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HEALTH CARE IN BRAZILIAN FEDERALISM

André Medici

Inter-American Development Bank[1]

[1] The views expressed in this paper do not reflect those of the Inter-American Development Bank.

Introduction to Brazilian Federalism

Brazilian federalism developed differently from the classical American federalism. The *United States of America* arose during the conflicts for the independence of 13 colonies (1776) that agreed to be unified under the umbrella of a Nation. Afterwards, other states joined the new federation; some by political will, some by force.

In the *United States of Brazil*, the Nation emerged earlier than states, despite the strong power of some regional oligarchies. After gaining its independence (1822), Brazil became a monarchy while other Latin American countries emerged as republics. External and internal pressures gradually contributed to a weakening of the Brazilian monarchy. On the external front, the slavery-based economy did not follow international agreements for freedom and civil rights driven by England. On the internal front, the centralism of the monarchy was not shared by regional oligarchies, and this encouraged, since the middle of the 19th Century, the ideals of republican opposition. In 1888, slavery was abolished and political forces against the monarchy proclaimed the republic one year later.

The republican era introduced new political arrangements known as the "policy of governors". Under this agreement, the Minas Gerais and São Paulo oligarchies took turns running the central government in a period known as the "Old Republic"[2].

Brazilian federalism began in the republican period, replacing the centralization process under the monarchy. During the first 30 years of the 20th century, the states enjoyed huge fiscal, political and administrative autonomy. The national government was supported by a weak tax base that did not allow the use of federal revenue sources to sustain policies at the regional level. On the other hand, states did not have to impose federal taxes.

Since independence, the central government managed conflicts to appease regional revolutions driven by the power of regional oligarchies in several states. Some of those movements continued in the republican era. The last of them occurred in São Paulo (1930) after the breakdown of the "policy of governors" agreement. To keep São Paulo from gaining independence and maintain the nation's integrity, the oligarchy of one of the most powerful southern states (Rio Grande do Sul) sent troops to São Paulo and to the capital (Rio de Janeiro), setting in motion a revolutionary process led by Getulio Vargas, a self-proclaimed dictator.

Vargas governed Brazil from 1930 to 1945. During the thirties and forties, his authoritarian government led a strong centralization process. He named state governors and centralized most public policies using federal rules. The Vargas Era was marked by the establishment of national policies in such areas as the labour market, social security, industry and commerce, generating the basis of Brazilian capitalism. The world economic crises of the thirties and the Second World War shrunk external markets for Brazilian

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[2] Brazilian historiography classifies as "Old Republic" the period from 1889 (beginning of republic system) to 1930 (beginning of Getulio Vargas dictatorship).

commodities. The Vargas government shifted the economic growth basis from external to internal markets, led by the rise of national industry and subsidized by state investment. To support this strategy, the central government dealt states partial tax reforms, increasing its weight in tax revenues. The rise of state bureaucracy increased the political and institutional structures, not just in central government but even in the states.

Despite the economic growth and institution building brought to the country, the Vargas Era exacerbated the economic and social disparities among states. Most of the economic growth was centered in the Southern States. The return to democracy in 1945 was followed by new ideas regarding the regional distribution of economic growth. Thus, the fifties were marked by the creation of state enterprises operating on a national scale in sectors such as oil production, mining and electricity. To reduce regional inequalities and support regional and integrated economic growth, the federal government created development banks and regional agencies (like BNDE and SUDENE). This new institutional framework generated tax incentives to channel capital and investment to less developed states of the Northeast and North.

Even then, the conflicts of interest pitting economic development against income distribution were still alive, providing some of the roots of the 1964 military revolution. The return to authoritarian government established a new centralization process, supported by massive tax reform in 1967. Income and production taxes were centralized in federal government. States were limited to consumer taxes as their main tax source. This process centralized most of the state revenues in the hands of the federal government. To mitigate the strong reduction of local government funds, the fiscal reform created federal funds to transfer part of central revenues to states and municipalities, using population size as a rule to distribute these funds[3]. These sources are known in Brazil as automatic transfers from national to local levels of government.

During the seventies and eighties, the federal Government increasingly limited the autonomy of local governments using the framework established with the 1967 fiscal reform. The National Congress approved several decrees specifying how states and municipalities should apply taxes and use fiscal revenues. On the other hand, the national government institutionalized negotiated transfers from national to local governments, targeted at such areas as health, education and labour. These transfers made up for a lack of funds to implement federal rules, mainly in social policy.

The fiscal centralism was exacerbated during the authoritarian period from 1964 to the end of eighties and deepened the inequalities among states. The return to democracy in 1985 and the new Constitution of 1988 reduced this centralism, passing the buck of several public policies to local governments and increasing the tax revenues of states and municipalities.

Even now, the federative conflicts in Brazil still remain: the economic crises of the late eighties and early nineties; the fiscal conflict among states to attract new investments;

[3] These funds were called "Fundo de Participação dos Estados" (FPE) and "Fundo de Participação dos Municípios" (FPM), channelling tax revenues to states and municipalities, respectively.

and the unbalanced power of municipalities against states stemming from the 1988 Constitution represent new challenges that feed the federative conflicts in Brazil. Nowadays, Brazil needs deep fiscal and administrative reforms to solve the federative conflicts. That could be part of the policy agenda for the 21st century.

Federalism and Health Policies in Brazil: an Historical Overview

In the beginning of the 20th century the federal government undertook public health initiatives in several states to reduce the incidence of transmissible diseases such as yellow fever, smallpox and the plague. Most of the campaigns were financed on a shared-cost basis by the central government and the states. This effort institutionalized public health services in many states.

The federal government also maintained public hospitals for indigents in the Republic's capital (Rio de Janeiro). Some states created public hospitals to care for people without means of payment. At this point, most of health care was private, funded and organized by families or charities.

The first federal initiative on pensions and health care policy was undertaken in 1923, with the introduction of social security benefits for railway employees in a model called CAP[4]. Employers, employees and the state funded the system. This model was replicated in other industry branches and until the mid thirties more than 300 businesses were covered by the CAPs.

Vargas changed this system, creating sectoral Pension Institutes between 1935 and 1945. Most of the CAPs were extinguished or folded into six Pension and Health Care Institutes (IAP). The main differences between CAP and IAP structure can be summarized as follows:

(a) CAPs were territorially-based and IAPs were national, with local offices in the states;
(b) CAPs were driven by enterprise councils and IAPs were public structures;
(c) CAPs were built on a voluntary basis and IAPs were mandatory.

The creation of IAPs progressively expanded the social security and health system into the formal labour market. Even then, this expansion occurred on a centralized basis. The local structure of the IAPs responds to centralized directions driven by the federal capital headquarters.

The distribution of sources and investments among local representations were based on a mixture of budgetary planning and political pressures by the workers' unions. For this reason, regional interests were represented to some extent in the sharing of funds.

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[4] The institution created to dispense these benefits was named "Caixa de Aposentadorias e Pensões" (CAP), providing employees with such benefits as pensions, health assistance and health care.

On the other hand, the quality, coverage and efficiency of the IAPs were very uneven, creating great inequality in health access and quality patterns among these institutions. The revenues of each IAP depended of the average wage of the professional categories involved. In addition, institutional and managerial capabilities as well as political linkages were crucial factors to determinate the success of the IAPs.

In the beginning of the sixties many political groups pressed for the institutional merger of the IAPs as a means of narrowing the gap among social protection agencies for different workers. But the strong corporatism of the better-positioned unions obstructed these efforts.

The military coup of 1964 and the authoritarian government it ushered in created favourable conditions for changing the pension and medical care system that had prevailed to that point. In 1967, in the midst of administrative, fiscal and financial reforms, social security reform was also undertaken, unifying five of the six IAPs into a single institution - the *National Social Security Institute* (INPS). The surviving Institute (Ipase), created to provide civil servants with pensions and health care, was abolished in the eighties and its health care structures incorporated into the INPS.

The INPS assumed responsibility for the health care of all formal workers, who at the time contributed 8% of their salaries; this was combined with 8% to 10% of the payroll of employers, irrespective of their branch of activity or professional category. The self-employed or employers (individually) who contributed double (16% to 18% of their basic income) were also included in the coverage. This extension of the coverage brought problems to the social security institutions, since the former IAPs did not take this new clientele of the INPS into account. It was necessary not just to expand the health care facilities, but also to contract a larger network of private establishments, which, by processes of buying and selling health care on a fee-for-service basis, were to become part of the network of medical care of the INPS.

The private sector, with the exception of charitable organizations (churches and hospitals attached to religious orders), did not have a very large network of facilities. It would be necessary to expand this network to deal with the new government demand. A fair proportion of the expansion of this network was financed using public resources from the *Social Development Support Fund* (FAS), set up in 1974 and funded by resources from the federal and sports lotteries, as well as from operating balances from the federal financial institutions.

The INPS operated on a centralized basis. Every state and most of the municipalities had local offices or the Institute, which responded to the local bureaucratic power and were linked with local policy.

In 1974 the social security structure initiated some institutional changes. The INPS was divided into three institutes separating the functions of administration and funding (IAPAS); pensions and social welfare benefits (INPS); and health care (INAMPS). The

process was consolidated in 1976 with the establishment of the National System of Pensions and Social Assistance (SINPAS) and the creation of its financial instrument, the Pensions and Social Assistance Fund (FPAS). Beyond the three aforementioned institutions (IAPAS, INPS and INAMPS), SINPAS comprised other agencies such as the *Brazilian Care Legion (LBA); the National Foundation for the Welfare of Children (FUNABEM); the Data Processing Enterprise for Social Welfare (DATAPREV) and the Drugs Distribution Enterprise (CEME).* Of all these institutions, two formed the health subsystem in the sphere of social security: INAMPS and CEME. These were intended to centralize the purchasing and distribution of medicines to the institutions which handled social security.

Despite all this, federal welfare structure remained practically unchanged until the mid-eighties. During the end of seventies and into the eighties, the federal government developed some agreements with states and municipalities to increase revenue sources and transfer money and responsibilities for health care. The integrated health actions program (AIS – 1984) and the decentralized and unified health system (SUDS – 1986) prepared the political and institutional environment for the huge decentralization at the beginning of the nineties.

With the Constitution of 1988, the *Unified Health System* (SUS) was created, which represented the formal unification of some of these structures. The SUS incorporated the university hospitals belonging to the Ministry of Education and the public and private health networks in the states and municipalities, forming a system, which theoretically involved national integration. In this context, health policies took on the following objectives and strategies:

Objectives:

- UNIVERSAL HEALTH CARE PROVISION: the entire public providers network (nation, states and municipalities) would now cover the population in a universal manner, without restrictions;
- EQUALITY OF CARE: as well as universal coverage, everyone would have access to the same forms of coverage throughout the entire national territory;
- COMPREHENSIVENESS: everyone would have access to health as a whole concept, or composed by actions of the individual, the community and the environment.

Strategies:

- DECENTRALIZATION: services would be controlled and carried out by the municipalities and the states, minimizing the role of the federal government;
- UNITY OF CONTROL: although decentralized, the system would now have a single control in each sphere of the government, avoiding the former duplication of efforts which existed among the structures of the INAMPS, the Ministry of Health and the state and municipal bureaus;

- SOCIAL PARTICIPATION: society would participate in the management of the system via Health Councils organized in all the spheres of government, which would have functions in the field of planning and supervision of health actions.

The SUS abolished the restriction of social security health protection to only formal labour market workers and their families, creating universal access to health care for all citizens. Even then, some health care systems such as those for the armed forces, public enterprises and civil servants have been kept private and have not been integrated into the SUS.

At the state level, the SUS is composed of the former regional INAMPS offices merged with the state health secretariats. All of their activities became subordinated to the control of these secretariats. At the municipal level, the local health secretariats were merged with the INAMPS local offices.

Federalism and Brazilian Health Policy in the Nineties

The nineties ushered in the era of decentralized Brazilian health policy. This decentralization could be understood from two perspectives: the financial side, represented by the increased autonomy of the states and municipalities to use the funds for their health needs; and the administrative side, characterized by the autonomy of each state and municipality in choosing the most appropriate model to develop health policy in its territory. The reality shows us that Brazil has secured more advances on the financial rather than managerial side of decentralization.

a) Financial autonomy

The states' and municipalities' autonomy to finance health care depends on the volume of federal transfers and the magnitude of the local tax base. During the eighties and nineties, the volume of federal transfers to states and municipalities increased very rapidly.

Table 1 shows two periods when federal transfers represented an important share of federal health expenditures: 1985-1991 and 1995-1999. Both periods contain moments when federal transfers had accounted for most or almost 40% of all federal health expenditures. During the first period (the eighties), transfers to states were more substantial than to municipalities. In the second period (the nineties), the opposite occurred: federal transfers to municipalities were larger than to the states. The Brazilian health federalism of the nineties followed the trend to strengthen the municipalities defended by the 1988 Federal Constitution.

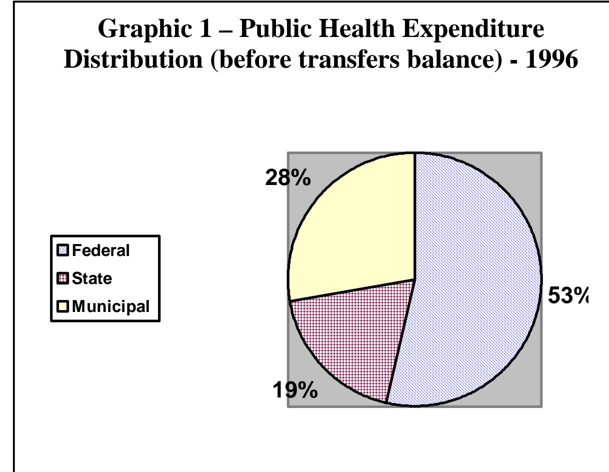
But which kind of criteria were used to distribute federal funds to local governments? During the eighties, political favoritism was the rule. Most of the states received unfair federal transfer amounts in exchange for political favours. During the nineties the federal government began to distribute health funds to local governments on a per capita basis and on the basis of historically-transferred values. In the near future, the trend could be to

distribute these funds according to technical formulas that match epidemiological and socioeconomic indicators.

Table 1
Brazil: Federal Expenditures on Heath Care and Federal Transfers to Sates and Municipalities 1982-1999 (US$ millions)

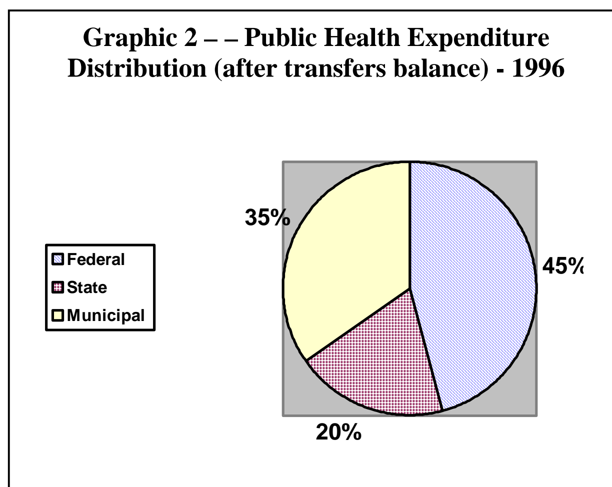
Years	Gross Federal Expenditures	Transfers to States (2)	Transfers to Municipalities (3)	Net Federal Expenditures (4)=(1) –(2) –(3)	(2 +3)/ (1) (%)
1982	9400,3	561,2	-	8838,8	6,0
1983	7824,0	477,1	-	7346,9	6,1
1984	8233,4	452,5	-	7780,9	5,5
1985	10573,8	859,2	37,0	9677,6	8,5
1986	9534,5	914,3	298,9	8321,3	12,7
1987	14743,7	2989,1	575,0	11179,6	24.2
1988	15400,7	6321,1	44,7	9034,9	41,3
1989	19172,4	5944,0	284,6	12943,8	32,5
1990	13659,1	3538,5	506,5	9614,1	29,6
1991	11344,1	2413,9	1120,3	7809.9	31,5
1992	10010,2	307,9	-	9702,3	3,1
1993	10294,6	855,7	137,3	9301,6	9,6
1994	10441,6	628,8	188,7	9624,1	7,8
1995	14500,3	796,1	698,8	13005,4	10,3
1996	12420,5	479,9	1379,3	10561,3	15,0
1997	14822,7	660,0	1930,0	12283,3	17,4
1998	13278,0	742,2	3383,6	9152,2	31,1
1999	13349,1	842,2	4036,7	8470,2	36,5

Source: IESP/FUNDAP and DISOC/IPEA



At the same time, the use of local funds to finance health policy increased in the last two decades, especially at the municipal level. The funds used by states and municipalities to finance health care went from US$ 2.5 to US$ 4.3 billion and from US$ 1.3 to US$ 6.4 billion between 1985 and 1996, respectively.

In other words, the federal level reduced its participation in the financing of health care as a proportion of public expenditures from 73% to 53% during this period. Considering the federal transfers to local levels, we can say that federal government managed only 45% of public health care funding in 1996 compared with 67% in 1985. Graphics 1 and 2 show the distribution of public health expenditures by level of government with and without the transfers balance among states and municipalities.



An important question to ask is how are federal health expenditures distributed by state? There are no rules. The federal government spent in states that still have federal health units, like hospitals and ambulatory care units. The concentrations of federal health facilities in the richest states turn federal expenditures very regressive. Considering the sum of federal, state and municipal expenditures, states like the Federal District spend over seven times more than others like Bahia, for example.

The government needs to resolve two questions regarding decentralization of health funding: the guarantee of more funds and the establishment of new rules to transfer funds from federal to local governments.

To address the first question, last year the government adopted new legislation stating that after 2005, states and municipalities must spend at least 12% and 15% (respectively) of their fiscal revenues on health policies[5]. It is expected that this measure will bring more stability to the financial flows for public health policies and an increase from 3.3% to 3.5% of public health expenditures as a share of GDP. This norm will also lead to even more financial autonomy for states and municipalities in health care matters.

To address the second question, in January 2001 the government approved new rules to transfer funds from municipalities using block grants[6]. To receive these grants, states and municipalities need to: (i) divide the state into health regions; (ii) create health plans for each region; (iii) design a hierarchy of health units in each region; (iv) apply a criterion for distributing basic amplified health plan funds among the units. This process is expected to be ready throughout the country at the beginning of 2002.

b) Administrative autonomy

Despite local governments' increase in financial autonomy where health policy is concerned, states and municipalities have not experienced substantial administrative autonomy in recent years. The SUS is very rigid in its principles and rules and do not transfer federal funds to municipalities that do not comply with the federal principles.

During the last 30 years governments of several countries have designed some general principles that are recognized as best practices to increase equity, efficiency and sustainability of public health policies (see Box 1). Most of these principles have not been adopted by the SUS, and states and municipalities are not allowed to use them either.

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[5] The Constitutional Emend number 29/2000.

[6] See "Norma Operacional de Assistência a Saúde (NOAS) 2001.

Box 1
Best Practices to Improve Equity, Efficiency and Sustainability of Public Health Policies

1) Use epidemiology in planning public health sector needs;
2) Separate the roles of financing, organization and provision of services;
3) Use supply subsides only when there are restrictions in the supply of health facilities and use demand subsides when there is a multiplicity of organizers and providers in a regulated competitive environment;
4) Use public subsidies for people without means to pay and use fees and co-payments to recover costs and moderate the demand of people with the means to pay for health services;
5) Use public subsidies to finance a package of cost-effective services covering the epidemiological, demographic and socioeconomic health profile of the population without means to pay;
6) In addition, use public subsidies to finance a package of high costs or risks that could not be supported by the population or private health insurance.

For this reason, even when they have sufficient resources, states and municipalities lack the freedom to adopt new regulatory or administrative tools to manage health care. The public sector is restricted to tasks related to organizing, buying or providing health services. Despite the government effort to stimulate the creation of health councils at local levels and other social participation mechanisms, the citizens cannot use the public subsidy to exercise their freedom of choice. In this environment there are few mechanisms to improve the quality, coverage and efficiency of health care. Most of the public mechanisms for evaluating local performance are targeted at the means and not the results reflected in better health indicators.

The lack of flexibility created a system that spends proportionally much more than the results achieved. In 1997, according to the World Health Organization (WHO), Brazil spent US$428 per capita and had a disability-adjusted life expectancy of 59 years. With this per capita expenditure, Brazilians could add six more years of healthy life.

When the same rules and criteria are applied in very heterogeneous situations, this leads to more uneven results. In 1997, infant mortality rates in the poorest municipalities of Alagoas State were almost 120 per thousand while in the municipalities with the best living conditions in Santa Catarina, they were less than 15 per thousand. Nowadays the federal government is creating special primary health care programs to alleviate the health conditions of the poorest municipalities and to narrow the gap, but it still remains.

Financial Flows from Federal Government to States and Municipalities

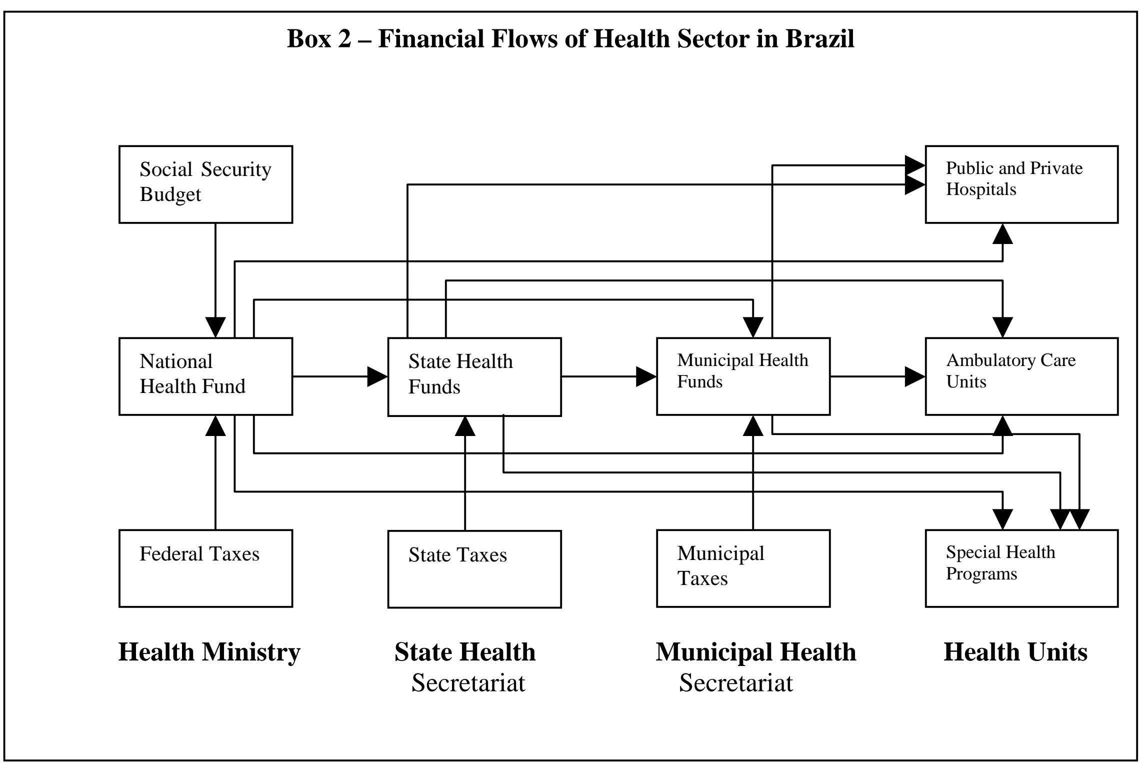
In the early nineties, the health sector was underfunded. The 1988 Constitution and the Organic Law of the SUS did not provide the legal basis to increase the resources for the SUS during its expected expansion. In a context of fiscal instability, the lack of a specific federal tax to finance health care in Brazil generated pressures to amplify the tax bases of the federal health sector. In 1995 the Brazilian government created the interim contribution for financial movement[7] to finance most of the health expenditures. At the

7 The official name is "Contribuição Provisória sobre a Movimentação Financeira (CPMF).

same time, the Brazilian government used debt mechanisms of the Works Aid Fund (FAT) managed by the Ministry of Labour to finance current costs and some investments. By the second half of the nineties most of the problems concerning health funding had almost been resolved. These resources were crucial for the expansion of the decentralization process.

As we saw in the previous section, federal transfers are an important source for financing the decentralization of health care in Brazil. Once the federal budget is set, several financial flows could determine transfers from federal sources to the local governments (states and municipalities). These resources are earmarked basically for the retroactive payment of private and public health services hired by local governments, as well as for ambulatory services and special health programs. Box 2 shows the financial flows of public sources in the Brazilian health sector.

Box 2 – Financial Flows of Health Sector in Brazil



In the Brazilian health system, public financing flows are centered on national, state and municipal health funds. These funds behave like single disbursement centres in each level of government and are responsible for the centralization of all the system's financial resources. The National Health Fund, for example, receives resources from the social security budget and federal taxes and transfers them to the state and municipal health funds. Besides that, these funds also directly reimburse health services delivered by providers to pay hospitals, ambulatory and special program expenses.

The state health funds receive transfers from the National Health Fund and tax revenues from state treasuries, transferring part of them to the municipalities and service providers.

The municipal health funds receive transfers from the National and State Health Funds and municipal taxes in order to pay the services providers directly and earmark resources for health programs.

The Brazilian health financial flows present some problems. First, there is no clear hierarchy among the decision-making bodies which determine where the resources end up. States and municipalities reimburse providers directly without further information about accessibility and quality of the services delivered, creating a common dysfunction in supply-driven systems known in the health economy literature as "third payer relationship".

Traditional audit mechanisms do not work well on the third payer system; this can be explained as follows: (i) public health funds transfer resources directly to the providers' bank accounts as payment for the services delivered based on the information contained in completed inpatient or ambulatory services endorsement forms; (ii) states, municipalities or the local representative of the Ministry of Health carry out audits using a sample of the services and checking the completed forms to identify mistakes that might warrant a possible cancellation of the payments to be made; (iii) in the meantime, the users do not know if the services declared and collected for by the service providers they went to are the ones that were carried out and the payer agent does not have the means to verify if the payment claimed corresponds to the services delivered to the users.

This process has generated two types of provider behavior: (i) disinterest in filling out the forms correctly, because they are not revised; (ii) a rise in fraud. In 1995 a sample survey sponsored by the Ministry of Health found that 46% of the delivered services were carried out irregularly. The post-1994 economic stabilization had led to a significant reduction in fraud, mainly by creating more transparent mechanisms to update the value of payments made by the SUS. On the other hand, since 1999 the government has instituted new mechanisms to control and reduce fraud, based on patient registration and better social control.

However, the best way to reduce fraud is to eliminate the third payer system. To do that it is necessary to increase the transfers to states based on block grants and reduce direct payments to providers. During the second half of the nineties the Brazilian government changed some of the mechanisms for transferring resources to states and municipalities, creating block grant transfers linked with basic primary care packages (PAB)[8]. In 1998 around 16% of federal expenses were transferred to states and municipalities to administer the PAB (US$2 billion). The creation of the expanded basic package (PABA)[9] in 2001, which includes activities of a fairly and highly complex nature, will extend the dimension of the transfers to states and municipalities under the umbrella of block grants.

Final Considerations

[8] The *Piso de Atenção Básica (PAB*) is a basic package of cost-effective health actions with an average cost of US$18 per capita.

[9] The Piso de Atenção Básica Ampliado (PABA) was created with the NOAS-2001.

Universal provision is the kind of social policy which arises from and develops alongside the expansion of the concept of citizenship, the end of the totalitarian governments of Eastern Europe (nazism, fascism, etc.), the predominance of social democratic governments and, to a lesser extent, Euro-communist tendencies, based on the idea that each citizen has inalienable social rights. From this arose the concept of the welfare state.

In this scenario, every individual would have the right, from birth, to a set of goods and services which should be supplied directly via the State or indirectly, through its power of regulation over civil society. These rights would extend from covering health and education at all levels, to assistance to the unemployed, to guaranteeing a minimum income and additional resources for raising children, etc.

Throughout the 1970s and ’80s, the Brazilian state sought to organize an "imitation" *welfare state*, in an attempt to satisfy some of the demands of the unprotected population. The diversity of mechanisms to incorporate uncovered and non-contributive citizens in the health care protection umbrella, even before the SUS, is a clear example of this "progress" towards universal coverage of social rights.

But the model of economic development and the basis of financial support of social policies in Brazil had been organized in a manner incompatible with the ideas of universality. As a corollary, there is a universality that in practice is exclusionary. In other words, Brazilian social policy, in addition to being inadequate – both quantitatively and qualitatively – to cover the needs of the population with the lowest income, in practice excludes the sectors of high and medium income; this differs from the type of universality established in the majority of the European countries in the golden age of the *Welfare State*. These make increasingly frequent use of independent private systems, either in the field of health, or in the field of (open or closed) private welfare entities.

The Constitution of 1988 enshrined the ideology of universal social policies in Brazil, at a time when the economic conditions for achieving real universality were becoming increasingly precarious. Accordingly, economic crises, crises in public finance and gains in constitutional rights have become, since the mid-1990s, one of the conflicts to be addressed by a possible reform of the State. The crisis in Brazil’s *Welfare State* arrived before the welfare state could in fact be fully implemented.

The great dilemma of universality in European countries, after the crisis of the ’70s, consisted in maintaining an equal social policy for equals, in a context of increasing social diversity. Such a condition was only possible thanks to the high level of homogeneity achieved through income policies and social policies developed under the concept of citizenship in the ’50s and ’60s.

In Brazil, social inequality is rampant. Data from the late 1990s show that more than 30% of Brazilian families had a total income of less than two minimum wages. In the Northeast, the figure was 53%. The richest 10 % in Brazil receive 52% of the income, while the poorest 10% get only 0.7%. More than half of working people do not contribute to any social welfare institute and in the poorest states, this figure exceeds 60%.

Since the middle of 1995 the health sector in Brazil has been addressing the need to carry out reforms; many of them have already been taken on, either by the Ministry of Health or by State and Municipal Health Secretariats that make up the SUS.

The need for reforms came from the generalized perception that the health system in Brazil presents, since its new configuration under the Constitution of 1988, a series of contradictions. The first contradiction lies in the opposing nature of the decentralized coupling of resources and of management of the system for the states and municipalities against the idea of a single health system.

As the states and municipalities are fairly heterogeneous, both in their level of development and the nature of the health problems they present, it is recommended that the system be single in terms of its principles (equality, universality, etc.), but not in terms of the form of management and use of resources. The organizational structure must be suited to the characteristics of each region.

On the other hand, financial decentralization must be more effective, allowing resources to be transferred automatically to the states, with a view to facilitating the role of these spheres as promoters of management innovations in the health system of each region. The idea of transferring resources to the states and municipalities in the form of block grants would make this process easier.

It is obvious that the health sector in Brazil requires investment. This must not be concentrated only in the public health networks, but also in charity and private networks, when providing services relevant to the country. This investment must be made freely, without political criteria and in accordance with the real needs of the population.

The pool of available or potential resources, both for investment and for funding health services in Brazil, does not allow for a level of expenditure compatible with the resources in developed countries. The epidemiological data, on the other hand, reveal the need for some priorities to be defined in terms of health expenditure. This being the case, a set of basic procedures should be defined which would consist of health financing priorities, with regional appropriations. Procedures not included in this set could (and even should) be funded, provided that the cost projections allow a surplus of resources for funding to be anticipated.

The matter of combating fraud will also benefit highly from decentralization and from the creation of supervisory mechanisms to promote the involvement of society (Municipal Health Councils) in the process. To do this, the planning of health projects must be transparent and the mechanisms for supervision known and applied by everyone.

Recovering the amount indicated in the payment tables for private service providers is the most urgent task. If it is not possible to obtain the necessary resources for this through public funds, means must be sought from society at large so that this recovery is possible. This may be done via joint payments or cost recovery quotas, on the part of patients, provided that their socio-economic situation can be identified and injustice can be avoided.

Health systems are not detached from the social, economic and cultural context in which they exist. Their limitations are the ethical, political and cultural conditions which characterize their situation. When Brazilian society is ready to be free of the atavisms of populism, of clientelism and of corruption and starts to operate in more participative patterns, with the increase in awareness of social control, it will be easier to set up efficient and more socially just health systems.

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