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ANALYSIS OF AUDIT COMPONENTS IN THE UNIFIED HEALTH SYSTEM

Análise dos componentes de auditoria no sistema único de saúde

Análisis de los componentes de auditoría en el sistema único de salud

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ABSTRACT

Objectives: to analyze the evolution and distribution of the audit components of the National Audit System in Brazilian municipalities and states, between the years 2008 and 2015. **Method:** a quantitative study with a descriptive approach was developed, which used secondary data, available at page of the Department of Informatics of the Unified Health System of Brazil, referring to the number of municipal and state components of the National Audit System structured by each region of the Country. **Results:** the data indicate that there is an increase in the number of municipal and state components in all regions. The Northeast Region stands out, which showed a significant increase in municipal and state components in the period. However, in all regions, registration of municipal audit components was less than 2%. **Conclusion:** the number of state and municipal components has increased over the years, but not enough to cover all the Federative Units.

DESCRIPTORS: Health management; Health care coordination and monitoring; Unified health system.

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RESUMO

Objetivo: analisar a evolução e a distribuição dos componentes de auditoria do Sistema Nacional de Auditoria nos municípios e nos estados brasileiros, entre os anos 2008 e 2015. **Método:** foi desenvolvido um estudo quantitativo de abordagem descritiva, o qual utilizou dados secundários, disponíveis na página do Departamento de informática do Sistema Único de Saúde do Brasil, referentes ao número de componentes municipais e estaduais do Sistema Nacional de Auditoria estruturados por cada região do País. **Resultados:** os dados apontam que há um crescimento no número de componentes municipais e estaduais em todas as regiões. Destaca-se a Região Nordeste, que apresentou expressivo aumento dos componentes municipais e estaduais no período. No entanto, em todas as regiões, o registro dos componentes de auditoria municipal foi menor que 2%. **Conclusão:** o número de componentes estaduais e municipais sofreu incremento ao longo dos anos, mas, não o suficiente para contemplar todas as Unidades Federativas.

DESCRITORES: Gestão em saúde; Regulação e fiscalização em saúde; Sistema único de saúde.

RESUMEN

Objetivos: analizar la evolución y distribución de los componentes de auditoría del Sistema Nacional de Auditoría en los municipios y estados brasileños, entre los años 2008 y 2015. **Método:** se desarrolló un estudio cuantitativo con enfoque descriptivo, que utilizó datos secundarios, disponibles en la página del Departamento de Informática del Sistema Único de Salud de Brasil, referente al número de componentes municipales y estaduales del Sistema Nacional de Auditoría estructurado por cada región del País. **Resultados:** los datos indican que hay un aumento en el número de componentes municipales y estatales en todas las regiones. Se destaca la Región Nordeste, que mostró un aumento significativo en los componentes municipales y estaduales en el período. Sin embargo, en todas las regiones, el registro de componentes de auditoría municipal fue inferior al 2%. **Conclusión:** el número de componentes estatales y municipales ha aumentado con los años, pero no lo suficiente para cubrir todas las Unidades de la Federación.

PALABRAS CLAVE: Gestión en salud; Regulación y fiscalización en salud; Sistema único de salud.

INTRODUCTION

The creation of the National Audit System (SNA) is foreseen in the Federal Constitution (FC) of 1988 and in the Organic Health Law, Law No. 8,080/1990. However, only in 1993, Law No. 8.689, the same law that extinguished the National Institute of Medical Assistance of Social Security (INAMPS), instituted the SNA and established the obligation of the federal government to create mechanisms for regulation and supervision, including the actions of Control and Audit in the three spheres of management.[1-3]

Audit decentralization has been structured since the Basic Operational Norm of the Unified Health System (SUS) (NOB-SUS/1996), through the Operational Norm of Health Care (NOAS 01/2002) and the Pact for Health.[4-6] In 2007, the National Policy for Strategic and Participatory Management in the SUS (ParticipaSUS) was approved, which addressed the importance of the implementation of state and municipal components of the SNA, as well as the promotion of this management device.[7] Decree No. 7,508/2011, which regulates the Organic Health Law (Law No. 8,080/1990), established the responsibility of the SNA in the control and supervision of the Organizational Contract for Public Health Action (COAP).[2,8]

At the federal level, the SNA is coordinated by the National Audit Department of the SUS (DENASUS), which is part of the Strategic and Participatory Management Secretariat (SGEP) of the Ministry of Health (MS). This body carries out audits and is responsible for strengthening the state and municipal components of the SNA, with the aim of bringing together work practices and processes in the states and municipalities.[9] In the state and municipal spheres, SNA activities are developed by the state and municipal health secretariats.[10]

In the public sphere, auditing is essential for the solidification of the SUS, "because it promotes, in a significant way, better fulfillment of its principles and guidelines, inspecting the development of actions and services provided to the population".[11] Auditing is also an important mechanism to support the decision making of managers, who can use audit reports to improve the quality of actions and services in the SUS.[10]

Given its complexity and scope, the SUS is in continuous development, and it is therefore essential to establish evaluation and control processes that can support decision-making. Thus, the importance of the SNA in its consolidation stands out.12 In this sense, the structuring of audit components in the municipal and state spheres is an important element for the SNA to meet the needs of the SUS.

Given the above, this study is justified by the need to explore the panorama of the audit components of the SNA. From this perspective, the present study aims to analyze the evolution and distribution of the audit components of the SNA in Brazilian municipalities and states, between the years 2008 and 2015.

METHOD

This is a quantitative study with a descriptive approach, which used secondary data collected in September 2022, from the 2013-2015 Roll of Guidelines, Goals, Targets, and Indicators - 2015 Edition, available on the webpage of the SUS Department of Informatics (DATASUS), of the Ministry of Health (MS), through the Health Information - TabNet.[13]

This Roll contains subsidies for decision making and goal setting by the federations, based on its indicators, as well as the methods for calculation, source, and relevance of data.14 It is indexed in the virtual database of DATASUS, whose system is essential for the development of the main management activities in SUS.[15]

The variables studied refer to the number of municipal and state components of the SNA structured, by Region, and correspond to indicators 66a and 66b of the 2013-2015 Roll of Guidelines, Objectives, Goals and Indicators, described by Resolution No. 05 of the Tripartite Interagency Commission, June 19, 2013.[16]

The selected period (2008-2015) was chosen given the availability of data in the DATASUS national database. In addition, the Microsoft Excel program was used to build the database, which enabled the insertion and description of the information inherent to the distribution and evolution of the number of SNA components structured over the years (2008-2015) in the municipalities and states of the federation, according to year and administrative region.

By using secondary data from the public domain, there was no need to submit the project to the Research Ethics Committee (CEP), according to ethical assumptions of research involving human beings and in accordance with Resolution No. 466 of December 12, 2012.[17]

RESULTS

The data obtained point out that there was relevant growth in the number of state and municipal components of the SNA structured, in all Regions of the country, between the years 2008 and 2015, as observed in Figures 1 and 2.

We highlight the behavior of the implementation of audit components in the Northeast region, which went from 01 (one) in 2008 to 06 (six) state components in 2015; and from 01 (one) to 20 (twenty) municipal components, between 2008 and 2015.

Table 1 shows the number and proportion of state audit components in 2015, in which it is possible to see a higher proportion of states with audit components in the Midwest (100%), North (71.43%) and Northeast (66.67%) regions.

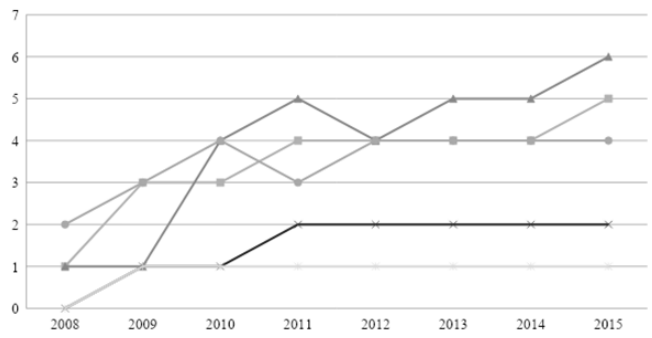
Table 2 shows the number and proportion of municipal audit components in 2015. The Regions with the highest percentages of structured municipal components are shown, namely: Northeast (1.11%), Southeast (1.08%), and Midwest (1.07%). It is worth noting that the North region had the lowest percentage (0.67%) at the municipal level, although it has evolved well at the state level.

DISCUSSION

The inherent growth in the number of auditing components in states and municipalities may be related to the publication of the health pact instituted in 2006 by Decree 399/2006, which is composed of three components: Pacto pela Vida (Life Pact), Pacto em Defesa do SUS (SUS Defense Pact) and Pacto de Gestão (Management Pact), which determine priorities to be adopted by all spheres of government. The management pact component determines the health responsibilities of the SUS management bodies, and auditing is among these responsibilities. Municipalities and states now have responsibilities in health planning and programming, and must "conduct/implement audits of the production of all public and private health services under their management, in coordination with control, evaluation, and care regulation actions.

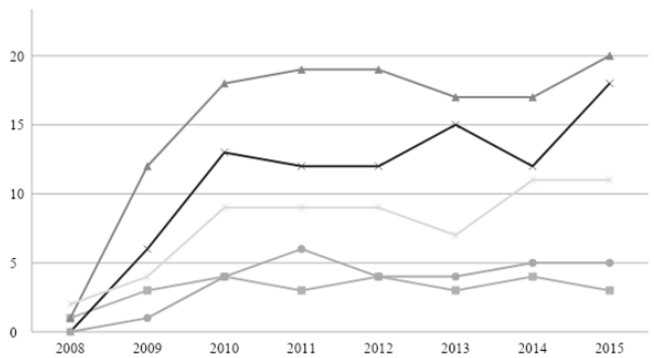
Considering the period between 2009 and 2010, it is observed that in all regions there was an increase in the number of state and municipal components. This may be related to

Figure 1 – Evolution of the state component by Region of Brazil. Brazil, 2008 and 2015



Source: own preparation, based on DATASUS data.

Figure 2 – Evolution of the municipal component by Region of Brazil. Brazil, 2008 and 2015



Source: own preparation, based on DATASUS data.

Table 1 – Number of state components. Brazil. 2015

Region	Total of States	State Components	
			%
North Region	7	5	71,43
Northeast Region	9	6	66,67
Southeast Region	4	2	50,00
Southern Region	3	1	33,33
Midwest Region	4	4	100,00
Total	**27**	**18**	**66,67**

Table 2 – Number of municipal components. Brazil, 2015

Region	Total of Municipalities	Municipal Components	
		N	%
Região Norte	450	3	0,67
Região Nordeste	1794	20	1,11
Região Sudeste	1668	18	1,08
Região Sul	1191	11	0,92
Região Centro-Oeste	467	5	1,07
Total	**5570**	**57**	**1,02**

the implementation, in 2009, of the second edition of the National Policy for Strategic and Participatory Management in Health (ParticipaSUS), which sought to accelerate and improve the audit process in the three spheres of SUS.[10,18]

Regarding the small number of audit components at the state level, especially in the Southern region, which, between the years 2009 and 2015, remained with the record of only one audit component (Graph 1), it may have an explanation in the discontinuity in the management of public administration due to the shortage of human resources, specifically in the Audit Service of the SUS, which was pointed out in a survey.19 Thus, it is believed that the shortage of manpower may have hindered the expansion of new audit components in that region.

The significant increase in municipal and state components in the Northeast may be associated with the spread of training courses for SUS managers, promoted by the National Program for the Qualification of SUS Managers and Managers - Mais Saúde, of the MH.[20] There was also another proposal related to the professional training of SUS managers, promoted by the MS's National Program for Managerial Training in Health, which launched a lato sensu post-graduation course with 180 hours to train middle and high school level professionals who play strategic roles in the management of health services and systems, including: regulation, control, evaluation, and auditing.[21]

Although it is not possible to point out a direct association between the growth of the municipal audit components of the SNA and the professional/manager training initiatives, it is worth considering them in the context of the period studied.

In the Midwest Region, it is observed that all states have a state audit component, which may be related to the fact that the respective region is home to Brasilia, headquarters of the Ministry of Health, i.e., the justification is that this region is located in a center of power, where professionals with auditing qualifications are concentrated. In this sense, another study corroborates the argument that the hierarchical influence and proximity to the central government enabled better structuring in the management sphere.[22]

When analyzing the proportion of state components in 2015, it can be observed that the South and Southeast regions had the lowest proportions, 33% and 50%, respectively. It is important to point out the relevance of these regions as important political and economic centers for the national scenario, which draws attention to the lack of priority for auditing in these regions.

In proportional terms, in relation to the number of municipalities versus the number of municipal components, the registration of municipal audit components was less than 2% in all Regions. This scenario may be associated with the lack of human and financial resources, which hinders the implementation of cost-related systems,[23] including, therefore, the audit components.

It can be seen that at the municipal level, the North Region presented the lowest percentage (0.67%) of audit components. However, the percentage related to the number of state components in that Region was 71.43%, which points to an incongruence among the management spheres in this Region.[13]

A study brought important data regarding the inequalities among health regions in the country, particularly the North region, in which the health services network is deficient. Among the difficulties, the low maintenance of human resources stands out, especially in small municipalities and the consequent concentration of medium and high complexity services in the capitals.[24-25]

These findings reflect how much the decentralization of the SUS, as well as the SNA, represent the context of inequalities among the different regions, which point to very diverse local organizational and political contexts, despite being governed by the same normative and organizational principles of the system. The organizational context was linked to the conditions of structure, installed capacity, network operation and existing programs.[22]

CONCLUSION

This study allowed the analysis of the evolution and distribution of the audit components of the SNA in Brazilian municipalities and states, between 2008 and 2015, which mapped the audit components in the regions of the country, denoting the variations (increase/decline) regarding the number of municipal and state components.

It can be said that the number of state and municipal components has increased over the years studied, but not enough to cover all the Federal Units. This finding demonstrates that the decentralization of the SNA still needs to be guided as a management priority with more attention and investment.

When considering the proportion of municipal components, which remained less than 2% in all regions in 2015, it can be seen the negligence in relation to the perception of auditing as an important mechanism to be incorporated into health management in municipalities.

The findings of this study point to the flagrant need for efforts and incentives aimed at the management of the SUS and the SNA, and contribute to critical-reflexive developments aimed at questioning the interests and or political disinterests involved in the auditing process.

DENASUS is responsible for permanently promoting training and incentives that contribute to the commitment of managers and public servants in state and municipal departments, in addition to supervising and supporting the federative units in the implementation of audit components.

Thus, we conclude that it is essential to adopt more effective measures of investment in material resources, personnel, and information technology for the deployment and implementation of SUS audit components in all federal units of the country. Only in this way, the SNA will be able to establish itself as a decentralized system capable of influencing the quality of health care in all areas of the SUS.

The limitations found throughout this study refer to the outdated data in the DATASUS database, due to the fact that in some municipalities/states there is no record of structured and functioning components. Furthermore, it was noticed the sparse publication of studies inherent to the subject that could dialogue with the findings of the results of this research, especially those that contemplate political and social aspects.

It is recommended that further research be carried out on this theme to explore other investigative prisms about the state and municipal components, especially studies that identify the factors that cause the delay in implementing new audit components, and how DENASUS develops strategies to accelerate the process of setting up these components.

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