Expansion of rehabilitation services in SUS in the light of the federal normative framework

ARTIGO ORIGINAL

A expansão dos serviços de reabilitação no SUS à luz do arcabouço normativo federal

Luciana de Assis Caetano[1], Rosana Ferreira Sampaio[2], Luciana Assis Costa[3]

http://dx.doi.org/10.11606/issn.2238-6149.v29i3p195-203

Caetano LA, Sampaio RF, Costa LA. Expansion of rehabilitation services in SUS in the light of the federal normative framework. Rev Ter Ocup Univ São Paulo. 2018 Sept-Dec;29(3):195-203.

ABSTRACT: The study aimed to analyze the national laws that relate to the creation, organization, financing and direction of rehabilitation services in the country after the constitution of the SUS. It is a documentary analysis study carried out in two stages: manual search of the documents, and critical analysis of these. A total of 56 legislations related to rehabilitation services among laws, decrees and ordinances of the Civil House and the Ministry of Health were collected and analyzed. Legislations analysis is divided into four dimensions: disability concept that guides the services of rehabilitation; design of assistance; guidelines for the implementation of rehabilitation services and procedures offered and, finally, financial transfer. The results indicate that the expansion of rehabilitation services occurred incrementally, and slowly, and only more recently, from 2012 onwards, of a structural nature, in the sense of establishing legislation that provides for the creation of a rehabilitation network focused on disabled people. It can be affirmed that today the rehabilitation services are anchored legally by a legislative apparatus that foresees the organization of the equipment, as well as the transfer for its financing.

Keywords: Unified Health System; Rehabilitation/legislation & jurisprudence; Health policy.

Caetano LA, Sampaio RF, Costa LA. A expansão dos serviços de reabilitação no SUS à luz do arcabouço normativo federal. Rev Ter Ocup Univ São Paulo. 2018 set.-dez.;29(3):195-203.

RESUMO: O estudo teve como objetivo analisar as legislações nacionais que se relacionam a criação, organização, financiamento e direcionamento dos serviços de reabilitação no país após a constituição do SUS. Trata-se de um estudo de análise documental realizado em duas etapas: busca manual dos documentos, e análise crítica destes. Foram levantadas e analisadas 56 legislações relacionadas aos serviços de reabilitação dentre leis, decretos e portarias da Casa Civil e do Ministério da Saúde. A análise das legislações se deu apoiada em quatro dimensões: concepção de deficiência que orienta os serviços de reabilitação; concepção de assistência; diretrizes para implantação dos serviços de reabilitação e procedimentos ofertados e por fim, os repasses financeiros. Os resultados apontam que a expansão dos serviços de reabilitação se deu de forma incremental, e lenta, e só a partir de 2012, de caráter estrutural, no sentido do estabelecimento de uma legislação que prevê a criação da rede de reabilitação voltada às pessoas com deficiência. Pode-se afirmar que hoje os serviços de reabilitação estão ancorados legalmente por um aparato legislativo que prevê a organização dos equipamentos, bem como os repasses para seu financiamento.

Descritores: Sistema Único de Saúde; Reabilitação/legislação & jurisprudência; Política de saúde.

This study is part of the master's degree dissertation: "Implementação dos Serviços de Reabilitação do SUS no Município de Belo Horizonte: avanços institucionais e desafios assistenciais."

1. Physical therapist, master's degree in Rehabilitation Science, Universidade Federal de Minas Gerais (UFMG) – Belo Horizonte (MG), Brazil. ORCID: 0000-0002-7880-4100.
2. Doctor's degree in Public Health, Postgraduate program in Rehabilitation Science, Universidade Federal de Minas Gerais (UFMG) – Belo Horizonte (MG), Brazil. ORCID: 0000-0002-4775-9650. E-mail: sampaioufmg@gmail.com.
3. Doctor's degree in Public Health. Postgraduate program in Rehabilitation Science, Universidade Federal de Minas Gerais (UFMG), Belo Horizonte (MG), Brazil. ORCID: 0000-0003-3664-4839. E-mail: lucianaassis.ufmg@gmail.com.

Corresponding address: Luciana de Assis Caetao. Rua Apucarana, 208 Apto 302 B. Bairro Ouro Preto. Belo Horizonte, MG. E-mail: lucianaacaetano@gmail.com.

INTRODUCTION

According to the World Health Organization (WHO), rehabilitation is "*a set of measures that assist individuals who experience or are likely to experience disability, to achieve and maintain optimum functioning in interaction with their environments*" (p.100)[1]. In general terms, rehabilitation can be considered in two perspectives: actions focused on the individual as defined by the WHO, and equipment that provides this type of care[2]. This study uses rehabilitation as the provision of services especially in the scope of Health Policy.

Until the end of the 1980s, rehabilitation services in the country were organized for basically two groups: formal workers, through Professional Rehabilitation Centers linked with the National Institute of Medical Assistance of Social Security (INAMPS)[3], and philanthropic services for individuals with disability[4].

This scenario gradually changed with the creation of the Unified Health System (SUS) in 1988. Since then, rehabilitation services have covered by Health Policies, which is a progress in the provision of these services in terms of universal access. However, it should be noted that rehabilitation has not received policies, with own rules, budgets and organizational devices. Rehabilitation began to be defined and organized according to regulations from several technical areas of the Ministry of Health (MoH), which have specific policies for People with Disability, the Elderly, Trauma and Violence[5], Workers, among others.

Then, although rehabilitation has been covered by Health Policies, it remains diluted in regulations from different subareas. Except for the health policy for people with disability, which concentrates the largest number of regulations associated with rehabilitation services, other services linked with health subareas have a punctual selective character and do not organize a care network, which justified this study with a focus on federal regulations of health policies for people with disability.

Regarding the selection of national laws, the MoH is responsible for creating and coordinating the national health policy, defining the common bases for the national territory, often involving other entities of the federation to implement services to be part of the health network[6]. It is not different in rehabilitation: the MoH has used directives that define and organize the rehabilitation services acting as an inductive mechanism to condition its implementation to the transfer of financial resources to states and municipalities.

"*The use of ministerial directives has been a valuable instrument, and probably the main instrument to coordinate national health actions, creating an arrangement in which the federal government assumes a central position, holding the power of agenda and exercising greater influence on the decision-making processes*" (p.31)[7] of health.

The continuity of public action, in this case the provision of rehabilitation services, is directly dependent on the institutional aspects that govern them, such as the existence of a legal apparatus, definition of a budget and structure. Then, this study aimed to analyze the national legislation for people with disability related to the creation, organization, financing and direction of rehabilitation services in the country after the creation of SUS. The specific objectives were: analyze the concepts of disability and rehabilitation that guide the standardization of services, analyze the current situation of regulations for the organizational structure of these rehabilitation services, and identify resources for rehabilitation services foreseen in the legislation.

METHODOLOGY

This is a document analysis study conducted in two stages: manual search for documents and critical analysis of these documents. Online search for document was conducted on official websites of the Brazilian government, such as websites of the MoH, legislative assemblies and portals, Brazilian Official Record (DOU), sites of people with disabilities, site of SUS audit system, MoH manuals, and revoked regulations cited in the most current legislation for people with disability, in order to access the history of all regulations related to rehabilitation after SUS was created, covering the period from 1989 to July 2017.

This document search found and analyzed 56 regulations related to rehabilitation services, including laws, decrees and directives of the MoH.

After the document search, the documents related to people with disability were arranged in chronological order and analyzed according to four dimensions: concept of disability that guides the rehabilitation services; concept of care; guidelines for the implementation of rehabilitation services and procedures offered, and, finally, financial transfer.

RESULTS AND DISCUSSION

Concepts of disability and care organization – history and constructions that guide rehabilitation services in SUS

Regulations that refer to rehabilitation services following SUS implementation are spread in several cross-sectional policies; however, many of them are associated

with the health of people with disability. They were enacted from 1989 to 2015 to organize and coordinate the actions and services offered to this specific population.

With the 1988 Constitution, the theme of people with disability was consolidated as a government responsibility, supported by several laws of the Civil House (Law 7853/1989 and Law 13146/2015 - Statute of People with Disabilities, Decree 3298/1999 - National Policy for the Integration of People with Disability, and Decree 7612/2011 - Living Without Limits Plan) that guide the MoH directives for the coordination of laws, setting rules and organizing the health rehabilitation services[8].

The rehabilitation services, in turn, since the first directives created in early 1990s, follow SUS concepts and guidelines, such as care universality, completeness, hierarchization and regionalization. Despite keeping the SUS bases from the Constitution, along the year the laws are influenced by new concepts disseminated across the world.

The concept of disability provided in national laws addressing rehabilitation services has changed over time, following international trends. The first laws (Law 7853/1989, MS/SNAS Directives 225/1992, 303/1992 and 304/1992, MS/SAS Directives 116/1993 and Decree 3298/1999) presented the concept of the WHO Family of International Classifications. In 1976, the International Classification of Impairments, Disabilities, and Handicaps (ICIDH) defined disability as a loss or abnormality, inability such as restriction or impossibility to perform activity in a 'normal' way, and handicap as a disadvantage that limits or prevents the fulfillment of a role that is 'normal' for that individual[9,10].

This concept of disability that places the individual as the cause of the limitation or obstacle and does not consider the organizational influence of the environment to understand the disability and handicap[11], guided the rehabilitation services and procedures at the national level until early 2000s, with priority to high and medium complexity levels.

In 1997, the WHO issued the second version of the ICIDH, which had new concepts: International Classification of Impairments, Activities and Participation – a Manual for the Dimension of Disablement and Health ICIDH-2. This new classification emphasized the environmental contexts and potentialities of the individual, removing the focus from inabilities and limitations[9]. With the change in the concept at the international level, national laws tried to follow the same idea (MS/GM directive 1060/2002 and other MS/GM directives until 2004).

Of note, the laws of late 1990s and early 2000s present characteristics of a transition in terms of concepts and service orientation. The group of people benefiting from these laws became larger with the understanding that all persons with disabilities, regardless of the disability nature, causal agent or degree of severity (Decree 3298/1999), and people with chronic diseases that result in handicap or inability (MS/GM Directive 1060/2002) would be beneficiaries of rehabilitation processes[9].

The creation of the State Network of Care for People with Disability (MS/GM Directive 818/2001) continued structuring rehabilitation services of medium and high complexity. This directive prioritized rehabilitation services for people with disabilities, with low-complexity services provide by outpatient units.

The following year, the directive establishing the National Policy for Persons with Disabilities (MS/GM Directive 1060/2002) made some progress in relation to the principles of rehabilitation and care. In addition to extend the policy to a larger population, it reinforced the creation of health service networks at different levels of complexity, prioritizing comprehensive care to persons with disabilities and including basic care and community-based rehabilitation (CBR) to the rehabilitation scenario[9].

CBR was proposed by the WHO to enhance and develop the potential of people with disability and their communities as agents in the process of rehabilitation and social inclusion[12]. However, the CBR operation would only be possible with a rehabilitation team in basic care, which became reality with the creation of the Family Health Support Center (NASF) in 2008.

The law that created NASF (MS/GM Directive 154/2008) considered the International Classification of Functioning, Disability and Health (ICF), introduced by the WHO in 2001, as an evolution of ICIDH-2. "The ICF changes the prior negative focus of disability and inability into a positive perspective, considering the activities that individuals with changes in body systems and/or structure can perform, as well as their social participation" (p.187)[10]. Human functionality and inability started to be understood as conditions determined by the environmental context, and not by physical and organic aspects. Changes in the concept of disability at international level led to changes in the concept of rehabilitation at national level, leading to a new form of organization and provision of services for people with disabilities.

The creation of NASF was a milestone because it introduced the ICF concepts in the national scenario and enabled the insertion of rehabilitation services in basic care. NASF also promoted CBR again, reinforcing comprehensive health care for people with disability, particularly rehabilitation services. After NASF, and

influenced by the 2007 International Convention on the Rights of Persons with Disabilities, the term 'people who have disabilities,' as previously used in legislations, changed to 'people with disabilities,' which is currently used. The changes in terminology reinforce the changes in concepts, since one does not have or carry the disability as suggested by the previous term, so the term 'people with disability" is more adequate[13].

The Convention was signed in 2007 by Brazil and introduced into the national legal system acting as a constitutional amendment[14]. It reinforces the change from the medical model to the social model in which the focus of the limitation is the environment, and not the disability itself, as indicated in the ICF[15].

The laws related to the health of persons with disabilities from 2008 to 2015, when the last law was analyzed, maintained the concept of disability and, consequently, of rehabilitation brought by the ICF. In the national scenario, the National Health Council of the Ministry of Health defined in 2012, through MS/CNS Resolution 452/2012 to use the ICF in SUS regulations.

However, the laws that define and regulate rehabilitation services in the SUS have considered, in the normative framework, the conceptual and philosophical changes based on the social model that guide the understanding and use of the term 'disability', according to international guidelines.

Rehabilitation services and financial transfers foreseen in SUS regulations

Financing of public policies is a crucial condition to ensure concrete actions planned by the State. In addition, the existence of funding for a particular policy indicates the government's priorities[16]. It shows the importance of a legal norm linked with financial transfers for policy implementation.

Figure 1 shows a summary of laws that regulate the implementation of rehabilitation services and procedures in the SUS foreseen in health regulations for people with disabilities from 1989 to 2015.

At the end of the 1980s, as illustrated in Figure 1, the first law addressing health services for people with disabilities was created by the Civil House of the Presidency of the Republic that created a network of specialized habilitation and rehabilitation services, as well as actions to promote and prevent disability (Law 7853/1989). However, as usually seen in laws, this regulation did not provide details of services and their sources of funding, and were therefore the subject of MoH directives in the 1990s[8].

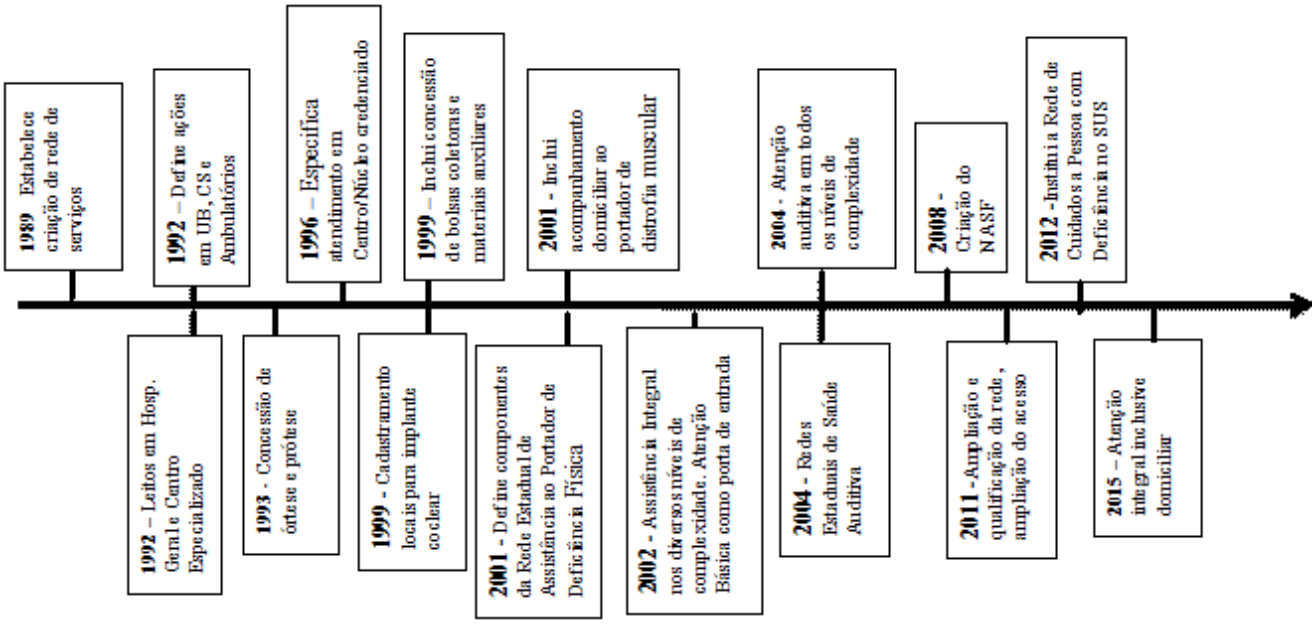

Figure 1: Timeline with the laws that present guidelines for the implementation of rehabilitation services and procedures in SUS

Since early 1990s, the directives that guided rehabilitation services for people with disabilities were particularly focused on the inclusion of medium and high complexity services in outpatient and hospital environments. These directives foresaw the inclusion of the services in the Outpatient Information Systems (SIA/SUS) and Hospital Information Systems (SIH/SUS) for financial transfer. These services inserted in the SUS financing lists included hospital beds for rehabilitation in general and specialized hospitals, specialized centers and rehabilitation outpatient environments, and provision of prosthetic and orthotic appliances and ancillary devices for transportation (MS/SNAS Directives 225/1992 and 303-306/1992, MS/SAS Directives 116/1993, 146/1993, 211/1996, 584/1999 and MS/GM Directive 1278/1999).

In this period, the financing system of the health system used before the SUS was maintained, which favored payment according to production and hospital and outpatient services[17]. This production-based payment for rehabilitation services considered a broader health scenario in Brazil, as established in the Basic Operational Norm of 1991 (NOB/91)[18].

The form of service financing started changing with the NOB/93. Municipalities started to receive funds from the National Health Fund for the Municipal Health Fund, which gave them greater autonomy in the payment for providers of both public and private outpatient and hospital services[18].

With the NOB/96, new transfer mechanisms between the federal entities were created. In addition, NOB/96 increased the percentage of fund-to-fund transfers from federal resources to states and municipalities, reducing the payment for procedures and valuing basic care. However, rehabilitation services continued to receive funds through procedures because they were still linked with the specialized health service offered at the outpatient and hospital levels[18].

In 2001, aiming to standardize the allocation of health resources in general, the Operational Norm for Health Services (NOAS/2001) was created, setting regionalization for health service hierarchization and access with greater equity. NOAS/2001 starts the implementation of health care networks mentioned in the first law for people with disability in 1989 (Law 7853/1989)[19].

To enable the implementation of the Health Care Network for People with Disability in the states and municipalities, as determined in MS/GM Directive 818/2001, the Ministry of Health changed, in MS/SAS Directive 185/2001, the description of the procedures in SIA-SUS list, including them in the high complexity/high cost outpatient procedures (APAC-SIA). It increased the possibility of offering outpatient and hospital services for the construction of a state rehabilitation network[20].

The idea of a network of services and appreciation of basic care remained in the laws that followed. In 2002, MS/GM Directive 1060/2002 reinforced the role of basic care as the front door to health services for people with disability, along with emergency services. In secondary care, the outpatient rehabilitation services were renamed to Rehabilitation Referral Centers (CRR) to provide specialized care to people with disability[9].

However, the rehabilitation services foreseen in the laws from the 1990s to 2008 had an incremental expansion, which can be seen, for instance, in the punctual inclusion of specialized procedures and services for specific populations, such as people with progressive muscular dystrophy, intellectual disability, physical disability, autism, and hearing impairment, all of these services linked with financial transfers per procedure (MS/GM Directives 1531/2001, 1635/2002, 2073/2004).

In the national health scenario, the incentive to basic care remained in 2003-2006. However, there was not a service network that exceeded municipal boundaries to enable service at other levels of care. Then, the Pact for Health was introduced in 2006, which introduced the regionalization strategy through the Regional Management Committees, currently called Regional Intermanagement Committees (CIR)[21]. In addition, three dimensions were defined in the Pact for Health: Pact for Life, Pact in Defense of SUS and Management Pact. The Pact for Life defined as a priority the consolidation and qualification of the Family Health Strategy, created by the federal government in 1994, as a model for basic care and a center to organize health care networks in SUS[22]. The Pact for Health changed the way resources were transferred to financing blocks.

In the case of rehabilitation services, this system of block financing will produce more effects after the creation of NASF that inserts rehabilitation services in basic care with its financing constituting the basic care block, and later, with the creation of the Specialized Rehabilitation Centers (CER), constituting the medium and high complexity outpatient and hospital block.

To provide comprehensive care, in 2008, the network of services for people with disability was reinforced with the insertion of rehabilitation in basic care, according to NASF. Then, the Health Care Network for Persons with Disabilities started to offer rehabilitation services at the three levels of complexity. NASF brought the rehabilitation service out of outpatient environments and hospitals, guided by the expanded concept of disability introduced by the ICF. In addition, the financial transfer for NASF teams was

made by fixed monthly amounts, according to the type of NASF (MS/GM Directive 548/2013). It was a fund-to-fund transfer, to the financing block of basic care, keeping the financing characteristic created in the 2006 Pact.

At the secondary and tertiary levels, the financial transfer was still by procedure, linked with medium and high complexity outpatient and hospital financing blocks, until MS/GM Directive 793/2012 created the Specialized Rehabilitation Center (CER), which is funded by cost and capital. The CER is one of the rehabilitation systems created to constitute the rehabilitation network based on the Living Without Limits Plan of 2011 (Decree 7612/2011). With the Plan, the theme of people with disability is again highlighted as a government topic. The laws created by the Civil House have great political influence, and with the budget allocation for service implementation, acted as a mechanism of pressure to organize a network of services for people with disabilities under the SUS.

Then, one year later, in 2012, the Ministry of Health issued MS/GM Directive 793/2012, which was a milestone in the structural organization of rehabilitation services. In other words, the services were no longer offered in an incremental and disarticulated manner, as seen in previous years, and were now provided in a network with the sites and services defined and articulated at the three levels of care. The directive defined the Health Care Network for People with Disability with the following components: NASF and dental care in basic care; in the secondary care the sites qualified to provide only one Rehabilitation Service, Specialized Rehabilitation Center (CER), the Orthopedic Workshop and the Center of Dental Specialties (CEO), and finally, hospital and emergency care in tertiary care; all of them ensuring comprehensive care and articulation between the equipment and the access to each site in a regulated manner.

The CER proposes to assist people with hearing, physical, intellectual, visual disability, ostomy and multiple disabilities in the same structure, and it can be a regional reference center if it is considered in the CIR action plan. The financing system by financial incentives of investment and costing (MS/GM Directive 835/2012) represented an important progress for rehabilitation services. It implies that the resource is currently linked with the broader service offered to patients, and not with the procedures performed, reinforcing the comprehensive care provided in the expanded conception of SUS care[23].

Then, this study concludes that only in 2012, specifically after MS/GM Directive 835/2012, the MoH started to finance expanded provision of rehabilitation services through financial incentives for investments and funding for the Specialized Health Care Network for People with Disabilities, either for the implementation of new services or improvement of existing rehabilitation services[23].

However, the expansion of rehabilitation services in SUS was gradual and slow, and only more recently, it assumed a structural nature, in terms of regulation of the rehabilitation network for people with disabilities. The CRRs created in 2002 coexist with the CERs established in 2012, with two different financing systems of rehabilitation services, by procedure and by cost, respectively. This double system for service payment reflects a moment of change, in which the concept of disability and rehabilitation was expanded, but the payment mechanisms are still in transition.

In 2015, the latest law addressing rehabilitation services for people with disabilities created by the Civil House strengthens the importance of this theme in the national legal system, but it does not establish new services or funding for the area. This law reinforces comprehensive health care with the provision of services at all levels of complexity and the importance of actions for disability prevention, universal access, and the provision of articulated services organized in Health Care Networks .The Health Care Networks are the current organizational model of SUS and are consolidated in the Consolidation Directive of MS/GM 3/2017.

Thus, even with all structural impasses faced by SUS, the laws analyzed in this study demonstrated the importance of the Policies for People with Disability in the organization, expansion, definition and financing of rehabilitation services offered by SUS.

However, it should be noted that, in the general context of health policy, in terms of financing and transfer of federal resources to subnational governments, in 2017, MS/GM Directive 3992/2017 ended the transfer by financing blocks (basic care, medium and high complexity in outpatient and hospital care, pharmaceutical care, health surveillance and SUS management) and replaced this system with only two blocks: cost block, for almost all federal resources, and investment block[24].

Many people criticized the change in health payment systems, mostly related to the weakening of the MoH as the formulator of SUS structuring policies and its limited role as a simple agent of resource transfer to the states and municipalities. In addition, potential aggravation of conflicts of interest at the local level may be observed, with risk of losing investments in structuring actions of the system, such as basic care and health surveillance[25].

In general, this change creates an environment of uncertainties and political bargaining that weakens

the system, as it does not ensure a connection between investments and the real health needs and SUS strengthening. Rehabilitation services can be directly impacted by this financial transfer process, because they may be in dispute over resources with other health actions and procedures, at all levels and specialties, thus increasing the risk of reduced provision of health services.

FINAL CONSIDERATIONS

The introduction and maintenance of people with disability in the Brazilian government agenda, achieved through efforts of social movements, non-governmental organizations, family activists and people with disabilities, allowed the creation of a Network of Rehabilitation Services in the Health Care Networks of SUS, due to their importance and complexity.

Besides keeping up with the changes in SUS, the changes in laws for services to people with disability over the years are multifactorial, also considering changes in the concepts of health-disease, disability and care in national and international contexts.

The rehabilitation services in SUS, through federal decrees and directives, are legally based on a legislative apparatus that foresees the organization of equipment and financial transfers for such equipment funding. It is an indication of progress and structuring of rehabilitation equipment in health, and acts as a mechanism that drives states and municipalities, in the context of decentralization and regionalization of health policy, to be responsible for the implementation of a rehabilitation network.

However, with the recent change in the transfer of resources to health in the context of financial and budgetary restrictions, the Ministry of Health shows a minor role as a driving agent, with consequent increase of conflicts and bargain at local level in terms of allocation of health resources. Therefore, representatives of social movements, administrators, coordinators and technicians of rehabilitation services are responsible for establishing greater articulation in defense of SUS, and specifically, of the rehabilitation area, to unify the various policies that regulate rehabilitation services in health to strengthen the area.

Participation of authors: Luciana de Assis Caetano: study conception; data collection, analysis and interpretation; text production. Luciana Assis Costa: study conception and design; data analysis and interpretation; text production and revision. Rosana Ferreira Sampaio: text revision. All authors participated in the approval of the final version of the study for publication.

REFERENCES

1. Organização Mundial da Saúde (OMS). Relatório mundial sobre a deficiência/World Report on Disability. São Paulo: Secretaria dos Direitos da Pessoa com Deficiência; 2012.
2. Brasil. Ministério da Saúde. Saúde da pessoa com deficiência: diretrizes, políticas e ações. Reabilitação [citado 02 jul. 2018]. Disponível em: http://portalms.saude.gov.br/saude-para-voce/saude-da-pessoa-com-deficiencia#reabilitacao.
3. Paulus Júnior A, Cordoni Júnior L. Políticas públicas de saúde no Brasil. Rev Espaço Saúde 2006;8(1):13-9.
4. Ribeiro CTM, Ribeiro MG, Araújo AP, Mello LR, Rubim LC, Ferreira JES. O sistema público de saúde e as ações de reabilitação no Brasil. Rev Panam Salud Publica. 2010;28(1):43-8. Disponível em: https://scielosp.org/pdf/rpsp/2010.v28n1/43-48/pt.
5. Cardoso LGRA. Estudo sobre a distribuição dos serviços de reabilitação: o caso do estado do Rio de Janeiro [dissertação]. Brasília: Fundação Oswaldo Cruz – FIOCRUZ; 2004.
6. Santos L. Região de saúde e suas redes de atenção: modelo organizativo-sistêmico do SUS. Cienc Saude Coletiva. 2017;22(4):1281-9. doi.org/10.1590/1413-81232017224.26392016.
7. Menicucci TMG, Costa LA, Machado JA. Pacto pela saúde: aproximações e colisões na arena federativa. Cienc Saude Coletiva. 2018;23(1):29-40. doi.org/10.1590/1413-81232018231.17902015.
8. Brasil. Ministério da Saúde. Secretaria-Executiva. Coordenação-Geral de Inovação Gerencial. Manual de orientação: elaboração de portarias no Ministério da Saúde. Versão preliminar. Brasília: Ministério da Saúde; 2010. (Série A. Normas e Manuais Técnicos.) [citado 11 ago. 2018]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/manual_de_orientacao_elaboracao_portarias.pdf.
9. Brasil. Ministério da Saúde (BR). Portaria nº 1060, de 5 de junho de 2002. Aprova a Política Nacional de Saúde da Pessoa Portadora de Deficiência [citado 2 jul. 2018]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt1060_05_06_2002.html.
10. Farias N, Buchalla CM. A Classificação Internacional de Funcionalidade, Incapacidade e Saúde da Organização Mundial da Saúde: conceitos, usos e perspectivas. Rev Bras Epidemiol. 2005;8(2):187-93. doi.org/10.1590/S1415-790X2005000200011.
11. Mângia EF, Muramoto MT, Lancman S. Classificação Internacional de Funcionalidade e Incapacidade e Saúde (CIF): processo de elaboração e debate sobre a questão da incapacidade. Rev Ter Ocup Univ São Paulo. 2008;19(2):121-30. doi.org/10.11606/issn.2238-6149.v19i2p121-130

12. Maior IL. Reabilitação baseada na comunidade. Uma proposta viável para o Brasil. Acta Fisiatr. 1996;3(2):7-8. Disponível em: http://www.revistas.usp.br/actafisiatrica/article/view/101997.

13. Curitiba, Paraná. Prefeitura Municipal. Assessoria Especial de Assistência à Pessoa com Deficiência. Terminologia. Terminologia sobre a pessoa que tem deficiência. Curitiba; 2013 [citado 23 ago. 2018]. Disponível em: http://www.pessoacomdeficiencia.curitiba.pr.gov.br/conteudo/terminologia/116.

14. Brasil. Decreto nº 6949, de 25 de agosto de 2009. Promulga a Convenção Internacional sobre os Direitos das Pessoas com Deficiência e seu Protocolo Facultativo, assinados em Nova York, em 30 de março de 2007 [citado 12 jul. 2018]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2007-2010/2009/decreto/d6949.htm.

15. Brasil. Secretaria Especial dos Direitos da Pessoa com Deficiência. Convenção sobre os Direitos da Pessoa com Deficiência. Brasília; 2010 [citado 23 ago. 2018]. Disponível em: http://www.pessoacomdeficiencia.gov.br/app/publicacoes/convencao-sobre-os-direitos-das-pessoas-com-deficiencia.

16. Salvador E. Fundo público e o financiamento das políticas sociais no Brasil. Serv Soc Rev. 2012;14(2):1-22. doi.org/10.5433/1679-4842.2012v14n2p4.

17. Fundação Getúlio Vargas (FGV). Centro de Pesquisa e Documentação de História Contemporânea do Brasil (CPDOC). Instituto Nacional de Assistência Médica da Previdência Social (INAMPS). Verbetes [citado 11 jun. 2017]. Disponível em: http://www.fgv.br/cpdoc/acervo/dicionarios/verbete-tematico/instituto-nacional-de-assistencia-medica-da-previdencia-social-inamps.

18. Scatena JHG, Tanaka OY. Os instrumentos normalizadores (NOB) no processo de descentralização da saúde. Saúde Soc. 2001;10(2):47-74. doi.org/10.1590/S0104-12902001000200005.

19. Brasil. Ministério da Saúde. Portaria nº 95, de 26 de janeiro de 2001. Aprova, na forma do anexo desta portaria, a Norma Operacional da Assistência à Saúde - NOAS-SUS 01/2001 que amplia as responsabilidades dos municípios na atenção básica; define o processo de reorganização da assistência; cria mecanismos para o fortalecimento da capacidade de gestão do sistema único de saúde e procede a atualização dos critérios de habilitação de estados e municípios [citado 2 jul. 2018]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2001/prt0095_26_01_2001.html.

20. Brasil. Ministério da Saúde. Secretaria de Assistência à Saúde. Manual de legislação em saúde da pessoa portadora de deficiência. Brasília: Ministério da Saúde; 2003. (Série B. Textos Básicos de Saúde). Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/manual_legis_port_def.pdf.

21. Machado RR. Políticas de saúde no Brasil: um pouco da história. Rev Saúde Pública (Santa Catarina). 2012;5(3):95-104. Disponível em: http://revista.saude.sc.gov.br/index.php/inicio/article/view/145/175.

22. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. 4a ed. Brasília: Ministério da Saúde; 2007. v.4. (Série E. Legislação de Saúde/Série Pactos pela Saúde 2006).

23. Brasil. Ministério da Saúde. Portaria nº 835, de 25 de abril de 2012. Institui incentivos financeiros de investimento e de custeio para o Componente Atenção Especializada da Rede de Cuidados à Pessoa com Deficiência no âmbito do Sistema Único de Saúde [citado 12 jul. 2018]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0835_25_04_2012.html.

24. Brasil. Ministério da Saúde. Portaria nº 3992, de 28 de dezembro de 2017. Altera a Portaria de Consolidação nº 6/GM/MS, de 28 de setembro de 2017, para dispor sobre o financiamento e a transferência dos recursos federais para as ações e os serviços públicos de saúde do Sistema Único de Saúde [citado 12 jul. 2018]. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt3992_28_12_2017.html.

25. JUSBRASIL. Financiamento da saúde [citado 25 ago. 2018]. Disponível em: https://cd.jusbrasil.com.br/noticias/585609431/financiamento-da-saude-e-tema-de-audiencia-na-quinta.

Submmitted in: 31.08.2018
Accepted in: 14.12.2018