analysis on the contribution of hospitals to the fragmentation of the universal healthcare systems, considering them both cause and a consequence for such phenomenon. The misconnection between hospital and primary healthcare seems to be an important cause capable of perpetuating the phenomenon of fragmentation. The austerity agendas, quite common to less virtuous economic cycles, may also contribute to the worsening of such phenomenon. This essay might be able to contribute to the broadening of such debates as for possible resolutions regarding the future sustainability of universal health systems, in order to offer a different proposal than the 'health system reform' so concentrated on the acclaimed 'universal coverage' model of healthcare systems.

KEYWORDS Health systems. Universal Health Coverage. Hospitals.

RESUMO *Este ensaio propôs-se a produzir uma análise crítica sobre a contribuição dos hospitais para a fragmentação dos sistemas universais de saúde, considerando-os causa e consequência desse fenômeno. A desconexão entre a atenção primária à saúde e os hospitais parece ser importante elemento causal capaz de perpetuar o fenômeno da fragmentação. As agendas de austeridade, comuns aos ciclos econômicos menos virtuosos, podem agravar esse fenômeno. Este ensaio pode contribuir para ampliar as discussões quanto a possíveis soluções para a sustentabilidade futura dos sistemas universais de saúde, para além do lugar comum da proposta de 'reforma dos sistemas de saúde' centrada na transição para o modelo de 'cobertura universal'.*

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Introduction

Hospitals play a complex role by acting as agents or as protagonists in the process of fragmentation of universal health systems. They are also products of this phenomenon, which, to a greater or lesser extent, affect even mature and consolidated health systems¹.

Fragmentation in universal health systems is an analytical element taken as a target of investigative efforts to understand its genesis and its relevant causal factors, especially regarding its repercussions on the perspectives, challenges and sustainability of the health system model under discussion.

Thus, this essay aims at producing a critical analysis on the contribution of hospitals to the phenomenon of fragmentation of universal health systems, considering ‘the hospital’ as the cause and consequence of this phenomenon.

Contemporary understanding of the role of hospitals in universal health systems, which is in line with reports of successful experiences, points to the abandonment of the objective image of the hospital as ‘the last link in the chain’ of systems, for its full integration and synergy with services crucial to achieving better health outcomes, such as Primary Health Care (PHC)¹.

Universal Health Systems are the result of the political, social and economic contexts that originate them. Public policies were and still are the instruments of translation and formalization of the wishes of societies that have chosen and pursued the consolidation of social welfare principles translated by guarantees of social protection, including the right to health.

The paths taken by the unification of the German State and the consequent spread of the logic of ‘social insurance’ throughout continental Europe in the late XIX century; the organization of the first universal health system by Lenin, after the Russian Revolution (1917); the proposition of a universal health protection policy by the

‘Dawson report’, in the early XX century, which resulted in the ‘Beveridge report’, the foundation for the post-WWII British National Health Service (NHS), after the Second World War (1948), demonstrate the path of maturation of universal health systems as a bet and provoke discussion as to their viability and sustainability¹.

Such models of health systems under analysis originate in times of great social distress, marked by the lack of resources and the lack of State policies dedicated to guaranteeing minimum priority efforts and protecting these societies undergoing rapid transformation.

Universal health systems have experienced successive decades of recession in global capitalism, especially in the first half of the twentieth century. They also went through further recessive cycles, which, although shorter, were also marked by important economic debacles, followed by cycles of recovery and stability.

In Latin America, it is important to highlight the expansion and impact of health actions triggered by universal systems from the revolutionary experience in Cuba (1959) and the construction of the largest universal health system in the world, in Brazil (1988), the Unified Health System (SUS). In the early 2000s, when progressive governments prospered a virtuous set of state policies on the American continent, there was a significant strengthening of universal health systems, as one of the stakes to overcome the serious regional socioeconomic problems stemming from brutal inequalities in distribution’s income².

Countercyclical economic moments, marked by the structural crises of global capitalism, affect nations that experience the application of the most distinguished frameworks of economic thought and development. This context has posed complementary risks to the sustainability of universal health systems, whose main threat lies in the measures resulting from austerity policies,

commonly applied in economic development environments that aim to meet the expectations of the main market players³.

A major contemporary threat to universal health systems, potentially inducing fragmentation, arises from the context presented. 'Universal coverage' has as basis a reformist agenda of the founding principles and guidelines of universal systems, such as the SUS, placing on the table a proposal to reduce the scope of its most relevant civilizing premises, purposes and commitments, such as universality, integrality of care and equity³.

Hospitals made up this path of development of universal health systems, but they precede them as a human initiative in favor of health, since the first records of these services are from ancient Egypt, although not similar to the hospital stereotype prevailing in modern societies⁴.

The enlightenment period marked the transition from health care based on religious benevolence to the beginning of the predominance of technical and scientific contributions, with the gradual conversion of focus from the suffering of the underprivileged to the production of a human practice committed to the application of acquired scientific knowledge. The emergence of the modern hospital induced changes in the means to provide health, which made these establishments the preferred places of care. The protagonists of care were also transformed or replaced by scientific knowledge, an inducing element of the delimitation of the field of knowledge and practices and, consequently, of the draft of precursor health professions, such as medicine and nursing⁴.

The beginning of the XX century delimited what would be a milestone in the process of health professionalization as an area of knowledge, the result of scientific development, as seen in the 'Flexner report' (1910). This process was greatly influenced by the ongoing Industrial Revolution, which accelerated the demarcation of professions and even the heyday of medical specializations

as areas of private professional knowledge⁵.

Hospitals have always been fertile ground for sowing any and all new human technological device applied to health and ended up materializing within themselves the expectations and desires that capitalist societies have also been able to weave for health services and systems.

It is interesting to note how the health itineraries of the bourgeois classes of the late XIX century and first half of the XX century took place. Usually, they were more focused on moving doctors to their families, assisted in their homes. These itineraries have undergone drastic reformulation, since, predominantly and in spite of the existence of offers, as foreseen in PHC and related models, families continue to move in search of the place that they recognize as capable of caring for their health par excellence, the hospital⁶.

The elements presented so far are relevant for the semantic and situational understanding of the contexts in which the phenomenon of the fragmentation of universal health systems is inserted. They are also fundamental for the delimitation of problems and the understanding of their relationships, as well as for the formulation of hypotheses and questions pertinent to addressing the challenges, perspectives and sustainability aspects of the universal systems addressed in this essay.

By aiming to produce a critical analysis of the contribution of hospitals to the phenomenon of fragmentation of universal health systems considering 'the hospital' as the cause and consequence of this phenomenon, this article, produced in the form of an essay, makes use of a dialogical effort to promote connections and cognitions between important theoretical references in the literature (scientific and gray) and experience reports, which have been offered by authors, managers and national authorities of universal health systems, as well as transnational health institutions and/or agencies.

However, it is not intended to exhaust this objective, but merely to induce the sequence

of this investigation, with a view to contributing to this discussion, which seems decisive for the sustainability and future prosperity of universal health systems.

The challenge agenda of universal health systems in the face of hospital fragmentation forces

Everyday elements create pressure and operational threat to universal health systems in all countries of the world. Therefore, they are challenges with characteristics of independent variables and a certain externality, which cannot be intervened, besides planning how to best organize the production and care management of individuals and populations.

The more it develops and the more dignified the living conditions of the human species become, the greater its longevity, an expectation that has always been longed for, but which exponentially feeds back the magnitude of the challenges of global health systems⁷. Half of human beings who have had the opportunity to live 60 years or more enjoy their existence today. To live even more and better, they will need health conditions that preserve their cognitive and motor autonomy, to maintain the possibility of performing their daily life activities, important sources of well-being, motivation and happiness⁷.

Human development also offers another major challenge to universal health systems: the consistent and accelerated epidemiological transition, manifested by a growing global burden of chronic conditions and non-communicable diseases, to the detriment of the previously prevalent infectious disease burden. This challenge imposes the necessary remodeling of health care strategies, actions, practices, monitoring and evaluation, since the predominant care models continue to reflect health needs that are very focused on acute conditions⁸.

The major issue is that care models designed for predominantly acute conditions remain very focused on care practices that are no more comprehensive than the colloquial ‘complaint and conduct’, quite unsuitable for health conditions that will require a long-term longitudinal standard of care of time – almost always for life, beyond the production of relevant autonomy for self-care⁹.

Over and above these two great challenges offered by the celebrated human development, effect of great learning promoted by the dissemination of tested practices in universal health systems, those undeniably intrinsic to these systems, chronically affected by the phenomenon of fragmentation can be found, to a greater or lesser extent.

The already commented and unsophisticated over-specialization of health professions, with special emphasis on medicine, has assumed an inertial pattern, and at the same time affects other health professions in a similar way. It is itself an asset capable of producing an undesirable segmentation of the caring individuals, so that it may be a rare event to find the health professional (individual or collective) who has a full view of the history of a given health condition, which determines, in a way, the *modus operandi* of health systems¹⁰.

Over-specialization finds its usual locus in health services with higher technological concentration and supposedly knowing, which would be enough to solve a significant part of health problems. Thus, in this context, it can be inferred that hospitals would act as inducers of the phenomenon of fragmentation of universal health systems¹¹.

This hypothesis is currently reinforced, since there are vectors of development of medical practices pointing to concepts such as ‘scientific-technological medicine’, in which the face-to-face care of patients begins to give way to ‘telecare’ practices, in the form consultations and even remote (*praxis*) surgical procedures. As a reinforcement of this assumption, it is worth mentioning that, due to economies of scale and better use of available

resources, the ‘telecare’ offered is based on hospital teams whenever possible¹².

It is perceived, with that, a relative hospital self-sufficiency, a construct that has prevailed as a common sense of the health professionals of these services and those who need it, or they exclusively think need it. The practical result is a deep and almost insurmountable disconnect between the hospital and other health strategies as fundamental as PHC, for example. This can be verified by the infrequent accomplishment of safe transfers of hospital services, for continuity of care in PHC, after health events that have passed through the hospital door due to some real need or not¹².

Here there is one more contribution to the role of hospitals in the phenomenon of fragmentation of universal health systems. By not recognizing that care production and management is necessary before the user arrives at the hospital and after hospital discharge, hospital staff and managers are not encouraged to know, implement and improve technologies that allow these connections with other health network care offering points¹².

There is no more emblematic example of the fragmentation that hospitals are capable of producing within themselves than the phenomenon of overcrowding. Prevalent in units that have Hospital Emergency Services (HES), it is precisely the fragmentation of care that makes the guarantees of connection between the various hospital services, necessary to produce effective care in a timely manner. This ends up storing a large volume of patients, beyond what would be necessary and desirable in HES, for too long, under observation without clear purpose¹³.

Of course one cannot ignore that hospital organization is complex in nature. Its organizational model is still able to challenge the greatest thinkers of the theme. Their governance is daily stressed by a kaleidoscope of power relations, which seek non-static and asymmetric points of balance throughout a routine working day¹⁴.

The hospital is an organization of multiple personalities, in which the instituted may vary at the taste of the clock. Those who have already ventured into this work know that hospital services have unique characteristics depending on their work shifts, whether day, night, weekly or on weekends. Many hospitals seem to cohabit each hospital, regardless of their size or legal and assistance nature. They eventually respond to the need for network integration invariably in the same way, with the same regularity. The question remains: how to overcome this size reduction machines¹⁵?

Understanding the possibilities of stress reduction of critical nodes of the fragmentation of universal systems from hospitals

As already pointed out, hospitals not only play a leading role in the process of fragmentation in universal health systems, but are also products of this phenomenon.

The paradigms of ‘social medicine’ elaborated in the XVIII century, whose central focus was on health promotion and disease prevention, which greatly influenced the canons of universal health systems, since its inception, *a priori* did not offer a clear strategy for dialogue and integration with another developing chain, that of ‘scientific medicine’¹⁶.

As the cradles of the latter, in a certain way, hospitals as instruments in the service of ‘scientific medicine’ have just been separated from the commitment to support a comprehensive health vision present in everyday aspects of society¹⁶.

Analyzing the above, it is possible to understand that different health strategies occupied the territories of care and ended up dissociated in an impervious way. Just as hospitals did not produce connections with other health services, other systemic organizational strategies

such as PHC and similar did not develop effective measures to connect with hospitals. The goal, however, would be to ensure the necessary continuum of care, and, in this sense, the teams that daily accompany and know more about people in hospital care, supposedly, should participate in the formatting of care plans decisively assisting the production of effective care. This integration, however, seems increasingly distant¹⁷.

Until the present time, hospitals in the most diverse systemic arrangements have, with few exceptions, been able to act as major units of procedures, without considering, with the necessary emphasis, that their mission should be focused on producing the health outcomes that matter most to them the people they care for¹⁸.

The problems and challenges enunciated, as well as their interrelationships, can contribute to the testing of perspectives and analyzes regarding the sustainability of universal health systems.

Contemporary bets for the production of some connection between PHC and hospitals in the universal health systems of mixed paying source (public and private), prevalent in those where there is clear asymmetry between such sources, with the preponderance of the private component, reopen already established practices tested by care models, such as the north-american managed care¹⁹.

The attempt to position the PHC as an access manager to the most complex and expensive levels of systems (gatekeeper) is emphasized, seeking an agenda of greater efficiency, induced by economic guidelines for the appropriate use of resources. It seems natural in 'times of austerity'. An access control per se is not capable of producing better health results, because it obscures bets that should be considered *a priori*¹⁹.

An analysis regarding the opportunity to consolidate universal health systems fits here, whose PHC has not been formatted as a strategy to help the underprivileged through minimum offers²⁰.

The English system makes clear the results of each pound invested mostly by the public paying source in structuring a multipurpose systemic model. Its PHC operates in a leading manner, present, producer of bonds, markedly multiprofessional, which has even allowed a consistent reduction of beds installed in the country, due to an effective replacement of health offerings and territorial integration for the necessary care in co-responsibility with the hospitals²¹.

It should be emphasized that meeting health needs, through less hospital infrastructure, produced by the interventions and bets mentioned above, is a decisive contributory element to the sustainability of universal health systems, such as the English²¹ one.

On the other hand, simply access control to higher levels of health system complexity did not guarantee a sustained reduction in beds, not even the resources needed to fund health care in the United States of America. This country is a world record holder in health spending in proportion to Gross Domestic Product (GDP), without achieving health outcomes, not even similar to those member countries of the Organization for Economic Cooperation and Development (OECD)²².

The new 'value-based health care' paradigm looms on the horizon announcing itself as a perspective for *lato sensu* health systems. 'Value' is presented as the health outcomes obtained from the financial resources employed for its production. On the one hand, it puts the importance of achieving health outcomes at the expense of the exclusive production of procedures understood mostly as a result to be achieved. On the other hand, it does not clearly propose how to reverse the inertia of health systems in the face of challenges such as the phenomenon of fragmentation²³.

As a contribution to these 'how', there are experiences produced within universal health systems that may inspire some answers, or good questions that induce innovations or improvement of solutions or technologies already applied.

Betting, more than ever, on a powerful PHC, present and synergistic with the different modalities of systems services is fundamental for their sustainability¹⁹.

There are structural challenges of PHC to be overcome, such as expanding the importance and participation of PHC in health worker training strategies and organizing health careers in order to recognize PHC as a non-exclusive but structuring axis. In addition, expand the autonomy of other health professionals, especially nurses, as a tool to expand PHC coverage and increase the effectiveness of health care¹⁹.

Broaden the scope of the hospitals in order to make them responsible for the care in the gaps between them and the PHC, clearly regarding the outpatient specialized care, through the production of connections powered by care management technologies such as 'matrix support'. Meetings mediated by information technologies, or not, in which specialized hospital teams become co-responsible for the construction of therapeutic projects shared with PHC more horizontally. In this context, there is a clear transfer of specific knowledge and consequent expansion of care autonomy in PHC, with future less need for sharing therapeutic projects, due to the learning promoted by these knowledge exchanges²⁴.

Still referring to the expansion of the scope of the hospitals, it is crucial to share with PHC the construction of knowledge and practices to enhance hospital exit routes for those who require home care support due to loss of autonomy. Home care can and should be shared between hospital and PHC referral teams, always under the supervision of the consistent supply chain and logistics, that are so natural for hospital organizations²⁴.

It is necessary, furthermore, to promote the organization of hospital referral teams, committed to daily care processes that are absolutely centered on patients and their needs, and not on health corporations. This bet allows to expand the integration capabilities with the PHC teams through several possible strategies,

such as matrix support in health network. It also allows the improvement of care practices by strengthening them through the construction of care lines, clinical protocols, the adoption of hospital internal regulation practices, formulation of hospital therapeutic projects in co-responsibility with PHC and guarantee of safe transfer for continuity of care²⁵.

Finally, producing a new way of thinking and operating territories, in favor of new geographic arrangements for health regions, seems to be important, especially with regard to the production and effective management of care in universal health systems. This bet allow hospital resources of the territories to be used at the most favorable scales of economy and effectiveness, as well as ensuring physical proximity to the service network responsible for a given population, which would favor the strategies previously presented²⁶.

Conclusions

In the path taken so far, it was possible to understand that hospitals play a very complex role in universal health systems. The way in which strategies, devices and/or technological arrangements have been organized, or not, to at least produce connections between these, PHC and other points of care of health networks, supposedly influences the performance of hospitals as agents or protagonists of the process of fragmentation of universal systems. Consequently, hospitals are also products of this phenomenon, since the universal health systems, for the most part, have tended to consolidate themselves from the separate development of at least two major components, namely: strategic actions of lower technical-operational complexity predominate and strategic actions of greater technical-operational complexity predominate.

Unfavorable economic cycles often inspire public budget expenditure containment strategies and invariably reach universal health systems through austerity measures. These

end up not only compromising the daily operations of universal systems, but ultimately abolishing the chances of prosperity of any essay that reduces the negative force of the phenomenon of fragmentation²⁷.

It is essential to highlight that universal systems are even more resilient the greater the understanding of their social roles in the form of structuring public policies. This can be seen by the greater participation of public budgets in their financing and their smaller fragmentation²⁸.

In this context and under austere financial conditions, more resilient universal systems are less affected when compared to less resilient universal systems. The analysis of historical series of systemic indicators, such as life expectancy and infant mortality, helps to understand the above²⁸.

Contemporary periods of austerity have led to debates in favor of the 'reform of universal health systems', proposing as a discussion the contrast between these and the 'universal coverage' model; which is marked by an agenda of measures devoted to reducing the scope of universal health systems, by limiting universal

access to the social protection offerings from which they were designed. The premise is that this agenda is capable of increasing the sustainability of health systems that make it a priority, which has not been verified by ongoing studies²⁹.

Investigative efforts of comparative analysis of health systems, widely used until then, seem to outline movements to try to understand more deeply the phenomenon of fragmentation in universal systems³⁰. However, based on the reflections offered by this essay, it seems pertinent to focus more on understanding the causal relationships and the repercussions of interventions dedicated to alleviating or remedying the phenomenon of fragmentation in universal health systems.

Collaborators

Beltrammi DGM (0000-0003-3964-3700)* and Reis AAC (0000-0001-7184-2342)*: design and planning; and critical review of the content. ■

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Received on 04/30/2019

Approved on 10/22/2019

Conflict of interests: non-existent

Financial support: non-existent