Financing Health Policies in Brazil
Achievements, Challenges and Proposals

André Cezar Medici

November 2002

André Medici, Senior Health Specialist, Inter-American Development Bank, Social Programs Division, Sustainable Development Department. The positions presented are responsibility of the author and cannot be attributed to the Inter.American Development Bank.

Summary

Introduction

Since the constitutional reform of 1988, the Brazilian government has been introducing changes in the health sector structure. Known as the "Brazilian Sanitary Reform," the new measures were implemented in a way that completely opposed that of mainstream health reforms in other Latin American countries, such as Chile and Colombia.

Health reforms in Latin America adopted a set of principles characterized by the channeling of public resources to the poor; the separation of regulation, insurance and provision of services; the introduction of competition among insurers and providers; and funding of the health system based on the demand side. The Brazilian health reform followed another path, trying to achieve free universal coverage by means of a supply-side public system.

While health reforms in other Latin American countries were implemented in a single legal framework that attacked the structured interests of providers, doctors and social groups, the Brazilian reform adopted a gradualist approach, trying to blend in stakeholders' interests and avoiding the rise of social conflicts.

When compared to the Brazilian case, many Latin American health reforms showed good short-term achievements in coverage (Colombia) and outcomes (Chile). Brazil didn't show fast achievements in preventing health outcomes but, even so, the gradualist approach allow some advantages at long run and good case managements, as can be seen in the Brazilian AIDS program.

On the other hand, most of the Latin American health reforms are experiencing problems or loosing social sustainability due to the lack of political support.

Even when the results are not that impressive, the political economy of the Brazilian health reform seemed more consistent than others in the regional context, yielding some lessons that should be studied and validated for other Latin American contexts. One of the pillars of its political economy was the decentralization of financing and health services provision from the federal government to states and municipalities.

This article tries to assess the decentralization process of the Brazilian health sector, evaluating the principal measures used by the government to address financing and equity issues in the composition and distribution of the expenditures. Based on this analysis, it describes some of the problems that still persist in relation to the public financing of health services in Brazil, pointing out some of the possible solutions.[1]

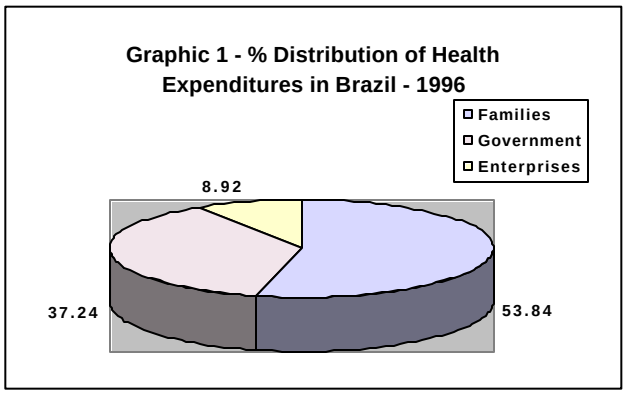
The first section describes the current features of the Brazilian health system. The second presents the main characteristics of the health decentralization process in the framework of the Brazilian Health Reform during the nineties. The third section summarizes the achievements of the reform; the fourth discusses the problems that still affect the health system, while the last presents some possible solutions to these problems.

[1] For a more detailed analysis of these aspects, see *Medici, 2002a*.

Main Features Of Brazilian Health System

A Pluralist and Fragmented System

The Brazilian health system is pluralist and fragmented in nature.[2] Three great flows of financing and services stand out: the first is handled by the public sector, i.e., the Unified Health System (*SUS, Sistema Unico de Saúde*)[3]; the second is based on a supplementary private system (SPS) financed with pre-payment by families and enterprises; and the third is financed directly by family expenditures.



In 1996, the health national expenditure reached US$61.4 billion (7.7% of the GDP)[4]. Families and enterprises account for almost two thirds of the health expenditures: the first with 54% and the second with 9% (see Graphic 1). Approximately one third of the family expenses goes towards payments for health insurance; another third is spent on medications and the last portion covers services and other health expenses. Government expenditures, through the SUS, represented 37% of the total health expenses in 1996.

Even though the Brazilian health care system is a pluralist one, it continues to be fragmented. Some efforts were directed towards trying to achieve a better coordination and integration among health initiatives financed by the public sector by means of an ample and continuous decentralization process that redefines the roles of the different government levels.

Equity Issues

Many problems associated with the distribution of private and public funds still remain. On one hand, the use of public funds does not respond satisfactorily to epidemiological needs and, on the other, the

[2] The term "fragmented pluralism" belongs to the conceptual framework of "structured pluralism" proposed by Juan Luiz Londoño and Julio Frenk. Fragmented pluralism is a situation where many health structures (public, private and social security) subsist without a regulatory system to organize the supply of the different providers and to promote efficiency in the use of health expenditures. The fragmented pluralist systems are characterized by superposition, inefficiency and lack of coordination among providers, leading to an overlapping of coverage, a waste of money and an increasing inequity.

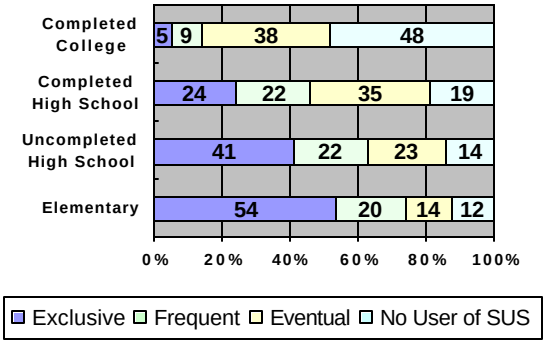
[3] The SUS was created under the Brazilian Constitution of 1998, which granted free and universal access to health services to the population. The SUS is built on three basic principles: universal and free access to health, integral coverage of the services, and equity in the distribution of public resources. The organizational principles for the SUS implementation are the decentralization with unified management at each government level (federal, state and municipal) and social participation. Different segments of the population are represented at the National Council of Health (CNS, Consejo Nacional de Saúde), as well as in the States and Municipals Councils of Health, whose mission is to approve decisions and monitor actions implemented by the government.

[4] The National Survey of Family Expenditures, coordinated by the Brazilian Institute of Geography and Statistics (IBGE), provides data to estimate how much families are spending onn health in 1996. An update of this household survey is scheduled for 2003.

poorest groups spent proportionally more on health than others with more financial means, denoting an evident inequality on the directionality of public funds (*Medici, 2002b*). For these reasons, public funds need to be directed to groups with less capacity to pay, thus freeing an important share of the family budget for use on other essentials.

The adoption of measures to solve these problems could contribute to improve Brazil's situation, which is not favorable when compared to basic health indicators of other Latin American countries.

Graphics 2 – % Distribution of the Brazilian population by levels of SUS utilization and schooling – 1998



The majority of the population in Brazil has access to health services only through the public sector, which represents one third of the national health expenditures. A 1998 national survey by the Brazilian Institute of Public Opinion and Statistics (IBOPE)[5] showed that 40% of the population used the SUS exclusively for health care needs, 44% combined the use of SUS with other systems, and 16% did not utilize SUS at all. Graphic 2 shows the results of this survey by schooling level.

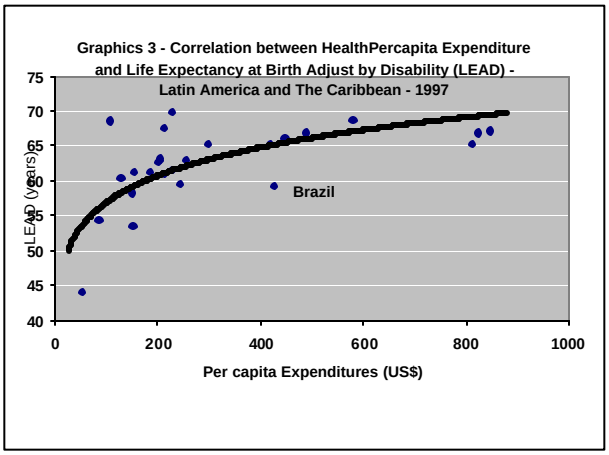
[5] This survey, carried out on February, 12-17, 1998, was sponsored by the National Health Foundation (FUNASA) and the National Council of State Secretaries of Health (CONASS). Two thousand families were interviewed in a sample that represented the entire national territory.

The data also shows that the inequity of the SUS is not related to its level of use by poor and richer groups. In fact, people with college education use the SUS less frequently than other groups with different schooling. But almost 40% of the population with college education uses the SUS eventually. Most of them contract private health plans but also use the SUS to cover expensive diagnostic and treatment procedures. As a result, this situation:

a) contributes to reducing the price paid to private health insurance and plans that exclude more intensively high cost and sophisticated technology procedures, even those that are covered freely by the public sector;

b) increases SUS costs, given the overutilization of these procedures by the middle class and high income groups;

c) reduces the funding and the possibility of investing on infrastructure to address the needs of the poorest. As shown, 12% of the population with elementary schooling or less do not use the SUS, probably because they do not have geographical access to the system. This segment, which does not have any access to health, represents 7% of the Brazilian population.



Health System Outcomes

If we consider some of the basic indicators, the outcomes of the Brazilian health care system improved in the nineties, but still are worse than the average health care in other Latin American and Caribbean (LAC) countries. Only eight countries in the region presented greater per capita health expenditures than Brazil[6] in 1997. Even so, when comparing the data of life expectancy at birth, adjusted by disability as a summarized outcome indicator, only three countries (Bolivia, Guatemala and Haiti), in the case of men, and five (Bolivia, Ecuador, Guatemala, Haiti and Peru), in the case of women, were in a situation that was worse than Brazil's.[7]

In other words, even when spending more, Brazil shows results that are worse than those registered in health outcome indicators for other LAC countries. This poor performance is also associated with income distribution inequalities, low levels of schooling and limited (or the lack of) access to safe water and sanitation.

Given the current level of health expenditure, there is some room to increase the efficiency of health programs and to improve outcome indicators. For example, in 1996, it was verified that in many northeastern towns infant mortality rates were higher than 100 by each 1000 born alive and, in average, 26% of the children younger than five years of age presented some form of malnutrition. On the other hand, maternal mortality rates in Brazil are still higher than the LAC average.

All these outcome indicators could improve even if the current level of health expenditure in Brazil remains unchanged.

Despite these efficiency problems, the Brazilian government is making some progress in the improvement of health conditions. Some outcome indicators improved at the end of the eighties and the beginning of the nineties, without a substantial increase of the public expenditure. The national health expenditures between 1987 and 1989 were greater than in the 1997–1999 period. Meanwhile, the infant mortality rates decreased by 31% (from 52 to 38 by each 1000 born alive), malnutrition decreased by 30% and the maternal mortality decreased by 70% between 1989 and 1997.

The improvement of health outcomes in recent years can not be attributed only to the better performance of health process indicators, such as the increase of pregnancy and birth care, and better vaccination coverage and medical care for children. The health promotion and disease prevention strategies adopted by the government through actions such as the health community agents (PACS) and family healths programs (PSF) will contribute to improve the good performance of the system. So, even with worse indicators than other LAC countries with the same or lower income level, Brazil achieved some progress during the nineties, producing better results with less spending. The decentralization of health financing and managing from federal to local governments made positive contributions, as will be discussed.

[6] These countries are Argentina (US$823), Bahamas (US$ 1.230), Barbados (US$ 814), Chile (US$581), Colombia (US$ 507), Costa Rica (US$ 489), Panama (US$ 449) and Uruguay (US$ 849). The Brazilian per-capita health expenditure was US$ 428.

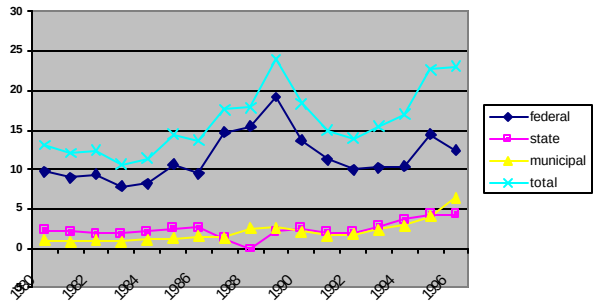
[7] In Brazil the life expectancy at birth in 1997 was of 63.7 years for men and 71.7 years for women.

Decentralization of Health Care Financing

Role of the State and Municipal Governments

In the last decades the public health expenditures in Brazil went through a progressive process of financing decentralization. Federal government participation in the public health financing was reduced from 73% to 54%, while the municipalities share increased from 9% to 18% between 1985 and 1996. The states maintained their participation at 18% during the same period (see graphic 4).

Graphic 4 - Public Health Expenditures in Brazil 1980-1996 (US$ billions)



In addition to a higher participation of states and municipalities in generating additional funds for the health sector, the federal government increased the amount of funds transferred from the central budget to states and municipalities, delegating to the local governments the responsibility of managing these funds. During the eighties and the nineties, a good part of the federal resources was transferred to states and municipalities in a negotiated fashion. In the eighties, the majority of the transfers were destined to the states, while in the nineties it went to the municipalities. As a consequence, the federal government reduced its participation in the management of public funds from 67% to 46% while the municipal participation increased from 10% to 35% between 1985 and 1996. In the same period, the states saw their participation reduced from 23% to 18%. Today, the decentralized levels of the government (states and municipalities) manage the highest amount of public health expenditures (approximately 53%).

But the role of the states in health management could be improved in the near future. New rules established by the Ministry of Health (MOH) in 2001 will lead to the strengthening of the states in their functions of regulating, coordinating and financing regional health nets[8]. On the other hand, the municipalities' autonomy, strengthened in the nineties, could be frozen in the next years, opening a space for other institutional arrangements, such as municipal consortia and regional health nets with shared coordination among states and municipalities.

The federal public health expenditures decreased in the first half of the nineties, given the impacts of the economic crisis over the public budget. In 1994 the federal government allocated less than 10% of the total federal tax revenues but, since 1995, expenditures increased again, representing almost 14% of the federal tax income by 1999.

Health expenditures in the states are financed by state tax revenues and federal transfers. In the early eighties, health expenditures (federal transfers excluded) represented almost 8% of fiscal revenues for the states. Between 1987 and 1990, the increase in federal transfers prompted the states to reassign their own fiscal revenues to other budget categories. Since the nineties the federal government started to shift the destination of health transfers from states to municipalities, increasing the participation of states tax revenues in the financing of

[8] See Operational Norm 1 (NOAS), approved by the MOH in January 2001.

healthcare at local level and recuperating the 8.5% share of fiscal revenues in 1996.

In municipalities, public health expenditures as a share of the municipal tax income increased gradually from 7% to 16% between 1980 and 1998. For that reason, municipal governments have been the most important partners of the health care decentralization process in Brazil.

The total amount of federal state and municipal health expenditures kept a relatively constant share of the public budget during the 1990s (between 11% and 12%), given the behavior of compensatory expenditures among different government levels. Between 1993 and 1998, health expenditures reduced their participation in federal social expenditures from 16% to 13% showing that government prioritized other social sectors than health.

Regularity, Efficiency and Payment Mechanisms

The 1988 federal constitution and related legislation established that at least 30% of the social security budget (a block of payroll taxes used to finance health, pensions and social assistance) should be assigned to health care; a plan that was never implemented. During the first half of the 1990's, public health expenditures never reached these figures due to instability and lack of resources. Since the second half of the 1990s, the increase in health federal expenditures was financed by the creation of new taxes, such as the Provisional Contribution over Financial Transactions (CPMF).

During the 1990s, the provision of health public resources was erratic, causing occasional lacks of financing especially at state and municipal levels. To solve this situation, in 2000 health authorities at executive levels pressed Congress for the approval of an amend to the Constitution, which would define a fixed share of the public budget (federal, states and municipalities) to be targeted to health care expenditures. It is expected that this measure will result in higher health expenditure levels and greater stability in the budgets for the sector. This approval was not endorsed by the economic authorities, who preferred more freedom in the yearly budget discussions among the legislative and executive branches of the government.

Health care expenditures still face some efficiency problems related to their supply-side orientation and the absence of a clear order in resource allocation and decision making processes. During the 1990s, the National Health Fund (FNS) – the principal federal fund for the sector – transferred resources to all states and municipalities, but also paid directly for public and private hospital and ambulatory care. The system by which these payments were made requires strong auditing, evaluation and supervision efforts to assure the best results. Even so, the MOH established legislation to rule the states' and municipalities' autonomy in resource management and still some of the municipalities are not able to comply with the minimal requirements.

To improve efficiency in the decentralization process, the MOH started to substitute some supply-side payment mechanisms (such as fee-for-services and prospective payments) for block grants related to primary health care and public health. That is the case of the Basic Health Package (PAB), which transfers resources to states and municipalities based on a per-capita set of high cost-effective health measures. The MOH established performance, impact and coverage indicators to evaluate the achievement of goals in the sector.

Nevertheless, these measures are not enough to guarantee efficiency in resource allocation. The SUS lacks epidemiological, geographical and social criteria to distribute the funds. For these reasons, the system still centers around hospital care and health expenditures determined by the needs of middle and higher income population groups. This explains why the poorest families compromise a substantial

share of their budgets to pay for drugs and health care[9].

Nature of Health Expenditures

The use of health public funds can be analyzed according to two basic criteria: a) categories under which expenditures can be classified; and, b) types of activities.

At the federal level, recurrent expenses (especially those related to personnel) represent the most important category in the economic expenditure criteria. Even so, there was a shift between the increasing transfers to states and municipalities and a reduction in recurrent expenses during the nineties, indicating that health services were increasingly managed at the local level (states and municipalities) and that the FNS has been a mechanism for transferring funds.

The most important categories are medical and sanitary assistance and administration, representing 72% and 22% of the total health public expenditures in 1996, respectively. During the nineties Brazil experienced a reduction in hospital expenses *vis-à-vis* an increase in expenses related to primary health care and public health.

Levels of Public Health Expenditures in the States

Public health expenditures are extremely heterogeneous among states and municipalities. In 1996 the lowest per capita expenditure was registered in the state of Tocantins (US$67) and the highest in the Federal District (US$440). This difference is, mostly, related to existing social and economic conditions in each state and to the fact that federal transfers to finance health care are not distributed according to health needs but, instead, to the the infrastructure in the sector and political lobbies of state governments.

When analyzing data from the eighties and nineties it is possible to conclude that the magnitude of the state per capita health expenditures is not correlated with the per capita gross domestic product (GDP) of each state. States like Roraima, for example, had a per capita GDP three times lower than São Paulo but also higher per capita health expenditures, because they are strongly supported by federal transfers. Therefore, there are no patterns guiding the distribution of federal transfers to states. On the other hand, tax income used by states and municipalities to finance health care show a correlation with the magnitude of the local GDP per capita.

To sum up, until the first half of the 1990s, the federal government did not make transfers to the states based on needs or outcomes, avoiding, by political reasons, the use of its power to make transfers to achieve a more equitable national distribution of health expenditures.

Health Expenditures and Outcome Indicators

The existing data for some outcome indicators show that there is a negative correlation between child mortality rates and the GDP per capita at the state level. This is highly expected even so child mortality is strongly rrelated with socioeconomic variables, as GDP per capita, at state level.

On the other hand, there is a direct correlation between health per capita expenditures and the efficiency of health information systems. To measure this second variable the proportion of child deaths with unknown or unclearly declared cause was used as a share of the total child deaths. The reduction of child mortality is strongly correlated with the capability to achieve better health information systems to prevent child mortality.

The existing data also show that in some Brazilian states (especially in the south,

[9] See MEDICI, A.C., "Family Health Expenditures in Brazil: Some Indirect Evidences of the Regressive Character of the Public Health Expenditure", Ed. Inter American Development Bank, SDS Technical Report, Washington, December 2002.

southeast and middle west regions), health expenditures yield positive results when they are associated with good epidemiological surveillance systems and affordable water and sanitation infrastructure. Good health information systems also allow the early identification of groups at risk to avoid child mortality and implement policies to promote healthier behaviors and prevent risks in the poorest segments of the population.

Achievements

Programs to Assure Coverage and Quality in Health Care

Since the beginning of the nineties, the Brazilian federal government created some programs to support primary health care that could rapidly improve health coverage and quality. These programs are based on the following features:

a) Financing actions to respond to the needs of the poorest groups, according to their morbidity and mortality profiles;

b) Transferring funds to the municipalities to finance a package of essential public health and primary care activities that better respond to the needs of the poorest;

c) Covering population without services in the rural areas and urban periphery by creating programs for family health care and home visits by health personnel;

d) Controlling and evaluating services provision through the development of epidemiological and surveillance information systems that generate sets of outcome indicators;

e) Developing legislation to promote easier and affordable access to health goods and services such as tests and drugs[10].

As mentioned, the main programs used to implement these goals are the Basic Health Package (PAB), the Health Community Agents Program (PACS) and the Family Health Program (PSF). All these programs, despite their slow and politically driven implementation, are tied to progresses in the decentralization process and brought about some improvement in coverage and quality of health services. Their achievements can be seen in a faster reduction of child mortality and malnutrition as well in the increase of coverage in ambulatory care and public health facilities.

The Way to Financial Decentralization

Even though the majority of public health expenditures in Brazil are still centered in the federal government, the participation of states and municipalities in the financing of the public health expenditures increased 47% in the last few years. Throughout the nineties, the municipalities became the most important actors in the decentralization process, not only for being able to increase resources assigned to health, but also because of their newly assumed responsibilities on managing local health networks and investments in the sector.

Despite the increasing heterogeneity of health fiscal capacities at the local level, which exacerbated health inequalities, the National Congress approved at the end of 2000 a constitutional reform that assures a minimum level of public revenues to the sector. This measure could contribute to achieving greater stability in financing, assuring higher levels of budget for health services in the poorest states and municipalities and reducing, at the same time, the heterogeneity of public health expenditures at the local level.
It can also be observed that the improvement of health indicators in the nineties is

[10] The Brazilian government has been promoting an active policy for the prescription and use of generic drugs, making it possible to establish standards, avoid unnecessary drug diversification and increase competition in the production, with the corresponding positive effects on quality and prices. Nowadays there are 236 generic health products registered, with a cost that is 46% lower than brand name products. According to the information presented by the minister of health Jose Serra in the conference "Addressing Health Inequalities: The Brazilian Experience", organized by the World Bank in Washington, on April 10 and 11, 2001, this represents an estimated yearly reduction of US$250 million on health public expending.

associated not only with the increase of funds but mainly with the increasing efficiency on the expenditures allocation.

Governance

The gradualism adopted for the health sector reform during the nineties guaranteed political stability and governance to the process. Even when it delayed the achievement of outcomes, this strategy minimized conflicts and resistance by health professionals. Health is the only social sector where the reform strategy has been supported by all political parties, facilitating political transitions after elections.

Problems that Still Remain

Fragmentation

The Brazilian health system is not unitary as constitutionally defined, but it is fragmented. There are two subsystems: one public (SUS) and another privately funded (SPS). They work independently from each other and without financial, institutional and organizational linkages. The 1988 federal constitution contributed to the reduction of this segmentation by creating the Unified Health System (SUS), which put all publicly funded health subsystems in the same framework. The programs under the SUS do not have any coordination with the private sector, but are mostly sponsored by firms and high and middle income families.

Legally, the services covered by the SUS are unlimited, universal and free of charge. In this sense, groups with high income continue to turn to the SUS for more complex and high cost procedures, which are not covered by private health plans. This contributes to reducing the average premium of private plans for the high and middle classes, but it causes the costs to be extremely high for the poor and, consequently, limits the possibilities of expanding the coverage of regular services sponsored by the SUS for this segment of the population.

Most doctors working for the SUS also hold positions in the private sector. For this reason, the SUS works as a privileged entry gate for those who already have private health insurance, spending the available resources and reducing the access for those, whose the only option for medical assistance is the SUS as a result of their socioeconomic condition.

Those who have private health coverage also count on the fiscal incentives (discounts on income tax) that allow them to continue making use of the "best of both worlds": inexpensive private health care plans (subsidized indirectly by the additional coverage given by the SUS), the use of SUS for complex procedures or advanced technology with the same doctors that serve under their private coverage plans and deduction on income tax by paying their private health insurance plans. Those who do not have private plans continue to face the scarcity of services available to care for their pathologies, the long lines waiting for medical assistance, public hospitals without funds or drug supply, and the difficulties in accessing basic services.

In this regard, the government tried to establish a new regulatory framework to impose discipline in the supplementary health private sector, with the creation of the National Council of Supplementary Health (CNSS)[11] and the National Agency of Supplementary Health (ANS), which is responsible for the implementation of the measures proposed by the CNSS.

The Brazilian government put into effect a regulation for health plans , thus allowing for: a) better instruments for consumer's defense; b) broader coverage to assure effective health protection; c) mechanisms to regulate the quality and price of health plans, as well as general operational conditions for health maintenance organizations and health plans; and, d) creation and implementation of instruments through which the SUS can recover the cost of health public services used freely by the population insured by private plans.

The first two objectives listed in the previous paragraph are specific functions that the state should perform to monitor health care plans, but the regulation of their prices is arguable. Even though market imperfections are always present in the health plan area, especially those

[11] The CNSS was created by Law 9.656 of 1998.

related to information asymmetry about quality and prices between suppliers and customers, the mandate of a regulatory agency is to correct market imperfections by: a) defining packages of health services; b) establishing rules to give more power to consumers and to make health plans contracts more equitable and fair; c) creating information systems to reduce disparities in the decision-making process regarding health plans, so that information about prices and quality of different providers easily reach consumers; d) defining and applying institutional and financial standards and guidelines to assure the quality of health plans.

Price controls are not efficient in the highly competitive sector of health insurance. Even in situations where market failures and asymmetric information are evident, price controls could lead to services of poor quality and low competitiveness, limiting the possibilities for a higher investment flow and a better performance of the sector.

Regarding public services used by those who are originally customers of private plans, in March 2000 the Brazilian government created a market price list for SUS health procedures (called TUNEP), which has being a reference for cost recovery. But many of SUS procedures are paid to providers according to another list (AIH) with prices lower than market values, since it is used by the SUS when purchasing services from private providers.

The government created the TUNEP using market prices as a means to establish negative incentives to the SUS utilization by customers of private health plans. But this strategy is evidently not working. Most private plans are suing public hospitals or municipal governments so that, instead of paying hospital bills as per TUNEP prices, the AIH price list is used to reimburse SUS procedures.

Another effort from the government to promote integration among the SUS and SPS systems is the creation of a national health card (SUS card) for the entire population. This magnetic card contains many information fields, including affiliation (or not) to SPS institutions. There are some advantages associated with this initiative. First, it facilitates the identification and counting of the population covered by each regional/municipal system, making it easier for authorities to plan for local future needs. Second, it allows the storage and transmission of data on SUS usage levels according to epidemiological and socioeconomic characteristics, contributing to the preparation of studies about efficiency and equity of health policies in Brazil and providing useful information for planning. Last, but not least, it allows the use of information to estimate the magnitude of financial flows between government authorities (states, municipalities) and between health plans operated by the private and public sectors, facilitating the implementation of cost recovery mechanisms.

The general use of the SUS card has not yet been implemented but is still being tested in some municipalities. The delays are associated with procurement processes and technical issues such as the scale and operation of the new card system.

Inequity in Financing

In January 2000, as mentioned, the Brazilian government approved the Constitutional Amendment 29/00 by which national and local public budgets for the health sector are increased. This measure is particularly important to increase state funds to health, given that Federal and Municipal health budgets expend values close to the established by the referred constitutional emend. While figures for the federal and municipal budgets were very close to the ones mandated by the constitutional amendment, this was particularly important since it contributed to the increase of state funds assigned to health.

Another sign of progress was the creation of the basic health package (PAB) to guarantee per-capita resources for financing primary care and cost-effective public health interventions. Nevertheless, most of federal transfers to states

and municipalities in the health sector are based on historical series of resource utilization and not on formulas that incorporate demographic, epidemiological and social needs.

Problems related with efficiency and equity in financing still remain. In Brazil, there are two types of health inequities: those related to the use of services by income level, and those associated with the regional distribution of public supply of health services. The first are difficult to measure, given the lack of information about health needs and especially the SUS utilization by income level[12].

Information on equity in financing at the regional level is easier to find. The existing data show that: a) with some exceptions, health public expenditures tend to be higher in the states where the GDP per capita is higher, while health needs are more numerous in states where per capita public expenditures in health are lower; and b) health federal transfers were not progressively distributed throughout states and municipalities and, for that reason, authorities were not able to modify the regressive nature of access to public health services at the regional level.

To address the current constrains on the public health financing system, the MOH is contracting studies to evaluate and develop instruments to enhance the SUS capability for planning and implementation. The purposes of some of these studies are to develop national health account systems, to create databases on costs and prices for hospital and ambulatory services; to evaluate the redistributive impact of public health expenditures; to elaborate resource distribution formulas to increase equity of federal health transfers to states and municipalities and to assess the impact of basic packages (PAB) and the family health program on coverage and equity.

Weak Local Autonomy

In the last few years many states and municipalities achieved more autonomy in managing their health programs. Even so, the SUS is still overwhelmed by strict federal regulations that limit the creativity of municipalities in their search for customized solutions to respond to the health needs of their citizens.

A case that well exemplifies that situation was the system developed by the Municipality of São Paulo during the period 1994-2000. This demand-driven health system (called PAS) centered on health networks headed by public hospitals. Each network was managed by a doctors' cooperative that competed with others to attract public clients in a free choice system. The municipal government paid to the cooperative a per-capita monthly amount to cover a package of health services. The municipal government also created a database and a monitoring system to avoid double affiliation and frauds. The system worked well for four years with high levels of acceptance according to opinion polls. Nevertheless, the PAS was never supported by the MOH or financed by federal transfers because it was considered "unconstitutional" in its use of competition and public health care "privatization," two elements that were implicit in the administration of the public networks by doctors' cooperatives[13].

Financial incentives and mechanisms for transferring federal resources to states and municipalities should be linked to patients needs. At the same time, achievements should be measured and evaluated by using impact

[12] Even when the household survey data (PNAD 1998) showed that the access to SUS is not regressive in terms of income level, the data from household expenditure surveys (POF 1996) showed that family expenditures on health are regressive, affecting proportionally more those families with lower income levels.

[13] The lack of federal and state financial support created problems in terms of the fiscal sustainability of the system. Reports of corruption in some of networks reduced the public credibility of PAS and the system was finally shut down after the municipal elections and the government change in the Sao Paulo Municipality in 2001.

indicators and not by just following previously defined bureaucratic procedures.

Municipalities should be free and able to choose the best way to organize their health systems according to their needs. This does not imply predefined management models nor financing frameworks defined from the top down to organize health care.

The current trend of the SUS is to increase financial transfers to states and municipalities on per-capita basis as a means to increase transparency and accountability. Simultaneously, it is expected that the use of fees for services and the reimbursement of medical bills to hospitals and doctors by the federal government will be eliminated. In other words, there will be a progressive elimination of *third payer systems* - the absurd situation where the federal government pays services directly to providers to reimburse medical services to citizens who do not know if the payment they receive corresponds to the service rendered.

Even when per capita-based systems have been used to transfer federal resources to states and municipalities, they are not conceived to pay health providers. Health services have been still remunerated by federal, state and municipal governments based on fee for services or reimbursements. There are few known experiences where public resources were used to contract private health insurers by capitation, as can be seem in the administration of Medicare and Medicaid programs in the United States. There are still few incentives in Brazil to combine higher autonomy of local health authorities with performance-based payments or demand-driven incentives.

The Brazilian government carried out some studies to evaluate new management models for the SUS at municipal and network levels, and some of their results have been applied to get more autonomy on public hospitals management, as the recent experience of the State of Sao Paulo shows.

Poor Performance

Even when the achievements of the last decade are considered, Brazilian health indicators are far from showing a good performance when compared with other Latin American countries with the same or a lower income level. In 1996, life expectancy at birth in Brazil was only higher to those of Bolivia, Guatemala, Haiti, Honduras and Nicaragua and similar to figures found in Peru and Ecuador. On the other hand, 22 out of 27 Latin American countries had lower per-capita health expenditures than Brazil, but 17 of these 22 showed equal or higher life expectancy than Brazil.

The estimated resources for the financing of health care in Brazil reach over 7% of the GDP. If performance and expenditures in the Brazilian health sector are compared to those of other Latin American countries, it is clear that the country has few economic constrains to improve its morbidity and mortality rates. Social inequality and the obstacles in trying to expand coverage to certain areas of the country are some of the problems in the road to reaching better health indicators.

The best way to improve health performance indicators is to satisfy the needs of the poor and to respond to the risks posed by serious diseases. According to recent estimates, Brazil has 51 million people (almost 1/3 of the population) living in poverty. Targeted health packages that address the epidemiological profile of the poorest segments of the population could be a quick answer to the challenge of increasing fairness and efficiency in the Brazilian health system.

The Road Ahead

In their efforts to attain more efficiency and equity, Brazilian health authorities adopted a gradualist approach to introduce innovations in management and financing without creating any conflicts with the constitutional principles of the SUS. The following suggestions were made in order to guarantee gradual changes in the SUS and also accelerate the results of measures taken to address the problems of fragmentation, financing, local autonomy and performance described previously.

Integration of the System

As mentioned, the Brazilian government tried to reduce the fragmentation of the health sector by creating a new regulatory framework for the SPS and establishing cost recovery mechanisms for customers of private plans that use SUS services. But this is not enough. If an integral linkage between the SUS and the SPS system is to be developed, other measures are needed, such as the possibility that SUS users can purchase SPS services or health plans financed by the SUS budget. What conditions are necessary for this to actually happen?

First, the SUS and SPS systems need to be organized under the same regulatory framework, allowing the SUS to create health plans, with a separation in the functions of financing, administration and service provision, and stimulating, when possible, competition among the two sectors in order to capture clients, independently of their capability to pay. According to the new regulation, the affiliation to a health plan should be the only way of accessing health care.

Second, both sectors need to offer an affordable and basic health plan that responds to the needs of the population according to their epidemiological profile. This plan should have different levels of public subsidies according to socioeconomic characteristics and would be paid on a per-capita basis to the chosen networks in both systems. The poorest segments of the population would be totally subsidized and the government would develop several other subsidies according to average income levels pondered by age, gender and other socio-economic characteristics.

Third, the system, currently regressive could turn in progressive guaranteeing more equity in the health financing by eliminating the tax exception for health in the income tax collection.

Forth, the managers of municipal health systems could choose to organize their system vertically or in health plans tied with a set of health development goals and performance indicators. These goals should be agreed upon at the federal level and their achievement should be the criteria to determine the amount of resources to be transferred. The regulation of the system should be a shared task among federal, state and municipal health authorities.

Even so, the heterogeneity of Brazilian municipalities leads to avoiding rigid or one-way solutions for all. Each municipality needs freedom to choose a health system that better fits their needs in terms of goals, costs and benefits. Given the scale and resources available for implementing health policies at local level, the current SUS model continues to be the best solution for most of Brazilian municipalities. This model would not work well in big cities or metropolitan areas where competition-based options are more effective to achieve a better quality of services, lower costs and customer satisfaction.

As Graphic 1 shows, the public sector spends less then 40% of the annual health expenditures in Brazil and many of these resources reach families that are able to pay. The integration of SUS and SPS systems under the same regulatory framework is the best way

to maximize health outcomes using the right incentives to achieve the goals contemplated by the Constitution.

Improving Equity in financing

The Brazilian health system shows signs of inequity because it spends fewer resources on the poorest families, over-concentrating funds on technology and high costs procedures. The creation of basic health packages, such as the PAB, has contributed to counteract this trend but it has not eliminated it. Increasing the implementation of health packages targeted to the poor could be a progressive approach for the elimination of financial inequity in the Brazilian health system.

Meanwhile, the long-term solution could be targeting public subsidies to the population with no means to pay for services, as well as the cost recovery of public services for those covered by private health insurances. Both recent government initiatives - cost recovery of public services used by SPS clients and the SUS card implementation – should contribute to eliminating the belief that an equitable system is free for all and to creating an information system to improve targeting.

To achieve a better regional distribution of federal funds, it is recommend that resource distribution formulas area adopted, as it occurs in many European countries. The following elements should be considered:

a) The economic expression of health regional needs based on the regional data of burden of diseases (morbidity and proportional mortality rates by cause, gender and age);
b) The available resources for heath in each region as an expression of the local fiscal capacity and effort. In this case, federal resources need to be assigned to regions with the best fiscal records but where tax income is not enough to cover health needs; and,
c) The creation of economic incentives to reward efficient managers (faster increase of health outcomes by money expended).

Inequities in health coverage depend on regional performance but are also tied to a fair distribution of federal funds. The current solution (defining a budget share to be expended in health) mitigates but does not solve the problem.

Real Local Autonomy

The solution could be quite simple:

a) Creating at municipal level, incentives and giving freedom of choice to adopt the best model for managing health care, establishing compromises tied to agreed health goals;
b) Promoting the separation between regulation and financing (as public functions), organization (public or private networks) and provision (public or private health units) to achieve more transparency, coordination and results in local health systems; and,
c) Creating incentives to the development of independent management systems for public hospitals and health units.

Improving Performance

The Brazilian health system improved data collection and the design of health performance indicators faster than other countries in the region. Even so, few systematic program evaluations resulted from this effort.

Pessimist analysis and optimistic actions are the two sides on the road to achieve better performance. Achieving better performance is impossible unless evaluation is improved. The creation of an independent agency to evaluate the performance of the Brazilian health sector could be an important step in that direction.
Reducing the high infant and child mortality rates is still an important challenge in Brazil. The reduction of child mortality is also one of the Millenium Development Goals (MDG's)[14].

[14] The Millennium Development Goals were agreed upon by 189 countries at the 55th General Assembly of United Nations and ratified in the Monterey

Since the beginning of the nineties, the Brazilian government tried to define plans to reduce infant mortality targeting the areas with a higher incidence. In these areas, isolated health interventions are not enough to reduce infant mortality, given the multi-causality of the problem. Some of these efforts, led by the Solidarity Community Program, achieved good results in specific areas, but the high incidence of child mortality still remains in many regions.

To address this issue, it is important, first, to identify the municipalities that present the worst conditions; discover the primary and secondary causes, define interventions to mitigate them and develop integrated packages that include actions, in areas such as employment, housing, water and sewerage, education, health and nutrition, to be implemented with strong support of the local communities.

Community participation and social capital building are key elements in strategies to turn vicious circles of poverty and child mortality into virtuous circles of development and life preservation.

Conference in March, 2002. In the case of infant and child mortality, the goal is to reduce it by 2/3 by 2015. The UNDP is responsible for monitoring the achievement of these goals.

References

AFFONSO, R.B.A & SILVA, P.L.B. "A Federação em Perspectiva: Ensaios Selecionados, Ed. FUNDAP, São Paulo, 1995.

_____, "Federalismo no Brasil: Descentralização e Políticas Sociais", Ed. FUNDAP, São Paulo, 1997.

ALBUQUERQUE, C.C.S., "Visão estratégica do sistema de saúde brasileiro", Porto Alegre, January 1997, mimeo.

AMADEO, E., LEVY, J.V.F., SIGELMANN, D., MELO FILHO, P.G.M., SILVA FILHO, G.A.& FAUSTO, S. "Orçamento Social da União". Ed. Ministerio da Fazenda, Secretaria de Política Económica, Brasilia, December 2000, mimeo.

ARRETCHE, M.T., & RODRIGUEZ, V., "Universalizar e Descentralizar a Atenção a Saúde", Ed. IESP/FUNDAP, São Paulo, 1999.

BANCO INTERAMERICANO DE DESARROLLO (1996), "Cómo Organizar con Éxito los Servicios Sociales", Progreso Económico y Social en América Latina – Informe 1996, Ed. BID, Washington, 1996

BANCO MUNDIAL, "Brasil: A Organização, Prestação e Financiamento da Saúde no Brasil: Uma Agenda para os Anos 90", Ed. Banco Mundial, Relatorio No. 12655-BR, Brasilia, January 1995

BRESSER PEREIRA, L. C. (1998), "Reforma do Estado para a Cidadania: A Reforma Gerencial Brasileira na Perspectiva Internacional", Ed. ENAP/Editora Nacional, 1998.

BRASIL: MINISTERIO DA SAÚDE, Portaria 1882/GM de 18 de dezembro de 1997, "Estabelece o Piso de Atenção Básica e sua composição"

BRASIL: MINISTERIO DA SAÚDE, Secretaria de Gestão de Investimentos em Saúde, "Estimativas de Impacto da EC No. 29/00", Ed. SIOPS, Brasilia, December 2000, mimeo.

BRASIL: MINISTERIO DA SAÚDE: Emenda Constitucional No. 29/2000, Brasilia, 2000.

ENTHOVEN, A., (1997) "Market-Based Reform of U.S. Health Care Financing and Delivery: Managed Care and Managed Competition" in SHIEBER (1997),

LEWIN, M.E. (1985), (org.), "The Health Policy Agenda: Some Critical Questions", Ed. AEI, Washington (DC), 1985.

LEWIS, M.E., & MEDICI, A.C. (1995), "Private Payers of Health Care in Brazil: Characteristics, Costs and Coverage" in Health Policy and Planning – a Journal on Health in Development", Ed. Oxford University Press &The London School of Hygiene and Tropical Medicine, London, Vol. 10.,Nr. 4, December, 1995, pp. 362-375.

LEWIS, M.E., & MEDICI, A.C. (1997), "The Challenge of Health Care Reform in Brazil: Balance and Trends", Technical Notes RE1-97-004, Ed. Inter-American Development Bank, may, 1997.

LONDOÑO, J.L, & FRENK, J. (1997), "Structured Pluralism: towards an innovative model for Health system reform in Latin America", Health Policy and Planning, 41:1-36, 1997.

MEDICI, A.C., (1995), "Saúde: Modelos de Gestão Descentralizada – Alternativas para o Brasil", in VELLOSO et alli, (1995).

MEDICI, A.C., 1997a), "A Economia Política das Reformas de Saúde", Ed. IAHCS, Porto Alegre, (RS), 1997.

MEDICI, A.C., (1997b), "A Dinâmica do Setor Saúde no Brasil: Transformações e Tendências nas Décadas de 80 e 90", Cuadernos de la Cepal, No. 82, Ed. CEPAL, Santiago de Chile, 1997.

\

MEDICI, A.C., LONDOÑO, J.L., COELHO, O. & SAXENIAN, H. (1997), "Managed Care and Managed Competition in Latin American and the Caribbean" in SHIEBER (1997)

MEDICI, A.C. (1999), "Uma Década de SUS (1988-1998): Progressos e Desafios" in DIAZ, J y GALVÃO, L., "Saúde Sexual e Reprodutiva no Brasil", Ed. HUCITEC & Population Council, São Paulo, 1999.

MEDICI, A.C. (2002a), "El Desafío de la Descentralización: Financiamiento Público de la Salud en Brasil", Ed. Banco Interamericano de Desarrollo, Washington (DC), 2002.

MEDICI, A.C. (2002b), "Los gastos en salud de las familias en Brasil: Algunas Evidencias de su carácter regresivo", Serie de Informes Técnicos del Departamento de Desarrollo Sostenible – (SOC129), julio del 2002.

MENDES, E.V (1998a), "A Pia Entupida: A Política de Serviços de Saúde no Governo Fernando Henrique Cardoso", Escola de Saúde de Minas Gerais/ Fundação Ezequiel Dias, Texto de Apoio No. 3, Belo Horizonte (MG), March 1998.

MENDES, E.V, (1998b) "O Sistema de Serviços de Saúde no Brasil", Ed. OPS., mimeo., Brasília, September 1998,

MILLER, V.J. (1985), "Recent Changes in Federal Grants and State Budgets" in LEWIN (1985).

MUSGROVE, P. (1995), "Cost Effectiveness and Health Sector Reform", Human Resources Development and Operational Policy Working Papers 48, World Bank, Washington (DC), 1995.

MUSGROVE, P. (1996), "Public and Private Roles in Health: Theory and Financing Patterns", World Bank Discussion Paper 339, Washington (DC), 1996.

OLIVEIRA JR., M., "Criterios para repasse dos recursos federais/ Papel Redistributivo do Governo Federal e Estadual no Financiamiento a Saúde", Ed. NESCON/ UFMG mimeo. January 2001.

SHIEBER, G.J. (1997), "Innovations in Health Care Financing: Proceedings of a World Bank Conference – march 10-11, 1997", World Bank Discussion Paper, No. 365., Washington (DC), July, 1997.

THE WORLD BANK (1989), "Brazil – Adult Health in Brazil: Adjusting to New Challenges", Report No. 7807-BR, The World Bank, Washington (DC), November, 1989.

THE WORLD BANK, (1994), "Brazil – The Organization, Delivery and Financing of Health Care in Brazil: Agenda for the 90's", The World Bank, Washington (DC), June, 1994.

THE WORLD BANK (1996), "Brazil – Health Sector Reform Project: Staff Appraisal Report", Ed. World Bank, Washington (DC), may, 21, 1996.

THE WORLD BANK, Operational Evaluation Department, "The Brazil Health System: A Sector Impact Study", Washington, March, 1998, mimeo.

VELLOSO, J.P.R., ALBUQUERQUE, R.A., KNOOP, J (coords) (1995), "Políticas Sociais no Brasil: Descentralização, Eficiência e Equidade", Ed. Forum Nacional/INAE e ILDES/Fundação Friedrich Ebert, Rio de Janeiro, (RJ), 1995.

WORLD HEALTH ORGANIZATION (2000) – "The World Health Report (WHR) 2000: Health Systems Improving Performance", Geneva, 2000.