HEALTH SECTOR REFORM IN BRAZIL: A CASE STUDY OF INEQUITY

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Health sector reform in Brazil built the Unified Health System according to a dense body of administrative instruments for organizing decentralized service networks and institutionalizing a complex decision-making arena. This article focuses on the equity in health care services. Equity is defined as a principle governing distributive functions designed to reduce or offset socially unjust inequalities, and it is applied to evaluate the distribution of financial resources and the use of health services. Even though in the Constitution the term "equity" refers to equal opportunity of access for equal needs, the implemented policies have not guaranteed these rights. Underfunding, fiscal stress, and lack of priorities for the sector have contributed to a progressive deterioration of health care services, with continuing regressive tax collection and unequal distribution of financial resources among regions. The data suggest that despite regulatory measures to increase efficiency and reduce inequalities, delivery of health care services remains extremely unequal across the country. People in lower income groups experience more difficulties in getting access to health services. Utilization rates vary greatly by type of service among income groups, positions in the labor market, and levels of education.

The movement for health sector reform in Brazil dates back to the 1970s, but its landmark was the new Constitution, approved in 1988. This Constitution institutionalized the universalization of social rights, including the right to health, which then became the *citizen's right* and the *state's obligation and responsibil-*

This study is part of the research project Health Reform in Brazil: The Quest for Equity, developed at the National School of Public Health–Oswaldo Cruz Foundation in Rio de Janeiro, Brazil, and financed by the Pan American Health Organization. The research is coordinated by Celia Almeida.

International Journal of Health Services, Volume 30, Number 1, Pages 129–162, 2000

ity. This extension of rights followed a dynamics contrary to the global tendencies that were becoming apparent internationally. The Brazilian health sector reform, as idealized and implemented at the end of the 1980s, was one of the last expansionist reforms of that decade. This reform process was based on ideas that had oriented the organization of health systems in the postwar world and was strongly influenced by the philosophy of the state as service provider. Its development, however, was fraught with contradictions and conflicts due to both domestic and international political and economic conditions as well as sectorial constraints.

A combination of economic crisis, important changes in the political scene (transition to democracy), and a significant revitalization of organized civil society and the political party system characterized the 1980s in Brazil. These factors had an important influence on the government's political agenda and the treatment of social and economic issues.

From an economic standpoint, the process of stabilization and structural adjustment began at the end of the 1970s, progressing in a slow and conflictive manner. Economic, political, and social instability have been part of the national daily reality for over a decade. Between 1979 and 1995 there were nine plans of economic stabilization in Brazil, five different currencies, five price freezes, 22 proposals for renegotiation of the foreign debt, and 19 modifications of foreign exchange rules (1). All of this was permeated by great uncertainty, several changes in ministers, and the impeachment of one president (Fernando Collor de Mello, in 1992). More recently, with the *Plano Real* (1994) and the President Fernando Henrique Cardoso governments (elected in 1995 and re-elected in 1998), the nation's course has been guided by more decisive responses to the conditions defined for the region by the international financial community. Indeed, the set of state interventions and political instruments has been subsumed under the primary goal of stabilizing the economy.

It must be emphasized, however, that unlike the reform process in the central countries in the last decade, health care reform in Brazil was not included in the government's agenda as a demand or as a result of adjustment policies. On the contrary, health care reform in Brazil seems to be in collision with those policies. In other words, in the beginning, there was no direct relationship between the political and organizational innovations in the health care system and the priorities of the state reform. This specific condition has influenced the timing for implementation and the content of the original reform proposal itself, affecting in a significant manner not only the budget allocated to health services but also the quality of care.

Health sector reform proposed the following:

1. Strengthening the public sector.
2. Increasing financial resources and diversifying sources.
3. Decentralizing the system.

4. Rationalizing the supply and delivery of services.
5. Reorganizing sectorial interests, with a new definition of the public/private relationship in the organization of health care.

Changes in the rights and responsibilities of the different levels of government and in the rules for financial allocation are dimensions of the decentralization process that acquired specific characteristics in the health care area, where important links with the central level were maintained. Still, the local government became a stronger service provider and interregional differences in services supply diminished. The intensity of these changes, however, differed greatly from one region to another. The necessary investments for implementation of the Unified Health System (Sistema Único de Saúde, SUS), created in 1989, did not follow, and the quality of health care services diminished.

One positive outcome of the Brazilian reform process was the creation of representative councils and management commissions at different government levels linked to the dynamics of decentralization. This amplified sectorial arena has exacerbated conflicts and revealed more clearly the distinct "projects" of the diverse actors seeking to institutionalize their demands.

The aim of this case study is to present the process of health sector reform in Brazil, focusing on the issue of equity in the system of health care services. We organize and discuss some of the data available, highlighting the main questions that should be emphasized and dealt with in order to overcome sharp inequalities in this sector. In the first part we describe the process of reform, with special emphasis on decentralization, focusing on the financial allocation and organizational structure; we then analyze health care supply and data on equity in service delivery (focused on hospitalization, morbidity, use, and access).

We conclude that underfunding, fiscal stress, and lack of priorities for the sector have contributed to the progressive deterioration of health care services, leading to the persistence of regressive tax collection and unequal distribution of financial resources among different regions. The data suggest that, in spite of regulatory measures to increase efficiency and reduce inequalities within the SUS, the delivery of health care services remains extremely unequal across the country. Proposals for state reform, regulation of the private health insurance sector, and the priority of basic care constitute a delicate moment for sectorial reform, which has gradually lost its character of "exceptionality," having been adapted to the premises of cost containment and focalized care that are prevalent on the health sector reform agenda in the developing world.

THE HEALTH SECTOR REFORM PROCESS

The Brazilian health system is a complex network of service providers and service buyers that are simultaneously interrelated, complementary, and competitive,

forming a complicated public/private mix funded primarily by public resources. The system is composed of three main subsectors:

1. The public sector, which comprises publicly financed and provided health services, including services from the federal, state, and municipal levels and the armed forces, which have their own separate health care services.
2. The private sector (profit and nonprofit) contracted by the public sector and paid through reimbursement systems, comprising publicly financed and privately provided services.
3. The free-choice private sector, financed out-of-pocket or by corporate health insurance, comprising privately financed and privately provided services with different levels of insurance premiums and tax subsidies.

This system is highly centered on health care and the hospital, characteristics that gained strength in the 1960s with the development of social security. Unlike most health care systems, general practitioners do not play a preponderant role in the Brazilian system, which as a rule is very much directed toward specialized care.

Historically, health care was largely financed by social security, while the Ministry of Health was responsible for public health in general, primary health care, and specific health care programs (psychiatric care, tuberculosis, etc.). The Ministry of Education was responsible for the management of teaching hospitals. The important growth of the private hospital sector was stimulated and subsidized by the public sector, mainly in the 1970s. Private health insurance began with development of the pre-payment plans linked to strategic industries. However, the expansion of coverage and the diversity of private health insurance came later in the 1970s.

The economic crisis of the 1980s—especially the financial crisis of the state—reduced tax revenues and social contributions, particularly at the start of the decade, with a varied impact on the volume of resources for health care. This led to the adoption of strategies to rationalize the health care system. At the same time, a large political movement in favor of health sector reform was organized. This movement was quite diversified and, as it was able to develop a strong mobilization for health care reform, it succeeded in exerting pressure on the National Constituent Assembly, which resulted in incorporation of most of the principles advocated by this movement into the new Constitution. Thus the process of health care reform involved a complex dynamics, with an overlapping of the economic crisis and the political-democratic transition.

Health sector reform brought on the creation of the SUS in 1989, which promoted the legal unification of the health system under the command of the Ministry of Health. Although the Constitution states that the private sector is to complement the public sector in the provision of services, the former actually plays a very important role in the delivery of health care services.

The New Constitution: Social Security and the Problems of Financing Health

Public policies on health sector financing in Brazil are characterized by insufficient resources, regressive collection of revenue, vulnerability of resources vis-à-vis economic cycles, centralization, and inequitable allocation. One of the most important innovations introduced by the Constitution in the area of social policy was adoption of the concept of social security, for this not only implied the acknowledgment of health as a citizen's right (health understood as a public good and a universal benefit), but also brought about a radical transformation of the health-financing system. Creation of the SUS is the materialization of the constitutional dictates in the organization of the system of health services, but its implementation and financing have been deeply affected by the manner in which the inclusion of health under social security has been operationalized. The reform of social security in 1988 was profoundly innovative, for it generalized access to a number of benefits which until then had been restricted to urban workers in the formal employment sector, as well as updating retirement pensions.

In theory, the new Constitution promoted cohesion between areas of social protection by creating the Social Security Budget. Moreover, it diversified financing sources as follows:

1. Social contributions off the payroll of formal employees and employers were maintained.
2. A new tax was levied on company net profits (CSLL).
3. Two other sources previously destined for generic social expenditures were reallocated: tax on company billings (COFINS) and lottery revenues.

Simultaneously, the social benefits of federal employees, which until then had been paid with Treasury funds allotted to the corresponding ministries, were now funded by the Social Security Budget. This meant incorporating a sizable population from quasi-government foundations with increased benefits, such as full retirement pensions (representing 42 percent of the payroll in 1993), without the corresponding prior employee contributions and with the suppression of employer contribution. Therefore, there was an increase in social security entitlements that was not followed by a corresponding increase in revenue (2, 3).

At the end of 1980s, total health expenditure was estimated at between 3.6 percent (4, p. 130) and 4.2 percent of the GNP (5, pp. 1–40; 6, pp. 10–11), with the total per capita expenditure for 1990 calculated as U.S.$121.32 (4, p. 130). In the same year, public expenditure on health represented 2.7 percent of the GNP, amounting to an average per capita expenditure of U.S.$95.60 (7). That is, of the total health expenditure, public resources accounted for nearly 67 percent and private expenditure for the remaining 33 percent. Moreover, public resources collection for health was highly centralized at the federal level, rep-

resenting more than 70 percent of the total national public resources for health since the beginning of the 1980s, and in some of the following years it reached almost 86 percent (8, p. 22).

The participation of different levels of government in health care system financing can be evaluated by the percentages of financial resources allocated by the federal, state, and municipal levels for that purpose. The federal level, which allocated approximately 10 percent of total resources in the early 1990s (8, p. 23), passed on no more than 2 percent of the total tax collection revenue, the rest being left to social contributions (6, p. 32). State governments contributed much less than 10 percent and, in some cases, the state government did not provide any resources for health, financing the delivery of services exclusively through federal funds (8, p. 23). The municipalities, on the other hand, expanded their participation, surpassing 15 percent of their budgets in some cases (6; 8, p. 23) and revealing a greater commitment to the population's health care. Therefore, at that stage, the state governments played a less important role in the decentralization process.

The regressive collection of revenues is a consequence, in general, of the characteristics of the Brazilian tax system and, particularly, of workers' payroll contributions, a system that ends up penalizing the low-income populations. Studies conducted during the late 1980s showed that low-income populations paid 36 percent of their earnings in taxes, while those who earned more than 100 times the minimum salary (MS) were taxed by only 14 percent (9). Regarding social contribution, despite the existence of tax brackets according to income level (8 percent up to three times the MS; 9 percent from three to five times the MS; and 10 percent from five to ten times the MS), because the tax ceiling is fixed at ten times the MS those who make the minimum salary contribute 8 percent of their earnings, while those who make 100 times the MS contribute only 1 percent (10). On the other hand, revenue vulnerability resulting from the economic crisis is evident in the evolution of sector expenditure in the early 1980s, which shows a more than 20 percent decrease in federal health expenditure (8, p. 16).

In short, the creation of the Social Security Budget had the following objectives:

1. Amplifying the diversification of financial resources in order to diminish revenue vulnerability in the face of recessive economic cycles (11, 12), and mitigating the regressive pattern of revenue collection by taxing private company profits.
2. Increasing resources destined for social security, taxing both company net profits and revenue (13).
3. Binding specific sources to social security in order to guarantee the financing of health and social benefits (13).

Nevertheless, after implementation of the Social Security Budget it became clear that its objectives were not attained. The total resources were less than predicted because revenue from the profits tax was lower than expected; one reason was that many companies obtained tax write-offs (14). These contributions, however, were later reinstated by the Supreme Court. On the other hand, the Social Security Budget also financed programs that were not under its scope (14), which represented 11.8 percent of its total amount (15), 5 percent of which was related to health (16). This transfer of expenditures was facilitated by the lack of a clear definition of the concept of social security and a precise decision about the percentage share of each area—health, social pensions and benefits, and social assistance. In short, resource vulnerability in the face of recessive economic cycles and regressive revenue collection remained, and later studies revealed that those sources of financing are also quite sensitive to economic performance (11). Thus the negative characteristics that have historically marked the financing resources of the social security system in general and of the health care system in particular remained unaltered despite changes in the legislation.

It is important to note that after 1992 the Ministry of Social Security stopped transferring to the Social Security Budget the resources derived from employee and employer payroll contributions (11, 14). The argument used by the Ministry was that these were needed to pay social security benefits. Moreover, as noted above, the absence of specific regulations on implementation of the Social Security Budget, particularly a definition of the percentage share of each area, paved the way for this decision. Obviously, the Minister at that time, Antonio Brito, had the enforcement power to sustain such a decision. In practice there was a "specification" of financing sources, and company revenue taxes became the main source for financing health care (11, p. 20; 14). The results of specifying sources have been extremely negative for health sector financing. In 1993, federal per capita health expenditure was only U.S.$44.60, the lowest since 1980 (14, p. 38; 17); and in 1994, the resources allocated for health by the Social Security Budget were about U.S.$62.00 per capita, which is also below the figure for the late 1980s (9, p. 22).

As criticism and difficulties due to sectorial underfunding grew, generating situations of serious fiscal stress, proposals for an earmarked revenue source to finance the health system gained momentum—the reintroduction of the CPMF (temporary contribution on financial activities). This new source was approved in August 1996, and again in 1998, as a provisional tax, after heated political discussion and in the midst of calamitous conditions in the entire health services network, becoming effective in 1997 and 1999. Criticism of the CPMF as an earmarked tax is well known, but the main point is the extreme unpopularity of one more tax to be paid and the fact that the tax collected was not used only by the health sector.

In short, despite the introduced changes, the aspects of the Constitution concerning social security financing resources for health were not sufficiently

defined to reverse the negative historical pattern, and this in turn jeopardized the attainment of equal opportunity of access to health care services, as we discuss later.

Decentralization: Management Models

The SUS management was conceived as a strategy to transform a traditional culture of centralization, bureaucratic authoritarianism, and lack of participation and social control in health services affairs, and to change irrationalities and inequalities resulting from that manner of handling health care. The new organization of health system and services redefined the roles of both executive and representative organs, such as the Health Councils, at the national, state, and municipal levels. The National Health Conferences were also reinstated (first established in 1947), held every four years as legitimate forums for discussing and formulating national health policies, with ample participation of representatives from organized civil society.

Implementation of the decentralization process by the Ministry of Health began in 1991, through the administrative instrument known as Basic Operational Norms (NOBs, in 1991, 1993, and 1996), a set of measures designed to create an information system for planning, establish the mechanism of financial allocation to the state and municipal levels, and define the managerial model.

In the long term, the SUS managerial model aims to attain democratization, accessibility, and equity through three principal vectors:

1. Consolidating a comprehensive, regionalized, and municipalized health system according to a rationale that harmonizes functions across government levels and integrates services of varying scope and complexity.
2. Investing authoritative bodies with the power to make all kinds of decisions about the health system and to conclude agreements between the parties involved in the management of services, with formation of partnerships as the crucial concept.
3. Assigning to local authorities the responsibility for effectiveness and equity of care provided to the population in each territorial unit, especially at the municipal level.

The SUS is organized at the federal, state, and municipal levels. The federal level is legally responsible for formulating and implementing national health policy. It is also in charge of system planning, assessment, and control, as well as funding distribution. The decision-making process at that level involves the following:

1. The National Health Council (CNS), which includes representatives of government agencies, service providers, health care professionals and users—the

most representative group at the CNS: 50 percent of total members. The CNS is in charge of formulating strategic planning and monitoring the implementation of the nation's health care policy.

2. The Tripartite Intermanagerial Committee (CIT), whose members include representatives from the Ministry of Health, the National Council of State Health Secretaries (CONASS), and the National Council of Municipal Health Secretaries (CONASEMS). Its main function is to approve the rules for operating the system.
3. The Ministry of Health, which manages the federal funds allocation under the supervision and approval of the CNS and proposes the operating rules to be approved by the CIT.

This management structure is mirrored at the state level (State Health Secretariat, Bipartite Intermanagerial Committee, and State Health Council) and municipal level (Municipal Health Secretariat and Municipal Health Council), coordinated by the respective Health Secretaries. Functions at the state level involve service coordination, distribution of financial resources, and decisions related to complex specialized technological interventions. These state-level functions are still evolving because so far the decentralization process has predominantly focused on the municipal level. The municipalities are responsible for handling the delivery of goods and services involved in health promotion, preventive care, health care, and rehabilitation (Table 1).

Table 1

Management structure of the Unified Health System (SUS)

Level	Executive body	Operational management	Financial management[a]	Social control
Federal	Ministry of Health	Tripartite Intermanagerial Committee	National Health Fund	National Health Council
State	State Health Secretariat	Bipartite Intermanagerial Committee	State Health Fund	State Health Council
Municipal	Municipal Health Secretariat	Municipal Board of Health	Municipal Health Fund	Municipal Health Fund

Source: Buss, P., and Gadhelha, P., Health care systems in transition: Brazil, *J. Public Health Med.* 18: 289, 1996.

[a]These are planned in the legislation, but the resources are not managed through these funds.

The decentralization strategy adopted by the central level through the NOBs is aimed at establishing the necessary managerial conditions to enable states and municipalities to assume the planned responsibilities and functions. Following NOB 93, two management conditions were implemented for the states (intermediate and advanced) and three for the municipalities (initial, intermediate, and advanced). In order to be classified in each of these stages, responsibilities and requirements are defined, and financial incentives have been established to stimulate the process. Municipalities that fail to participate in this qualification process remain in the condition of service providers, with the corresponding state assuming responsibility for SUS management in that municipal territory (Table 2 on p. 140).

Some fundamental alterations were introduced with NOB 96 (Table 3 on p. 142). The central objective of this NOB is to promote and consolidate the full exercise of the health care managerial function by municipal government. The main innovation is the priority given to basic care, understood as a "package" of procedures to be defined locally according to certain parameters and financed through the Basic Health Care Quota (Piso Assistencial Básico, PAB) distributed per capita to municipalities. At the same time, financial incentives are also being put in place to encourage the introduction of two programs, the Family Health Program (PSF) and the Community Health Agents Program (PACS).

Two conditions of management are currently in place for municipalities (full management of the entire system and management of basic care) and one for the states (full management of the entire system). With NOB 96 there was also a reversal of the previous trend toward the municipalities, and the states' role in coordinating and conducting the state health system, of which the respective municipal systems are a part, was restored and strengthened.

The decentralization process implies a politicization of managerial decisions that demand strong involvement of the actors participating in the process. On the other hand, the process requires deep changes at the technical-operational level, demanding a capacity-building effort as well as a revision of values, habits, and procedures. A number of recent studies have revealed at least two important problems: (*a*) radical municipalization has led to greater fragmentation of the system, divesting the states of authority (3, 18–20); and (*b*) the very composition of the intermanagerial forums reproduces existing power relations, maintaining historical inequalities in the distribution of resources (21–23). Nevertheless, several innovative and successful experiences are occurring at the local level throughout the country.

Allocation of Financial Resources in the Unified Health System

The systematic distribution of financial resources from the federal level to the states and municipalities consists of different resource flows, the most important

of which are destined for (*a*) the funding of hospital activities, and (*b*) the funding of outpatient activities.

The same payment mechanism used for reimbursing hospital admissions provided by private services contracted out by the federal level was also adopted in 1991 to finance hospital admissions provided by public services, thus becoming one of the most important criteria for financial allocation. The allocation of financial resources is accomplished by an Authorization for Hospital Admission (AIH) billed by the different providers—public, philanthropic, or private hospitals. The AIH is applied exclusively to the payment of hospitalizations that are reimbursed through a prospective payment system. The payment unit in this system is the "procedure"; the value of each procedure is previously defined at the central level, without distinguishing between the different providers (except for university hospitals). In other words, financial resources are distributed through a prospective payment mechanism.

Each state has an AIH quota and a financial cap.[1] However, the definition of the AIH quota merely expresses the population size of each state, without taking into consideration distributive factors such as demographic inequalities, epidemiological profile, and regional socioeconomic conditions (5, pp. 43–44; 16). The financial cap, in turn, establishes maximum limits that tend to perpetuate the existing distributions.

In summary, funds are allocated to each state according to AIH billing, always respecting the corresponding quantitative and financial ceilings. When the difference between the AIH billing and the financial cap is positive, the balance is passed on to the municipal health authorities, provided they are classified as intermediate or advanced management. This decision means that the total funds allotted to the state can be passed on only to those municipal authorities that fulfill the requirements and responsibilities established for the more advanced managerial stages; the remaining local authorities receive resources according to the billed service production.

As described above, the requirements and responsibilities defined for the different managerial stages make up an extensive and growing set of factors that affect the allocation of financial resources and the effective implementation of the decentralization process. Of these factors, three are foremost: the Health Councils, the Unified Health Funds, and the need for technical conditions for programming and monitoring service delivery. On the other hand, payment based on service production has established a competition between public and private service providers with different administrative autonomy. Public

[1] Calculation of the annual quantitative ceiling, delimited in the number of AIHs corresponding to each state, is based on population numbers, the parameter being 0.09 AIHs/per inhabitant-year. The financial cap is the product of the AIH quota for the state and the historical mean value of the AIH in that state.

Table 2

Decentralization strategy, basic operational norm 1993 (NOB 93)[a]

Conditions of management	Duties	Requirements	Financial incentives
States			
Intermediate (*Parcial*)	Integrated programming process with the municipalities Investment policies Coordination of the referrals network, epidemiological surveillance, blood transfusion centers, and public health laboratories Management of specialized technological interventions Environmental control and occupational health	State Health Council State Health Fund State Health Plan Management report Plan for careers and salaries for civil servants Counterpart funds	Receives, through contracts, resources corresponding to the FAE, or a financial balance equivalent to the difference between the financial cap established and approved by CIT and effective expenditure
Advanced (*Semiplena*)	Same as above Total responsibility over management of service provision under its responsibility	Same as above	Receives global volume of resources equivalent to the global financial cap (outpatients + hospital + FAE), defined and approved by CIT

Municipalities			
Initial (*Incipiente*)	Programming and control of outpatient and hospital care delivered in the municipality PHC provision, epidemiological and sanitary surveillance	Municipal Health Council Municipal Health Funds or special account	Receives, through contracts, resources corresponding to the FAM
Intermediate (*Parcial*)	Management of part of the local system (outpatient care network, programming and control of hospital admissions, PHC provision, and epidemiological and sanitary surveillance)	Municipal Health Council Municipal Health Fund Municipal Health Plan Management report Plan for careers and salaries for civil servants Counterpart funds	FAM Financial balance equivalent to the difference between the financial cap established by CIB and approved by CIT, and effective expenditures
Advanced (*Semiplena*)	Management of total local system	Same as above	Receives the volume of funds corresponding to the overall financial ceiling (outpatients + hospital + FAM) set by CIB and approved by CIT, for the system under its management

Source: Lucchese, P., Descentralização do financiamento e gestão da assistência à saúde no Brasil: a implementação do Sistema Único de Saúde—retrospectiva 1990/1995, *Planejamento e Políticas Públicas* 14: 123, 1996.

[a]Abbreviations: CIB, Bipartite Intermanagerial Committee; CIT, Tripartite Intermanagerial Committee; FAE, Factor for Support to the State; FAM, Factor for Support to Municipalities; PHC, primary health care.

Table 3

Decentralization strategy, basic operational norm 1996 (NOB 96)[a]

Conditions of management	Duties	Requirements	Transfers/financial incentives
States			
Management of the state health systems	Elaborate PPI and coordinate and negotiate in CIB Elaborate and implement priorities setting for health investments in the state Elaborate norms and mechanisms for high-complexity health care Elaborate intersectorial policies Coordinate referrals network, epidemiological surveillance, blood transfusion centers, and public health laboratories Organize the networks and the SIA/SUS referral system Environmental control Health surveillance actions and PDAVS Contracting services included in PAB of ineligible municipalities	State Health Council State Health Fund CIB State Health Plan Management report Counterpart funds Review transfer of hospital and outpatient management to eligible municipalities Review technical and administrative capacity Review functioning of epidemiological and health surveillance actions PPI Have 60% of eligible municipalities or 40% with 60% of the population Have 30% of the value of TFA for municipalities	Regular, automatic transfer of the FAE, PAB, PBVS, and IVISA Remuneration for services produced in health surveillance Fund transfer for actions in epidemiology and disease control

Complete (*Plena*)	Same as above Total responsibility over management control and payment of service provision under its responsibility Operation of the SIA/SUS and SIH/SUS and input to databases of national interest	Same as above Assure the implementation PPI of outpatient, hospital, and high-complexity actions Review mechanisms to monitor provision of out-patient and hospital services Have 80% of eligible municipalities or 50% with 80% of the population Have 50% of the value of TFA with regular, automatic transfers to the municipalities	Same as above Remuneration for services produced in health surveillance Elaborate complementary normalization for payment of care service providers under contract negotiated with CIB and approved in CES Fund transfers for actions in epidemiology and disease control
Municipalities			
Full management of the PHC system (PAB)	Program basic outpatient and hospital referral services Manage own units and outpatient units of the state and union Reorganize units under public management Provide services covered by PAB, control and effect payments Operate SIA/SUS of PAB services Authorize AIHs and UCAs Carry out actions in health and epidemiological surveillance and disease control	Municipal Health Council Municipal Health Funds Municipal Health Plan Management report Counterpart funds Capacity for actions in health and epidemiological surveillance Have the human resources available	Regular, automatic transfer of funds of PAB, PBVS, for actions in epidemiology and disease control Subordinated to the municipal management of all basic health units (public and private)

Table 3

(Continued)

Conditions of management	Duties	Requirements	Transfers/financial incentives
Municipalities (cont.)			
Full management of municipal system	Management of total local system including basic assistance (PAB/PHC) (control, payments, and contracts) Guarantee service provision in its territory Administer supply of high-complexity procedures Operate SIH and SIA/SUS Assess impact of actions Health surveillance and actions in epidemiology and disease control	Municipal Health Council Municipal Health Fund Municipal Health Plan Linked Management report Counterpart funds Prepare and implement PPI Have health surveillance, epidemiology, and disease control services Assure supply of services in PAB, diagnostic support in clinical pathology and basic radiology	Same as above Complementary normalization for providers' payments Subordinated to the municipal secretariat of the whole referenced network Fund transfers for disease control

Source: reference 23, pp. 65–66.

[a]Abbreviations: AIH, Authorization for Hospital Admission; CIB, Bipartite Intermanagerial Committee; CIT, Tripartite Intermanagerial Committee; FAE, Support for the State Factor (NOB 1993); FAE, Specialized Care Fraction (NOB 1996); FAM, Factor for Support to Municipalities; IVISA, Health Surveillance Impact Valuation Index; IVR, Result Valuation Index; PAB, Basic Health Care Quota; PBVS, Basic Health Surveillance Quota; PDAVS, Deconcentrated Activities of Health Surveillance Program; PHC, primary health care; PPI, Concerted Integrated Programming; SIA, Outpatient Information System; SIH, Hospital Information System; TFA, Care Financial Ceiling; UCA, Outpatient Coverage Unit; CES, State Health Council.

institutions cannot decide wage policies, create incentives to increase productivity, or realize investments.

Outpatient services delivered by the different service providers—public, philanthropic, or private—are reimbursed according to amounts established at the federal level. However, the total resources allocated for each state may not exceed the financial caps, which are based on observed historical expenditure. The crucial problem in this flow is the manner of defining these caps, which rather than diminishing existing disparities have consolidated inequalities (24). The list of requirements for receiving the total resources for outpatient services is smaller than that for funding hospital activities: the State Health Secretariats need only be classified as initial management in order to receive the difference between billings and the defined financial cap.

Another financial incentive was intended to stimulate the managerial development of local health authorities: states and municipalities could receive additional resources of about 5 percent of the corresponding outpatient cap. However, because of insufficient resources, this incentive to improve management was not implemented and the positive balance between billings and financial caps was not passed on to the corresponding authorities.

In short, the logic behind the allocation of financial resources in NOB 93 was basically tied to service production levels, introducing a service buying–selling relationship between the different government levels and failing to take into account fundamental factors that would permit a more equitable interregional distribution of resources. Thus the equality of opportunity for access to health services, guaranteed by the Constitution, cannot be achieved. A look at the estimated distribution of resources by region according to population demonstrates that the poorer areas have the biggest differential rates (Table 4). Regions with precarious socioeconomic and health conditions continue to receive fewer resources per capita than the more developed regions (25).

Table 4

Comparison between population distribution and estimated financial resources distribution by the Ministry of Health, as percent, by geographical region, Brazil, 1994

Region	Population	Resource distribution	Differential
North	7.09%	5.27%	–25.69%
Northeast	28.86	14.66	–14.54
Southeast	42.60	47.15	10.68
South	14.89	16.10	8.10
Midwest	6.55	6.82	4.14

Source: reference 25, p. 94.

Finally, as mentioned earlier, changes in the distribution arrangements implemented by the Ministry of Health were introduced in 1998, financing of ambulatory activities through the PAB (NOB 96), which is distributed per capita to municipalities. These norms have become operational very recently and we do not yet have enough information to evaluate this process.

THE SUPPLY OF HEALTH CARE SERVICES

The three subsectors of the system of health care services—public, private contracted-out, and private—make up a disconnected nonhierarchical network that delivers different levels of care to different population groups. The Unified Health System was created in 1989 with the intention of favoring the public sector and integrating a regionalized system organized by level of competence and type of care, wherein private care would be complementary, but in practice these objectives have not been attained. The SUS consists of a network of public health services, mostly state and municipal, and contracted-out private services mainly for specialized or hospital care. The private system is considered "supplementary" and consists of doctors' offices, specialized clinics, and private hospitals (for-profit and nonprofit) contracted by private health insurance plans and/or paid for directly by the patient (Table 5). It is estimated that the SUS is responsible for 70 percent of total health expenditures and annual hospital admissions (26), and 26.8 percent of the Brazilian population is currently covered through private health insurance plans (27).

The public network is composed mainly of primary health care services—Health Units and Health Centers—(95 percent) and emergency services (65 percent), while specialized care (74.5 percent) and hospital care (79 percent) are concentrated in the private network. In 1992, the system had a total of 24,096 primary health care establishments, 8,042 outpatient clinics, 8,668 clinics for complementary diagnostic exams, and 7,057 hospitals—amounting to nearly 50,000 registered establishments (28).

The basic health services network underwent a marked expansion, especially from 1980 to 1986, mainly in Health Centers (8.6 percent per year). Their numbers increased nearly fivefold as a result of the rationalizing measures that restricted hospital admissions and encouraged outpatient care, following significant changes in health policy aimed mostly at cost containment. Since implementation of the SUS (1990) the municipalization process has been intensified, with the important rise of Health Units and Outpatient Clinics (6 to 7 percent per year), despite the reduction in federal public investments from 1990 to 1992. This growth has varied across the regions, with higher rates in the North and the South (growth rates 482 percent and 295 percent, respectively) and predominating at the municipal level. Heterogeneity is also evident within a region or state; 604 municipalities concentrated mainly in the states of Amazonas, Pará, Piauí, Maranhão, and Tocantins do not have Health Centers. A more homoge-

Table 5

The private health insurance system in Brazil

Type	How they work	Coverage	Number of companies	Annual billing (1996)
Medical companies (similar to HMOs)	Provide services through their own or contractual service network, charging fixed prices per user[a]	17.3 million	700	U.S.$3.7 billion
Medical cooperatives (Unimeds)	Physicians organized in cooperatives, provide services in their offices or in contracted hospitals and clinics, charging fixed prices per user	10 million	320	U.S.$3.5 billion
Employer-related health insurance (self-insurance plans, prepaid plans, and others)	Provide a set of health care services to employees of a company, through providers administered directly by the company or through a third-party administrator (e.g., HMO); fixed periodical payment, on a per capita basis, paid partly by the employer and partly by the employee; providers reimbursed based on fixed prices (per procedure or fee-for-service); some plans typically managed care	9 million	300	U.S.$4.6 billion[b]
Traditional private health insurance	Reimbursement system, limited by contract, with free choice of doctors and hospitals	6 million	40	U.S.$3 billion
Brazil (estimated)		42.3 million	1,360	U.S.$14.8 billion

Source: ABRAMGE (Associação Brasileira de Medicina de Grupo—Brazilian Association of Group Medicine), *Folha de São Paulo,* September 14, 1997, p. 4.

[a] Most health plans offered by these companies are related to employers' health insurance for their employees. Some companies also adopt the reimbursement system.

[b] Expenditure with costs of self-management plans.

neous distribution of these services is seen only in the South and in the state of São Paulo (29).

For basic health care services, the number of Health Units (lowest complexity level) in 1992 represented 27 percent of the total number of ambulatory services in Brazil, with the largest concentration in the Northeast (47.9 percent). Health Centers represented 46.5 percent, constituting the main type of ambulatory care in the country as a whole, although concentrated in the Southeast (40.0 percent). A comparison between numbers of ambulatory services in each region reveals the predominance of Health Units in the North and Northeast, meaning that other basic health care services are present in smaller numbers; in the more developed regions, Health Centers predominate, with greater equilibrium in the supply of other types of services for that level of complexity (29, pp. 10–12).

Specialized care services represent 25 percent of Brazil's total ambulatory establishments, 83 percent of which are mostly private, with larger concentrations in the more populous municipalities, particularly in the Southeast (56.2 percent), and smaller in the North (2.1 percent) (29, pp. 10–12). Seventy-five percent of these services are concentrated in the richest part of the country (Southeast, South). From 1990 to 1992, the growth of public specialized care declined while in the private sector this type of service increased. Only 28.9 percent of all specialized care services are managed exclusively by the SUS, and nearly 62 percent are private or are contracted out by private health insurance or directly through companies that offer pre-payment plans for their employees. The largest concentration of company-linked clinics is in the Southeast (Table 6).

The picture is inverted, however, for hospital services: 80 percent of the network has contractual links with the SUS, reaching 91.2 percent in the South. Proportionally, there are more hospitals in the Southeast (33 percent) and Northeast (30.5 percent). Almost 40 percent of all hospitals have contracts simultaneously with the SUS and with private health insurance companies, with the largest concentration in the South (70 percent) (Table 6). Although there are no conclusive data, this overlapping of clienteles generally results in a greater availability of hospital beds for private patients, with higher utilization of services by patients with private health insurance plans. Altogether, these hospitals have a capacity of 452,852 beds (336,966 private and 115,886 public), the distribution of which is even more concentrated, with 44.7 percent in the Southeast (29, pp. 24–25). The SUS segment is made up mainly of contracted private hospitals in all regions of the country. Hospital beds per inhabitant are predominantly private for all regions except the North (Table 7). Classification of hospitals according to the number of beds reveals that for the country as a whole, 50 percent of hospitals have under 40 beds. The distribution by region indicates that the Southeast, with 26 of the 38 hospitals having over 500 beds, has a greater number of large hospitals than the other regions (29, p. 27).

Table 6

Percentage distribution of specialized care clinics for type of contract, by geographical region, Brazil, 1992

Region	SUS only[a]	SUS and private health insurance[b]	Private health insurance and others	Total
	Specialized care			
North	27.3%	5.2%	67.5%	100%
Northeast	35.5	14.5	50.0	100
Southeast	25.2	6.3	68.5	100
South	36.2	14.4	49.4	100
Midwest	16.7	5.8	77.5	100
Brazil	28.9	9.3	61.9	100
	Hospitals			
North	56.4%	16.0%	27.7%	100%
Northeast	63.0	23.2	13.9	100
Southeast	29.5	42.8	27.7	100
South	23.0	68.2	8.8	100
Midwest	31.5	42.9	25.5	100
Brazil	41.0	39.1	19.9	100

Source: reference 29, p. 27.

[a] Can be a public hospital or a private one (for-profit or nonprofit) contracted by the SUS (financed only by public resources).

[b] Only private hospitals (for-profit and nonprofit) contracted by the SUS and by private insurance companies and/or pre-payment health plans (financed by public and private resources).

Private health insurance coverage increased by 73 percent from 1987 to 1996; only 20 percent of the population had this type of coverage in 1987, compared with 26.8 percent in 1996. This growth was concomitant with a deterioration of public services (Table 8). However, the increase in supplementary private coverage was not followed by a reduction in the use of public health care services, particularly of highly complex or emergency services; rather, as a rule, there is an overlapping of utilization. In other words, clients use available services indiscriminately, according to their possibilities and to the severity of their illness or injury.

As in the regional distribution of health care services, physicians are also concentrated in the Southeast (58.8 percent). When one considers the physician con-

Table 7

Percentage distribution of public and private hospitals and beds per 1,000 inhabitants, by geographical region, Brazil, 1992

	No. of hospital beds			Beds/1,000 inhabitants		
Region	Public	Private	Total	Public	Private	Total
North	48.7%	51.3%	100%	1.1	1.1	2.2
Northeast	33.6	66.4	100	0.9	1.8	2.7
Southeast	22.2	77.8	100	0.7	2.5	3.2
South	17.2	82.8	100	0.6	2.9	3.5
Midwest	23.3	76.7	100	0.9	3.0	3.9
Brazil	—	—	—	0.8	2.3	3.9

Source: reference 29, p. 25.

Table 8

Growth rate of private health insurance coverage in Brazil, 1987–1996

	Population coverage			Percent of total population	
	1987, millions	1996, millions	Growth rate, percent	1987	1996
Prepaid plans and others	23.7	36.3	51.2%	19.4%	23.0%
Private health insurance	0.7	6.0	757	0.6	3.8
Total	24.4	42.3	73.4	20.0	26.8

Sources: For 1987: Towers et al., apud A. C. Médici and C. A. Czapski, *Evolução e Perspectivas dos Gastos Públicos com Saúde no Brasil,* Ministério da Saúde, Brasilía, 1995. For 1995: ABRAMGE, *Folha de São Paulo,* September 14, 1997, p. 3.

centration outside the state capitals, the picture is more striking: 64 percent are concentrated in the more developed regions. In other words, hinterland cities in the Southeast have a much better supply of physicians than do the less developed regions. This distribution of physicians results in a deficit in the poorer regions and cities and a surplus in the richer ones. For the distribution of other health professionals (nurses and dentists) the picture is the same: concentration in the richest parts of the country (Table 9).

Table 9

Health professionals per 1,000 inhabitants, by geographical region, Brazil, 1994

Region	Physicians/ 1,000 inhabitants[a]	Nurses/ 1,000 inhabitants[b]	Dentists/ 1,000 inhabitants[b]
North	0.50	0.84	0.24
Northeast	0.65	0.80	0.40
Southeast	1.61	2.18	1.11
South	1.20	1.54	0.67
Midwest	1.18	1.82	0.75
Brazil	1.16	1.61	0.69

Sources: For physicians: FIOCRUZ/CFM, *Physicians' Profile in Brazil,* p. 47, 1997. For nurses and dentists: Ministry of Health, *Buletin SAS,* 1(2): 33, 1(3): 12, 1994.
[a] Population data from Brazilian Census Bureau (IBGE), 1996.
[b] Population data from IBGE, 1994.

EQUITY IN THE DELIVERY OF HEALTH CARE SERVICES

Hospital Care

The last national health survey carried out in Brazil—the National Interview Survey in Nutrition and Health (PNSN), with data from 1989—showed that hospital admission rates were unequally distributed among geographical regions, with the less developed regions having the lowest rates. The national rate was very high—about 12 percent—and admission rates excluding first admissions were also considerable—5.3 percent.

More recent data on hospital admissions from the Inpatient Information System of the Unified Health System (SIH/SUS) show that in 1996 admissions were fewer and more evenly distributed among the geographical regions than in 1989 (Table 10). However, it is important to note that the data in this table are not strictly comparable. Data from 1989 cover all admissions in the country, whereas the 1996 data are related only to admissions financed by the SUS. However, if one applies 1996 national rates to the population covered by private insurance—estimated at 42 million—the national utilization rate in 1996 would become 9.56 percent, suggesting a reduction in the admission rate between 1989 and 1996.

Between 1993 and 1996 there was a sharp decrease in admissions financed by the SUS—19.54 percent (Table 11). This decline started in 1995 and continued through 1996, resulting mainly from two measures adopted by the Ministry of

Table 10

Hospital admission rates per 100 inhabitants, by geographical region, Brazil, 1989 and 1996

Region	1989[a]	1996
North	9.22%	7.27%
Northeast	8.61	7.92
Southeast	12.13	6.71
South	14.30	8.16
Midwest	14.13	7.13
Brazil	11.73	7.35

Sources: For 1989: National Interview Survey in Nutrition and Health (PNSN), 1989. For 1996: Inpatient Information System (SIH/SUS/Ministry of Health) and Brazilian Census Bureau (IBGE).
[a] Excludes rural population in the North.

Health: (*a*) introduction of stricter control over the quality of SIH/SUS data, and (*b*) reduction in the admissions ceiling financed by the SUS, from 10 per 100 to 9 per 100 inhabitants. The decline in admissions was not homogeneous among the geographical regions, which resulted in less unequal admission rates by geographical region in 1996 than in 1993. It appears that measures directed at controlling inpatient care also reduced existing geographical inequalities within the SUS.

The North had almost no reduction in hospital admissions between 1993 and 1996 (growth rate –0.003 percent) and had the largest growth rate in expenditure (28.5 percent). In 1996, the less developed regions—North (7.27 percent) and Northeast (7.92 percent)—had larger admission rates than the Southeast (6.71 percent), the most developed region in the country. Nonetheless, private insurance coverage is much larger in the Southeast, which implies that "total" admission rates may have a different and more unequal distribution than that observed in Table 11.

Apparently, the observed decline in admissions was not followed, as expected, by a decline in expenditure. Between 1993 and 1996 there was an increase of 12.48 percent in SUS expenditure on inpatient services. This was due to a rise in the mean value of the payment unit (*procedimento realizado*) of the reimbursement mechanism adopted by the SUS. In 1994, adoption of a new policy for economic adjustment (*Plano Real*) by the federal government led to an increase of almost 30 percent in the mean value of the SUS payment unit. Thus, the gap between the unit payment (30 percent) and the expenditure growth rate (12 percent) suggests that despite the observed increase in expenditure, the

Table 11

Inpatient admission rates per 100 inhabitants, total admissions, and growth rate (1993–1996) for inpatient admissions and expenditure by the SUS, by geographical region, Brazil, 1996

Region	Admission rates[a]	Total admissions 1996[a]	Change in admissions, 1993–96	Change in expenditure, 1993–96
North	7.27%	842,361	–0.003	28.5
Northeast	7.92	3,603,753	–18.04	9.2
Southeast	6.71	4,700,767	–23.56	11.61
South	8.16	1,977,567	–7.78	14.22
Midwest	7.31	808,206	–18.96	16.96
Brazil	7.35	11,932,654	–19.54	12.48

Source: Inpatient Information System (SIH/SUS/Ministry of Health) and Brazilian Census Bureau (IBGE).

[a] Not included are 38,102 admissions of patients with unknown place of residence.

cost-reducing policies of the Ministry of Health, adopted between 1995 and 1996, had a positive impact.

As with admissions, the growth rate of expenditure was uneven among the geographical regions, with the North having the largest rate of increase (28.5 percent). However, despite a better distribution in admission rates across geographical regions, SUS expenditure on inpatient care in 1996 remained concentrated in the Southeast (46 percent) (Table 12). This region also has a larger share of expenditure relative to its number of admissions (39 percent) and number of inhabitants (43 percent). On the contrary, the North and Northeast have a smaller share of expenditure (4 and 24 percent, respectively) compared with their share of total admissions (5.9 and 29.6 percent) and number of inhabitants (7.2 and 28.5 percent).

In 1993, the mean value of a SUS admission in Brazil was U.S.$188.49, increasing to U.S.$263.04 in 1996. Admissions in the Southeast in 1996 cost, on average, U.S.$308.63, with a growth rate of 46 percent in four years, while in the North and Northeast they cost U.S.$160.70 and U.S.$211.80, respectively, representing a growth rate of about 33 percent in each region. These numbers suggest that the supply of services in the Southeast is more complex and might be responsible for better care quality.

In short, despite regulatory measures to increase efficiency and reduce inequalities within the SUS, inpatient care delivery in 1996 remained highly unequal across the geographical regions, with inhabitants of the less developed areas less likely to have access to appropriate care. Between 1993 and 1996,

Table 12

Total admissions and expenditure for inpatient services by the SUS, by geographical region, Brazil, 1993 and 1996

	1993				1996			
	Expenditure		Admissions		Expenditure		Admissions	
Region	U.S.$ millions	%	No., thousands	%	U.S.$ millions	%	No., thousands	%
North	105	3.8	873	5.9	135	4.3	842	7.1
Northeast	699	25.0	4,397	29.6	763	24.3	3,604	30.2
Southeast	1,300	46.5	6,150	41.5	1,451	46.2	4,701	39.4
South	511	18.3	2,412	16.3	584	18.6	1,998	16.6
Midwest	180	6.4	997	6.7	211	6.7	808	6.8
Brazil	2,795	100.0	14,829,769	100.0	3,144	100.0	11,593	100.0

Source: Inpatient Information System (SIH/SUS/Ministry of Health).

there were only marginal variations in the proportional participation of the geographical regions in SUS expenditure. These very small variations in expenditure offset the effect of a better regional distribution of hospital admissions on existing inequalities in the consumption of health care services.

Mortality and Morbidity

Health indicators have improved significantly in the last decades: life expectancy has increased and the general and cause-specific death rates have diminished. But regional differences and variations by income level persist. Life expectancy at birth illustrates this point quite clearly: it is lower in lower income groups (57.5 years) and in poorer regions (51.5 years in the Northeast) and higher in high income groups (73.5 years) and in the richest region (75.0 years in the Southeast). The differences between urban and rural areas remain, life expectancy being lower in the rural areas in both regions and markedly lower in the Northeast.

Proportional mortality rates by cause of death have changed significantly, with a pointed increase in external causes (accidents and violent deaths in general) (30). Infant mortality rates range from 26.5 per 1,000 for households with a monthly income above the minimum wage and adequate sanitary facilities, to 86.4 per 1,000 for households earning below the monthly minimum wage and with inadequate sanitary facilities, reaching as high as 97.2 per 1,000 in the Northeast (31). The pace of mortality rate reduction declined in the 1980s, especially in the poorer regions (–15.28 percent in the North and –17.41 percent in the Northeast, versus more than –35 percent in the Southeast, South, and Midwest), further increasing inequalities among regions and income groups (32). Rates of infant deaths due to diarrhea are also lower in the more developed regions of the country. The incidence and prevalence of epidemic and endemic infectious diseases are on the rise, spreading across the country as well as between social groups.

As has been observed in many countries, PNSN data show that the distribution of self-reported morbidity in Brazil in 1989 had a negative association with income. The rate in the lowest income group was 33 percent higher than that in the highest income group.

Use of Health Care Services

Contrary to observed morbidity patterns, utilization rates (including all types of services—ambulatory, outpatient, inpatient, emergency) increased as income increased, both for individuals who reported restricted activity and for those who did not. Inequalities in health care service delivery appeared to be greater for individuals with morbidity than for those without. For individuals with morbidity, the highest income group had a utilization rate 53 percent higher—50 percent higher for people without morbidity—than the lowest income group. Thus, in

Brazil, in 1989 individuals at a greater risk of becoming ill were less likely to have access to health care services (Table 13).

Utilization rates by type of service also varied, highlighting the large inequalities in quality of care delivered across income groups. The highest income group used about 500 percent more private services and about 100 percent more outpatient services than the lowest income group. On the other hand, people in the lowest income group used 67 percent more Health Center Services and 43 percent more emergency services than the highest income group. There were no social inequalities in the use of inpatient services.

Access to Health Care Services

In Brazil in 1989, 58.28 percent of individuals who reported morbidity sought care, and 98 percent of those who sought care got treatment. Utilization rates varied markedly, and these variations can be interpreted as a function of differences across social groups in the decision to seek care. One hypothesis for explaining social variations in the decision to seek care is that they result from social differences in access to health care services. People in lower income groups would have more difficulty in getting access to health care services, delaying their deci-

Table 13

Age- and sex-standardized health care service utilization rates per 100 inhabitants, by morbidity and per capita family income (quintile), Brazil, 1989[a]

	Age- and sex-standardized utilization rate	
Income quintile	With morbidity	Without morbidity
Lowest	45.14%	9.31%
2nd	52.94	9.19
3rd	62.90	10.83
4th	62.30	12.35
Highest	69.22	13.93
Brazil	58.26[b]	10.87
Prevalence ratio[c]	1.53	1.50

Source: National Interview Survey in Nutrition and Health (PNSN), 1989.

[a] Excludes rural population, children less than 2 years old, and people from families without income.

[b] Gross rate.

[c] Prevalence ratio (rate of highest income group divided by rate of lowest income group); 1 = equality between the income groups; >1 = inequality in favor of the highest income group; <1 = inequality in favor of the lowest income group.

sion to look for treatment. An argument in favor of this hypothesis is the higher rates of utilization of low-complexity and emergency services by the lower income groups, suggesting less access to appropriate care (Table 14).

In 1989, various health systems were operating in Brazil, each with highly different patterns of efficiency and quality of care. The poor had access to primary health care services and emergency/inpatient care, while the higher income groups obtained treatment at more complex ambulatory services and used less emergency and inpatient care. The difference in utilization patterns of the lower and higher income groups is mainly explained by an increase in the use of private practice. Clearly, the health care system existing in 1989 was extremely unequal since the difference in utilization patterns depended on people's purchasing power and/or access to private insurance plans, which was restricted to a segment of the employed population in the formal labor market (Table 15).

Use of health care services in Brazil in 1989 also varied greatly across occupations, positions in the labor market, and level of education of the family head (33). The higher users were among the better educated people in the labor market. There were only marginal inequalities due to race.

THE ISSUE OF EQUITY

The current debate centers on administrative reform at the governmental level, and the government proposal is clearly in keeping with the broad international reform agenda, including both privatization and contracting out. This implies a

Table 14

Indicators of access to health care services per 100 inhabitants reporting morbidity, by per capita family income (quintile), Brazil, 1989[a]

Income quintile	Seeking care	"Satisfied" demand
Lowest	58.4%	95.7%
2nd	61.6	97.7
3rd	67.6	98.0
4th	60.9	99.1
Highest	65.5	98.8
Brazil	66.42	98.3
Prevalence ratio[b]	1.16	1.03

Source: National Interview Survey in Nutrition and Health (PNSN), 1989.

[a] Excludes rural population, children less than 4 years old, and people from families without income.

[b] As explained in Table 13.

Table 15

Age- and sex-standardized utilization rates per 100 inhabitants by type of service, for people with morbidity, by family income per capita, Brazil, 1989[a]

	Income quintile				
Type of service	Lowest	2nd	3rd	4th	Highest
Health center	28.8%	20.9%	21.0%	12.4%	7.6%
Inpatient	24.7	28.6	21.8	19.7	16.4
Pharmacy	20.2	18.0	17.3	13.7	16.8
Private practice	9.0	13.4	19.3	29.2	42.3
Emergency	8.0	6.4	6.6	6.4	3.0
Health Clinics	6.3	9.7	13.4	18.2	10.9
Other	2.9	2.9	0.6	0.3	3.1

Source: National Interview Survey for Nutrition and Health (PNSN).
[a] Excludes rural population and children under 2 years old.

delimitation of institutional scope, as well as the creation, redefinition, and transformation of institutions. But social and health services, among others, are not considered "exclusive activities" of government; that is, they can be carried out by any organization with private legal statutes, albeit financed by public resources. It is this conception that has given rise to the proposal to transfer these activities to the *non-state public sector* (known as *publicization*), to achieve more flexibility within the public sector and to alleviate the government's duties in health care delivery.

A focus on managerialism and market-oriented reforms directed at responding to consumer demands and the introduction of competitive mechanisms to stimulate better service performance are the main governmental reform guidelines. Nevertheless, a number of mechanisms to make management more flexible are already in place in various subnational administrations, and the process of decentralization itself has exacerbated the fragmentation of the system and weakened the legitimacy of the SUS as a national institution. At the same time, the parliament and the government are engaged in a clash over the regulation of private health insurance, whose lobbies are powerful, well-organized interest

groups. This dynamics, in addition to the impasse brought about by the economic situation, by the government's reform proposals, and by the reelection in 1998 of President Cardoso, challenges the implementation of health reform as it was initially visualized.

There was a turning point in the reform agenda with NOB 96, implemented in 1998: the role of the federal government as formulator and regulator of the system is being consolidated; the change in the role of state and municipal governments from provider to system manager is being made more explicit; and the state level is being restored as the sphere for coordination and articulation of the various municipal health service networks. Financing by automatic per capita transfer (PAB), although more redistributive than the previous allocation arrangement, may introduce new distortions (23, pp. 35–36).

In summary, a new health care system is being defined which, although decentralized, is still strongly dependent on the federal government. We cannot yet evaluate the results of this new dynamics, which was only recently inaugurated. While having the merit of encouraging autonomy and strengthening the local level under the coordination of the state, and possibly making health services more effective, it may also further fragment the system and render service distribution less egalitarian, thus consolidating an increasingly dual system.

In any case, the government tends to favor a very narrow concept of social policies focused on the poor. The federal government does have a rhetorical commitment to the principles of the SUS, but the actual implementation does not fulfill the expectation of overcoming inequalities and improving the public health care system, upon which nearly 115.5 million Brazilians depend.

Although in the Constitution the term "equity" appears ambiguous, this concept is implicit in the universality of health care coverage and equivalency of benefits and services for urban and rural populations. Briefly, the concept in the constitutional text establishes *equal opportunity of access.* Regarding social security in general and health in particular, the constitutional text allows for different interpretations of equality of opportunity. The real objective of this concept, however, can be inferred from the contents of the Organic Health Law (34), which covers those extrasectorial factors that determine health conditions—food, housing, water and basic sanitation, income, education, and access to essential goods and services, among others. As such, it can be inferred from the Constitution and the complementary legislation that the concept of *equal opportunity for access to health care services* refers to *equality of opportunity for equal needs* and implies a positive discrimination to compensate for existing inequalities in the determinants of population health, which are considered socially unjust. The implemented policies, however, have not guaranteed the effective exercise of these rights, restricting their validity to no more than a formal definition. In other words, the law may be progressive, but the same cannot be said of the practice.

One of the main obstacles to more equity is, without doubt, the sectorial financing policy, which is characterized by a continuing regressive collection of

revenue and allocation of resources. Furthermore, the perverse historical development of the public/private combination, the lack of adequate and effective regulation, limited managerial capabilities, and the absence of a clear priority assigned to health in the government agenda—all highlight both the inadequate capacity for policy enforcement and a lack of accountability regarding the citizen's right to health. It is fair to assume that this debate will continue to be complex and that the entire reform process will remain extremely conflictive.

Acknowledgment — Many thanks to Tatiana Wargas de Faria Baptista, our auxiliary researcher, for the revision work on the article.

Note — This case study was presented in the workshop Towards Equity? Health Sector Reform and Access to Basic Health Services, Oslo, October 1–3, 1997.

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