ARTICLE
https://doi.org/10.22239/2317-269x.01769

Management of health actions of the State Health Departments: analysis of their respective health regulations

Gestão das ações sanitárias das Secretarias Estaduais de Saúde: análise dos respectivos regramentos e códigos de vigilância sanitária

Alex Sander Duarte da Matta[I,*]

Lindinalva Helena Barbosa Teixeira[II]

Artur Iuri Alves de Sousa[I]

ABSTRACT

Introduction: The performance of health surveillance in the States, Federal District and Municipalities was established through health codes, regulated by Acts and Laws. **Objective:** In this sense, we sought to make a situational diagnosis regarding the composition and organizational structure in the 27 Federated Units. **Method:** A qualitative study of legal rules was conducted through active searches of these documents, which were analyzed for attributes correlated to health surveillance action. **Findings:** It was observed that about 30.0% were published before the 1988 Constitution, but there are more recent rules, such as those of Piauí, Rio Grande do Norte and the Federal District, published in the 2010s. It was observed that 88.9% of the rules include actions integrated into the health system, such as health care, epidemiological surveillance, environmental surveillance and worker health. Another attributes were little present in the rules, such as: those related to the competencies of the public health laboratories network (48.1%), the management of risk factors (22.2%), funding (33.3%) and health surveillance rates (18.5%). **Conclusions:** State and the Federal District laws are based on generalist norms, which no longer meet the longings of contemporary society or the reality of the determinants and health conditions of their territories. Therefore, there is a need for harmonization and modernization of these legal rules, with the promotion of new legal frameworks, capable of producing the safety and effectiveness of health surveillance actions practiced in each territory.

KEYWORDS: Health Management; Regulation; Health Codes; Health Surveillance Actions

RESUMO

Introdução: A atuação da vigilância sanitária nos municípios, estados e no Distrito Federal foi estabelecida por meio de códigos de saúde, regulamentados por decretos e leis. **Objetivo:** Realizar um diagnóstico situacional quanto à composição e à estrutura organizacional nas 27 unidades federadas que compõem o Sistema Nacional de Vigilância Sanitária (SNVS), por meio da análise da legislação sanitária vigente. **Método:** Foi realizado um estudo qualitativo dos regramentos jurídicos, por meio de buscas ativas desses documentos, sendo estes analisados quanto a atributos correlacionados à ação da Vigilância Sanitária. **Resultados:** Observou-se que cerca de 30,0% foram publicados antes da Constituição de 1988, mas há regramentos mais recentes, como os do Piauí, do Rio Grande do Norte e do Distrito Federal, publicados na década de 2010. Observou-se que 88,9% dos regramentos abrangem ações integradas ao sistema de saúde, como assistência à saúde, vigilância epidemiológica, vigilância ambiental e saúde do trabalhador. Outros atributos se mostraram pouco presentes nos regramentos, como: os referentes às competências da rede laboratórios de saúde pública (48,1%), ao gerenciamento dos fatores de riscos (22,2%), ao financiamento (33,3%) e às taxas de fiscalização sanitária (18,5%). **Conclusões:** As legislações estaduais e do Distrito Federal estão amparadas em normas

[I] Agência Nacional de Vigilância Sanitária (Anvisa), Brasília, DF, Brasil

[II] Consultora da Organização Pan-Americana de Saúde (OPAS), Maceió, AL, Brasil

* **E-mail:** alex.matta@anvisa.gov.br

Received: Aug 28, 2020
Approved: Nov 10, 2020

generalistas, que não mais atendem aos anseios da sociedade contemporânea nem a realidade dos determinantes e condicionantes de saúde de seu território. Portanto, verifica-se a necessidade de harmonização e modernização desses regramentos jurídicos, com a promoção de novos arcabouços jurídicos, capazes de produzir a segurança e a efetividade das ações de vigilância sanitária praticadas em cada território.

PALAVRAS-CHAVE: Gestão em Saúde; Regulamentação; Códigos Sanitários; Ações de Vigilância Sanitária

INTRODUCTION

Health is the right of all and the duty of the State, to be guaranteed through social and economic policies aimed at reducing the risk of disease and other conditions and universal and equal access to actions and services for health promotion, protection and recovery.[1] Therefore, health is a fundamental human right, and the State must provide the essential conditions for this right to be upheld.[2]

The set of health actions and services provided by federal, state and municipal agencies and public institutions, of direct and indirect administration, and foundations maintained by the government forms the so-called Brazilian Unified Health System (SUS). Health surveillance actions are under the SUS field of action.[2]

In this sense, to assess the impact of health surveillance actions in preventing or intervening in a health problem, the map and the health profile of the relevant territory must be determined; the various types of manufacturing, commercial and service-providing establishments must be identified and quantified and the following activities should be performed: describing their situation and respective risk management; proposing a systematic plan for monitoring the quality of the work done there; designing monitoring and evaluation indicators for the inspection work and verifying the efficiency of these actions; identifying critical points; and proposing strategic actions for improvement or intervention.

Federal Law n. 9.782 of January 26, 1999,[3] which defined the National Health Surveillance System (SNVS), describes that it is up to the Union, through the National Health Surveillance Agency (Anvisa), to monitor and coordinate state, district and municipal health surveillance activities. Considering that the Federal Constitution of the Federative Republic of Brazil of 1988[1] established a federative model based on the autonomy of federated entities, the use of the word "coordinate" does not mean unilateral initiatives, but rather a tripartite decision-making process.

The health surveillance work in the entities that make up the SNVS was established through health codes or sanitary codes regulated by decrees and laws. The objective of this article is to perform the situational diagnosis of the composition and organizational structure of the SNVS entities at the state and district level through the analysis of the composition of the health codes in force in Brazil's 27 federated units (FUs).

METHOD

This is a qualitative study of the legal regulations under health surveillance (sanitary codes, health codes, among other legal norms), in force in the 27 Brazilian FUs. An active search for these regulations was done online and by request via email to the managers of the state and district health surveillance bodies. The period of search for regulations was from June 1st to July 25th, 2020.

The analysis of legal regulations considered the following attributes: scope; regarding the health system; health regulation objects; definition and assignment of competences of the public health laboratory network; identification and management of risk factors and classification of health risks; identification of public acts and forms of health regulation; and description of the regulation procedures and health control of products, services, environments, and professional activities. We also analyzed: the definition of the health authority; the acts for the designation of health authorities; acts of codes of conduct and ethics; instruments for educating and training health professionals; and instruments for describing health infractions and penalties.

The following were evidenced: health administrative procedures and procedural flow; procedure for tax analysis; instruments to promote communication and information on health alerts; instruments for the health information system; instruments for society participation; internal audit and evaluation; instruments for defining the forms of financing; and instruments for defining health inspection fees.

Descriptive analysis was performed for the presence or absence of such attributes in health regulations. The classification regarding the presence or absence of the attribute considered analyses done by different researchers. When there was any divergence about the classification, the attribute was discussed in a group that tried to come to a consensus about the classification. This study did not need the approval of the Research Ethics Committee because it was based exclusively on the analysis of information contained in publicly accessible legal regulations.

RESULTS

We observed that the legal health regulations in force in the 27 FUs were published through decrees, complementary laws, and state laws (Table 1). We also observed that the states of Piauí, Rio Grande do Norte, and the Federal District are the FUs with the newest regulations. On the other hand, there are FUs with regulations that were published in the 1970s—Rio de Janeiro and Rio Grande do Sul. More than half of these regulations date

back to long ago, from between the 1970s and the 2000s, and of these, 30.0% were written before the Federal Constitution of 1988. Many current regulations were published between 2001 to 2010 (Amazonas, Roraima, Amapá, Paraíba, Sergipe, Paraná, Mato Grosso and Goiás), however, most regulations were published in the 1980s and 1990s, totaling 14 FUs (Table 2).

When analyzing the scope of the regulations, we observed that 100.0% of them had a definition of the FU's duties, whereas 88.9% had the definition of the municipality's duties. With regard to the objects of health regulation, we observed that 100.0% of them deal with food, additives, beverages and drinking water; drugs, medications, supplies and related products; cosmetics, perfumes, hygiene products and similar products; household sanitizers and similar products; products, reagents, equipment, and other medical devices; healthcare services; and services of interest to health. On the other hand, only 29.6% of the regulations deal with inspection of professional practice (Table 3).

Still in the analysis of attributes, we observed that 48.1% of the rules contained definition and assignment of competences of the public health laboratory network, 22.2% had identification of risk factor management and classification of health risks, 18.5% had specification of acts of codes of conduct and ethics, 40.7% had instruments for the participation of society, 40.7% had internal audit and evaluation, 33.3% had instruments for defining the forms of financing, and 18.5% had instruments for defining health inspection fees (Table 3).

As for the assignments and competences of the public health laboratory network, we observed that more than half of the FUs do not have neither a definition, assignments or competences. Assignments within the scope of risk management and classification are observed in six of the 27 FUs, namely: Amazonas, Federal District, Minas Gerais, Mato Grosso do Sul, Paraná, and São Paulo (Figure).

As for the guidelines adopted to define the health authorities, the Health Department of the state of Pará does not have such powers. The same happens in the state of Alagoas, which, despite detailing the duties, did not identify the health authorities. A large number of state health departments defined the acts of designation of these health authorities: Federal District, Espírito Santo, Goiás, Maranhão, Minas Gerais, Mato Grosso, Paraíba, Piauí, Paraná, Rio Grande do Norte, Rondônia, Roraima, Rio Grande do Sul, Santa Catarina, Sergipe, São Paulo, and Tocantins (Table 4).

Regarding the guidelines for the conduct and ethics of these health authorities, they were found in the regulations of the states of Espírito Santo, Paraná, Rio Grande do Norte, Roraima, and São Paulo. As for the common guidelines observed in the published regulations, including those referring to instruments, procedures and administrative procedural flows for the investigation of health infractions, enforcement of penalties and performance of laboratory analyses for tax analysis, only the regulations of the health departments of the states of Bahia and Pernambuco do not describe them in their regulations (Table 4).

Guidelines for the information system and the communication of health alerts were absent in the following states: Acre, Bahia, Pernambuco, Piauí, Rio de Janeiro, Rio Grande do Norte, and Sergipe (Table 4). Guidelines for society's participation in planning were found in the health regulations of many FUs, as follows: Amazonas, Amapá, Federal District, Goiás, Maranhão, Piauí, Paraná, Rondônia, Roraima, Sergipe, and São Paulo (Table 4).

Chart 1. Legal and health regulations in force in the 27 Brazilian federated units, 2020.

Federated Unit	Legal and Health Regulation	Date
Rondônia	Decree Law n. 36[4]	12/17/1982
Acre	Complementary Law n. 6[5]	12/27/1982
Amazonas	Complementary Law n. 70[6]	12/03/2009
Roraima	Complementary Law n. 62[7]	14/01/2003
Pará	State Law n. 5.199[8]	12/10/1984
Amapá	State Law n. 719[9]	11/13/2002
Tocantins	Decree n. 680[10]	11/23/1998
Maranhão	Complementary Law n. 39[11]	12/15/1998
Piauí	State Law n. 6.174[12]	02/06/2012
Ceará	State Law n. 10.760[13]	12/17/1982
Rio Grande do Norte	Complementary Law n. 31[14]	11/24/1982
Paraíba	State Law n. 7.069[15]	04/12/2002
Pernambuco	Decree n. 20.786[16]	08/10/1998
Alagoas	State Law n. 4.406[17]	12/12/1982
Sergipe	State Law n. 6.345[18]	01/03/2008
Bahia	Decree n. 29.414[19]	01/05/1983
Minas Gerais	State Law n. 13.317[20]	09/24/1999
Espírito Santo	State Law n. 6.066[21]	12/31/1999
Rio de Janeiro	Decree n. 1754[22]	03/16/1978
São Paulo	State Law n. 10.083[23]	09/23/1998
Paraná	State Law n. 12.331[24]	11/23/2001
Santa Catarina	State Law n. 6.320[25]	12/20/1983
Rio Grande do Sul	Decree n. 23.430[26]	10/24/1974
Mato Grosso do Sul	State Law n. 1.293[27]	09/21/1992
Mato Grosso	State Law n. 7.110[28]	02/10/1999
Goiás	State Law n. 16.140[29]	10/02/2007
Federal District	Law n. 5.321[30]	03/07/2014

Source: Prepared by the authors, 2020.

Chart 2. Year of publication of legal and health regulations, 2020.

Period	Federated Unit
1971-1980	RJ; RS
1981-1990	RO; AC; PA; CE; AL; BA; SC
1991-2000	TO; MA; PE; MG; ES; SP; MS
2001-2010	AM; RR; AP; PB; SE; PR; MT; GO
2011-2020	PI; RN; DF

Source: Prepared by the authors, 2020.
AC: Acre; AL: Alagoas; AM: Amazonas; AP: Amapá; BA: Bahia; CE: Ceará; DF: Federal District; ES: Espírito Santo; GO: Goiás; MA: Maranhão; MG: Minas Gerais; MS: Mato Grosso do Sul; MT: Mato Grosso; PA: Pará; PB: Paraíba; PE: Pernambuco; PI: Piauí; PR: Paraná; RS: Rio Grande do Sul; RJ: Rio de Janeiro; RO: Rondônia; RN: Rio Grande do Norte; RR: Roraima; SC: Santa Catarina; SE: Sergipe; SP: São Paulo; TO: Tocantins.

Chart 3. Percentage distribution of the presence of the attributes analyzed in the health regulations of the 27 Brazilian federated units, 2020.

Attributes	N	%
Scope of the health code		
Definition of duties of the federated unit	27	100,0%
Definition of the duties of the municipality	24	88.9%
Regarding the health system		
Definition of integrated healthcare actions	26	96.3%
Definition of epidemiological surveillance and health protection actions	26	96.3%
Definition of environmental sanitation and environmental surveillance actions	26	96.3%
Definition of worker health surveillance actions and working conditions	24	88.9%
Health regulation objects		
Sanitation and environment	25	92.6%
Buildings, housing and others	20	74.1%
Food, additives, beverages and drinking water	27	100.0%
Drugs, medicines, supplies and related products	27	100.0%
Cosmetics, perfumes, toiletries and similar products	27	100.0%
Household sanitizers and similar products	27	100.0%
Products, reagents, equipment and other medical devices	27	100.0%
Health care services	27	100.0%
Services of interest to health	27	100.0%
Supervision of professional practice	8	29.6%
Definition and assignment of competences of the public health laboratory network	13	48.1%
Identification and management of risk factors and classification of health risks	6	22.2%
Identification of public acts and forms of health regulation	27	100.0%
Description of procedures of the forms of regulation and health control of products, services, environments and professional activities	27	100.0%
Definition of health authority	26	96.3%
Acts for designation of health authorities	17	63.0%
Has acts of codes of conduct and ethics	5	18.5%
Instruments for educating and training health professionals	24	88.9%
Instruments for describing health infractions and penalties	24	88.9%
Has health administrative procedures and procedural flow	24	88.9%
Procedure for tax analysis	24	88.9%
Tools to promote communication and information on health alerts	19	70.4%
Instruments for the health information system	21	77.8%
Instruments for society participation	11	40.7%
Internal audit and evaluation	11	40.7%
Instruments for defining the forms of financing	9	33.3%
Instruments for defining health inspection fees	5	18.5%

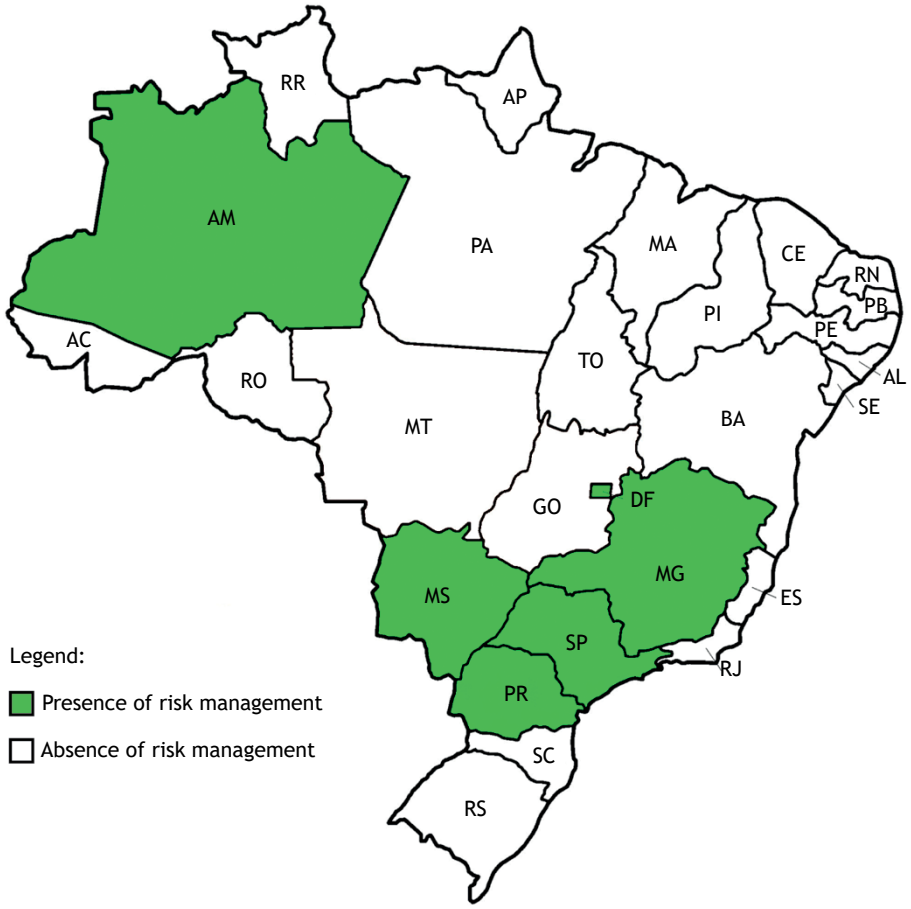
Source: Prepared by the authors, 2020.

As for the controls and performance of internal audits, these guidelines were provided for in the regulations of the state health departments of the following states: Amazonas, Goiás, Maranhão, Minas Gerais, Paraíba, Piauí, Paraná, Roraima, Santa Catarina, Sergipe, and São Paulo (Table 4). The forms of financing and application of health surveillance fees are described in the regulations of the following states: Alagoas, Amazonas, Amapá, Espírito Santo, Goiás, Maranhão, Paraíba, Piauí, Paraná, and Sergipe (Table 4).

DISCUSSION

This study identified that some regulations in force were published in the 1970s, like those of Rio de Janeiro and Rio Grande do Sul, and some are more recent, like those of Piauí, Rio Grande do Norte and the Federal District, published in the 2010s. Of the regulations we analyzed, about 30.0% were published before the 1988 constitution. In general, at least 88.9% of the regulations address actions that are integrated into the health system, like healthcare, epidemiological surveillance, environmental surveillance and worker health. Some attributes are rarely found in the regulations, like those addressing the competences of the public health laboratory network (48.1%), the management of risk factors (22.2%), financing (33.3%), and health inspection fees (18.5%).

Overall, the legal regulations have proved heterogeneous in the application of the topics and guidelines established in the SUS regulations. These are complex systems where state and district



Source: Prepared by the authors, 2020.

Figure. Distribution regarding the presence (Yes) and absence (No) of the management and classification of health risk in the health regulations by federated unit, 2020.

laws are supported by general norms that were mostly drafted at an identical or similar historical moment, based on a legal framework that no longer meets the aspirations of contemporary society nor match the reality of health determinants and conditions in the territory.

It is quite worrying that less than half of the states do not have the definition and assignment of competences of the public health laboratory network in their regulations. Within the health structure, the services that enable knowledge and analysis of laboratory data sets are particularly relevant to support epidemiological surveillance and health surveillance actions, which are both fields of action of public health.

The public health laboratory is an integral part of the health surveillance structure and an essential instrument for the control of products of interest to health. Thus, the laboratory network, in particular the health surveillance laboratory network, works in the production of scientific and technological knowledge through prior control and fiscal analyses in order to assess the quality and compliance of the products. It is therefore fundamental for risk analysis and management, as well as for informed decision-making in health surveillance. Also, these public health laboratories are responsible for monitoring health control actions and participating in epidemiological surveys. This time, the health codes must include this laboratory support, considering that it contributes with accurate and reliable information for the solution of important health problems in the country.[31]

Anvisa's RDC n. 207, of January 3, 2018,[32] in its art. 2 and respective items, provides for the premises for the organization of health surveillance actions. The degree of health risk intrinsic to activities and products subject to health surveillance is a common principle to all of them and should be systematically addressed by the federated entities. The study revealed that only six states address the management and classification of health risks in their regulations, namely: Amazonas, Federal District, Minas Gerais, Mato Grosso do Sul, Paraná, and São Paulo. It is demonstrated, therefore, that this practice should be widely adopted in state regulations through the implementation of a model that encourages risk management considering the particularities of each territory.

With regard to professional practice, the analysis indicated that less than 30.0% of the state health regulations provide for inspections in this area. Supervising professional practice is a way to protect society and professionals alike. When compliance with the specific standards of the profession and the legislation

Chart 4. Presence (Y) or absence (N) of the attributes analyzed in the health regulations in the Brazilian federated units, 2020.

FU	AC	AL	AM	AP	BA	CE	DF	ES	GO	MA	MG	MS	MT	PA	PB	PE	PI	PR	RJ	RN	RO	RR	RS	SC	SE	SP	TO
Attributes																											
1- Does it have a Sanitary Code or a Health Code?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2- Regarding the scope of the Health Code:																											
a) Does it define the duties of the state?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
b) Does it define the duties of the municipalities?																											
	Y	N	Y	Y	Y	Y	NA	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
3- As for the Health System, does it describe the actions in:																											
a) Definition of integrated healthcare actions?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
b) Definition of epidemiological surveillance and health protection actions?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
c) Definition of environmental sanitation and environmental surveillance actions?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
d) Definition of worker health surveillance actions and working conditions?																											
	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
e) Health surveillance actions																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
4- As for the objects of health regulation:																											
a) Sanitation and environment																											
	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
b) Buildings, housing and others																											
	N	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
c) Food, additives, beverages and drinking water																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
d) Drugs, medicines, supplies and related products																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
e) Cosmetics, perfumes, toiletries and similar products																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
f) Household sanitizers and similar products																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
g) Products, reagents, equipment and other medical devices																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
h) Health care services																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
i) Services of interest to health																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
l) Supervision of professional practice																											
	N	Y	N	N	Y	Y	N	N	N	N	N	N	N	Y	Y	N	N	N	Y	Y	N	N	Y	N	N	N	Y
5- Does it provide for the definition and assignment of competences of the public health laboratory network?																											
	Y	Y	Y	Y	N	Y	N	N	N	N	N	Y	N	N	Y	Y	N	Y	N	Y	Y	N	N	Y	N	N	Y
6- Does it provide for the identification and management of risk factors and classification of health risks?																											
	N	N	Y	N	N	N	Y	N	N	N	Y	Y	N	N	N	N	N	Y	N	N	N	N	N	N	N	Y	N
7- Does it provide for the identification of public acts and forms of health regulation?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
8- Does it have the description of procedures of the forms of regulation and health control of products, services, environments and professional activities?																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
9- Does it define the health authority?																											
	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10- Does it have acts for assigning health authorities?																											
	N	N	N	N	N	N	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y

Continue

Continuation

FU	AC	AL	AM	AP	BA	CE	DF	ES	GO	MA	MG	MS	MT	PA	PB	PE	PI	PR	RJ	RN	RO	RR	RS	SC	SE	SP	TO
11- Does it have acts of codes of conduct and ethics?																											
	N	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	Y	N	Y	N	N	N	Y	N
12- Does it provide for instruments for educating and training healthcare professionals																											
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N
13- Does it provide for instruments for describing health infractions and penalties?																											
	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
14- Does it provide for health administrative procedures and procedural flow																											
	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
15- Does it provide for a tax analysis procedure?																											
	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
16- Does it provide for tools to promote communication and information on health alerts?																											
	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	N	N	Y	Y	Y	Y	N	Y	Y
17- Does it have instruments for the Health Information System?																											
	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	Y	Y	Y	Y	Y	Y	N
18- Does it have instruments for the participation of society?																											
	N	N	Y	Y	N	N	Y	N	Y	Y	N	N	N	N	N	N	Y	Y	N	N	Y	Y	N	N	Y	Y	N
19- Does it have an internal evaluation and audit system?																											
	N	N	Y	N	N	N	N	N	Y	Y	Y	N	N	N	Y	N	Y	Y	N	N	N	Y	N	Y	Y	Y	N
20- Does it have instruments for defining the forms of financing?																											
	N	N	Y	Y	N	N	N	Y	Y	Y	N	N	N	N	Y	N	Y	Y	N	N	N	N	N	N	Y	N	N
21- Does it have instruments for defining health inspection fees?																											
	N	Y	Y	N	N	N	N	N	Y	N	N	N	Y	N	Y	N	N	N	N	N	N	N	N	N	N	N	N

Source: Prepared by the authors, 2020.
AC: Acre; AL: Alagoas; AM: Amazonas; AP: Amapá; BA: Bahia; CE: Ceará; DF: Federal District; ES: Espírito Santo; GO: Goiás; MA: Maranhão; MG: Minas Gerais; MS: Mato Grosso do Sul; MT: Mato Grosso; PA: Pará; PB: Paraíba; PE: Pernambuco; PI: Piauí; PR: Paraná; RS: Rio Grande do Sul; RJ: Rio de Janeiro; RO: Rondônia; RN: Rio Grande do Norte; RR: Roraima; SC: Santa Catarina; SE: Sergipe; SP: São Paulo; TO: Tocantins; NA: Not applicable.

that governs it is monitored, society can rely on duly qualified professionals that work according to the legislation and comply with all relevant health standards.

With regard to the application of health surveillance fees, only five states had this content in their regulations. This number is worrying, especially considering that the fee is a tax and, pursuant to art. 77 of the National Tax Code, Federal Law n. 5.172, of October 25, 1966,[33] has as its triggering event the regular exercise of police power or the effective or potential use of a specific and divisible public service provided to taxpayers or made available to them. This is the case of services provided by health surveillance. Art. 150, I, of the Federal Constitution of 1988[1] enshrines the principle of tax legality by dictating that "the Union, States, Federal District and Municipalities are prohibited from demanding or increasing a tax without a law that determines that". Therefore, states that have fees for the collection of health permits without the foundation of a legal provision directly hurt the Federal Constitution. Thus, to preserve the integrity of the legal and administrative framework, implementing health codes that include legal provisions on fees is essential for health surveillance management, under penalty of judicialization of the matter.

With the advent of new legislation that correlates with the work of health surveillance, such as the Economic Freedom Law, Federal Law n. 13.874, of September 20, 2019,[34] a review of the legal framework will enable greater security and effectiveness in health surveillance actions carried out in each territory, especially considering the changes that have occurred in recent years in the political, economic, social, and legal arenas. It is possible to encourage cross-sector collaboration among several health-related areas, especially primary care, epidemiology, occupational health and environmental health in initiatives that are in line with the SUS principles and guidelines that were outlined in 2001, at the 1st National Conference on Health Surveillance.[35]

Considering the limitations of the study, the results make reference to a descriptive analysis of the presence or absence of the attributes in health regulations. The classification regarding the presence or absence of the attribute considered the diagnosis made by different researchers. When there was any divergence about the classification, the attribute was discussed in a group that tried to come to a consensus about the classification. In this context, the results we found reveal the need for these guidelines to be standardized and updated in order to promote the integrity and universality of health actions, with the improvement of health surveillance actions. This process must be collective, with the active participation of different stakeholders, so that legal norms can be drafted to meet the changes arising from the dynamics of social relations, as well as the agility arising from the incorporation of new technologies and innovation.

CONCLUSIONS

In the analysis of the state health regulations currently in force, we can observe some heterogeneity in the application of the topics and guidelines established in the SUS regulations. For this reason, it is imperative that the states and the Federal District, through their health surveillance bodies, review the guidelines of their regulations considering the particularities of each territory, as they are unique and individual. It is extremely valid, however, to pursue the legal standardization and update considering artifacts in the scope of quality management and monitoring and evaluation, which will support the effective evaluation of some results of health surveillance work that are now invisible.

This process must be collective, with the active participation of different stakeholders, since most federated entities are based on a legal regulation that is, in turn, based on a historical context that no longer meets the demands of contemporary society.

Any new health regulation to be proposed should consider the principle of the degree of health risk intrinsic to activities and products, even because the current legal norms call for this change, this paradigm shift by many health surveillance bodies. Legal norms should be drafted so as to meet the changes arising from the dynamics of social relations, as well as the agility arising from the incorporation of new technologies and innovation. In the same way, may they foster entrepreneurship, reduce bureaucracy and enable tax relief, with the facilitation of business environments so that society can benefit from safer products and services that promote and protect the health of the population.

REFERENCES

1. Senado Federal (BR). Constituição da República Federativa do Brasil. Brasília: Senado Federal; 1988.
2. Brasil. Lei Nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial União. 20 set 1990.
3. Brasil. Lei Nº 9.782, de 26 de janeiro de 1999. Define o sistema nacional de vigilância sanitária, cria a Agência Nacional de Vigilância Sanitária, e dá outras providências. Diário Oficial União. 27 jan 1999.
4. Governo do Estado de Rondônia. Decreto lei Nº 36, de 17 de dezembro de 1982. Dispõe sobre o sistema de saúde do estado de Rondônia e aprova normas sobre promoção, proteção e recuperação da saúde. Diário Oficial do Estado. 27 dez 1982.
5. Governo do Estado do Acre. Lei complementar Nº 6, de 27 de dezembro de 1982. Institui o código de saúde do estado do Acre que aprova a legislação básica sobre a promoção, proteção e recuperação da saúde de dispõe sobre o subsistema estadual de saúde. Diário Oficial do Estado. 28 dez 1982.
6. Governo do Estado do Amazonas. Lei complementar Nº 70, de 3 de dezembro de 2009. Institui, no âmbito do estado do Amazonas, o código de saúde e dá outras providências. Diário Oficial do Estado. 4 dez 2009.
7. Governo do Estado de Roraima. Lei complementar Nº 62, de 14 de janeiro de 2003. Dispõe sobre o código sanitário do estado de Roraima e dá outras providências. Diário Oficial do Estado. 15 jan 2003.
8. Governo do Estado do Pará. Lei Nº 5.199, de 10 de dezembro de 1984. Dispõe sobre o sistema de saúde do estado do Pará e aprova a legislação básica sobre promoção, proteção e recuperação da saúde. Diário Oficial do Estado. 31 dez 1984.
9. Governo do Estado do Amapá. Lei Nº 719, de 12 de novembro de 2002. Dispõe sobre o código de saúde do estado do Amapá e dá outras providências. Diário Oficial do Estado. 13 nov 2002.
10. Governo do Estado do Tocantins. Decreto Nº 680, de 23 de novembro de 1998. Institui o código sanitário do estado do Tocantins. Diário Oficial do Estado. 24 nov 1998.
11. Governo do Estado do Maranhão. Lei complementar Nº 39, de 15 de dezembro de 1998. Dispõe sobre o código se saúde no estado e dá outras providências. Diário Oficial do Estado. 16 dez 1998.
12. Governo do Estado do Piauí. Lei Nº 6.174, de 6 de fevereiro de 2012. Dispõe sobre o código de saúde do estado do Piauí e dá outras providências. Diário Oficial do Estado. 7 fev 2012.
13. Governo do Estado do Ceará. Lei Nº 10.760, de 16 de dezembro de 1982. Dispõe sobre o sistema de saúde do estado do Ceará e aprova a legislação básica sobre a promoção, proteção e recuperação da saúde. Diário Oficial do Estado. 17 dez 1982.
14. Governo do Estado do Rio Grande do Norte. Lei complementar Nº 31, de 24 de novembro de 1982. Institui o código estadual de saúde e aprova normas básicas sobre promoção, proteção e recuperação da saúde, e dá outras providências. Diário Oficial do Estado. 25 nov 1982.
15. Governo do Estado da Paraíba. Lei Nº 7.069, de 12 de abril de 2002. Institui o Sistema Estadual de Vigilância Sanitária da Paraíba, cria a Agência Estadual de Vigilância Sanitária da Paraíba e dá outras providências. Diário Oficial do Estado. 13 abr 2002.
16. Governo do Estado de Pernambuco. Decreto Nº 20.786, de 10 de agosto de 1998. Regulamenta o código sanitário do estado de Pernambuco. Diário Oficial do Estado. 10 ago 1998.
17. Governo do Estado de Alagoas. Lei Nº 4.406, de 10 de dezembro de 1982. Dispõe sobre o sistema de saúde do estado de Alagoas e aprova a legislação básica sobre promoção, proteção e recuperação da saúde. Diário Oficial do Estado. 11 dez 1982.
18. Governo do Estado de Sergipe. Lei Nº 6.345, de 2 de janeiro de 2008. Dispõe sobre a organização e funcionamento do Sistema Único de Saúde no estado de Sergipe, e dá outras providências. Diário Oficial do Estado. 3 jan 2008.
19. Governo do Estado da Bahia. Decreto Nº 29.414, de 5 de janeiro de 1983. Regulamenta a lei Nº 3.982, de 29 de dezembro de 1981, que dispões sobre o subsistema de saúde do estado da Bahia, aprova a legislação básica sobre a promoção, proteção e recuperação da saúde e dá outras providências. Diário Oficial do Estado. 6 jan 1983.

20. Governo do Estado de Minas Gerais. Lei Nº 13.317, de 24 de setembro de 1999. Código de saúde do estado de Minas Gerais. Diário Oficial do Estado. 25 set 1999.
21. Governo do Estado do Espírito Santo. Lei Nº 6.066, de 31 de dezembro de 1999. Regula a organização e o funcionamento do Sistema Único de Saúde, no âmbito do estado do Espírito Santo, estabelece normas de promoção, proteção e recuperação da saúde e dispõe sobre as infrações sanitárias e respectivo processo administrativo. Diário Oficial do Estado. 3 jan 2000.
22. Governo do Estado do Rio de Janeiro. Decreto Nº 1.754, de 14 de março de 1978. Medicina e saúde pública: estabelecimentos relacionados e exercício profissional. Diário Oficial do Estado. 15 mar 1978.
23. Governo do Estado de São Paulo. Lei Nº 10.083, de 23 de setembro de 1998. Dispõe sobre o código sanitário do estado de São Paulo. Diário Oficial do Estado. 24 set 1998.
24. Governo do Estado do Paraná. Lei Nº 13.331, de 23 de novembro de 2001. Dispõe sobre a organização, regulamentação, fiscalização e controle das ações dos serviços de saúde no estado do Paraná. Diário Oficial do Estado. 26 nov 2001.
25. Governo do Estado de Santa Catarina. Lei Nº 6.320, de 20 de dezembro de 1983. Dispõe sobre normas gerais de saúde, estabelece penalidades e dá outras providências. Diário Oficial do Estado. 22 dez 1983.
26. Governo do Estado do Rio Grande do Sul. Decreto Nº 23.430, de 24 de outubro de 1974. Dispõe sobre a promoção, proteção e recuperação da saúde pública. Diário Oficial do Estado. 25 out 1974.
27. Governo do Estado do Mato Grosso do Sul. Lei Nº 1.293, de 21 de setembro de 1992. Dispõe sobre o código sanitário do estado de Mato Grosso do Sul, e dá outras providências. Diário Oficial do Estado. 22 set 1992.
28. Governo do Estado do Mato Grosso. Lei Nº 7.110, de 10 de fevereiro de 1999. Dispõe sobre a promoção, proteção e recuperação da saúde e dá outras providências. Diário Oficial do Estado. 10 fev 1999.
29. Governo do Estado de Goiás. Lei Nº 16.140, de 2 de outubro de 2007. Dispõe sobre o Sistema Único de Saúde, as condições para promoção, proteção e recuperação da saúde, organização, regulamentação, fiscalização e o controle dos serviços correspondentes e dá outras providências. Diário Oficial do Estado. 5 out 2007.
30. Governo do Distrito Federal. Lei Nº 5.321, de 6 de março de 2014. Institui o código de saúde do Distrito Federal. Diário Oficial do Distrito Federal. 7 mar 2014.
31. Santos AR. A rede laboratorial de saúde pública e o SUS. Inf Epidemiol Sus. 1997;6(2):7-14. https://doi.org/10.5123/S0104-16731997000200002
32. Agência Nacional de Vigilância Sanitária – Anvisa. Resolução RDC Nº 207, de 3 de janeiro de 2018. Dispõe sobre a organização das ações de vigilância sanitária, exercidas pela união, estados, Distrito Federal e municípios, relativas à autorização de funcionamento, licenciamento, registro, certificação de boas práticas, fiscalização, inspeção e normatização, no âmbito do sistema nacional de vigilância sanitária SNVS. Diário Oficial União. 5 jan 2018.
33. Brasil. Lei Nº 5.172, de 25 de outubro de 1966. Dispõe sobre o sistema tributário nacional e institui normas gerais de direito tributário aplicáveis à união, estados e municípios. Diário Oficial da União. 26 out 1966.
34. Brasil. Lei Nº 13.874, de 20 de setembro de 2019. Institui a declaração de direitos de liberdade econômica; estabelece garantias de livre mercado; altera as leis Nº 10.406, de 10 de janeiro de 2002 (código civil), Nº 6.404, de 15 de dezembro de 1976, Nº 11.598, de 3 de dezembro de 2007, Nº 12.682, de 9 de julho de 2012, Nº 6.015, de 31 de dezembro de 1973, Nº 10.522, de 19 de julho de 2002, Nº 8.934, de 18 de novembro 1994, o decreto-lei Nº 9.760, de 5 de setembro de 1946 e a consolidação das leis do trabalho, aprovada pelo decreto-lei Nº 5.452, de 1º de maio de 1943; revoga a lei delegada Nº 4, de 26 de setembro de 1962, a lei Nº 11.887, de 24 de dezembro de 2008, e dispositivos do decreto-lei Nº 73, de 21 de novembro de 1966; e dá outras providências. Diário Oficial União. 20 set 2019.
35. Agência Nacional de Vigilância Sanitária – Anvisa. Relatório final. In: Anais da 1ª Conferência Nacional de Vigilância Sanitária; Brasília, Brasil. Brasília: Agência Nacional de Vigilância Sanitária; 2001.

Acknowledgement

To the managers of the state and Federal District health surveillance bodies who took the time to research their health regulations. To the Office of the National Health Surveillance System (ASNVS/Anvisa), for enabling this study. Also, to the Pan American Health Organization (PAHO), for their collaboration in the project.

Authors' Contribution

Matta ASD, Teixeira LHB, Sousa AIA — Conception, planning (study design), acquisition, analysis, interpretation of data and writing of the manuscript. All authors approved the final draft of the manuscript.

Conflict of Interest

Authors have no potential conflict of interest to declare, related to this study's political or financial peers and institutions.