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DEMOCRACY AND UNIVERSALITY: DEBATING THE CONDITIONS OF APPLYING SUCH CONCEPTS TO BRAZIL'S PUBLIC HEALTH ACTIONS AND SERVICES

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Abstract

*This paper reviews the determinants and conditionalities of the process of universalizing public health in developed countries, notably the European ones, and in Brazil, and is aimed at highlighting their differences. The first part discloses the main interpretations on the constructing of the Welfare State, emphasizing the characteristics of that historical moment and its articulation with prevailing accumulation standards. The second part is orientated towards understanding the conditions in which universality in Brazil's health service actions has been defined, highlighting the fact that the general patterns of capitalism's are no longer those of the post-war period. It emphasizes that the new environment interacts with and constrains the Brazilian trajectory, especially in regard to Federal Government actions, stressing inequality as an indelible feature of Brazilian society, which could be considered as an obstacle to enforcing universality in the country. Nevertheless, despite the impairments, there has been some uneven progress in the Brazilian population's health status, achieved after the establishment of the Brazilian Unified Health System (*Sistema Único de Saúde – SUS*), notably through the Family Health Program (*Programa de Saúde da Família*).*

Key words: determinants of public health universality; inequality and universality; accumulation and universality patterns.
Classification JEL: I18, I38, H53.

Introduction

The idea of the right to universality of health actions and services cannot be dissociated from the principle that the Federal Government should ensure social risk coverage to its population. Worldwide, that principle is best represented in the Welfare State (WS), which resulted from a long-lasting constructing process.

However, whenever this principle is brought up, whether to advocate for it or to point out the impossibility of maintaining it and the need for establishing other foundations for social protection, it usually appears as a product of the economic growth period experienced by the developed capitalist countries, after the end of World War II. This association is made as much by analysts and researchers, as by those who hear or read about the contributions it can make.

Although this is not a totally mistaken association, its limitation to the period of economic growth of the glorious thirty years, as it is referred to in French literature, not only obscures its constructing process and hinders the possibility of dimensioning the factors that have facilitated its adoption. In other words, when one attaches emphasis almost exclusively to its economic aspect, the result is considered as a determinant and does not facilitate understanding the difficulties faced in implementing universality in countries with different structures, like the Latin American countries. Nevertheless, even if we consider only the economic plane, we can clearly observe that the distance between the post-war economic realities experienced in developed countries and in Brazil after the 1988 Constitution is extremely great.

This paper aims at highlighting the fact that the determinant and conditioning elements of universality of public health in Brazil are significantly different from those existing when it was implemented and developed in developed countries, mainly the European ones. To that end, the first part is devoted to the construction of the Welfare State and presents the general lines of the main theories that try to explain its construction and provide an alternative interpretation. It describes the characteristics of its historical context and its interaction with the prevailing patterns of accumulation. The second part is orientated to understanding the conditions that have defined the universality of Brazil's health service actions. It starts with the Unified Health and Social Security System, and emphasizes the political moment of its emergence. Then, it points out that the general situation of capitalism today is different from that of the post-war period, and shows how this new environment interacts and constrains the Brazilian trajectory especially in regard to Federal Government actions, stressing inequality as an indelible feature of Brazilian society, which would hamper enforcing integral universality. Finally, it highlights that despite the impairments, there have been advances in the Brazilian population's health status. The third part is devoted to systematizing the final remarks.

1. The Construction of Social Protection in the Developed World[1]

1.1 The construction of social protection as an universal right in developed countries: different theories for explaining it

The *Welfare State* comprises a set of public policies orientated towards promoting coverage of risks related to disability, disease, work accidents and unemployment[2]. The specialized literature

[1] This part is a summarized and reviewed version of Marques (1997), Chapter 1.

[2] Some authors also include housing and education. The restricted definition is employed here because in most of the countries the policies on replacement income and health care are considered, whether in the light of resources involved and of policies developed, which is major object of public action in what concerns social protection. The replacement income comprises income guarantee in the event of disability, oldness, unemployment and death.

usually identifies different causes for its origin and development. However, in general, the causes may be gathered into two major lines of explanation: one that assigns primacy to the economic order and the other considers the political factors as determinants. The advocates of the first interpretation understand the WS as a need entailed by the changes resulting from industrialization, or as a response to the capitalist system's demands for accumulation and for legitimizing itself. Among those who assign utmost relevance to political conditioning elements, some consider the WS as a result of the gradual expansion of rights, or an agreement between capital and organized work, or historical settings unique to the State structures and political institutions.

The main authors who consider the WS as a response to the changes entailed by industrialization are: Harold Wilensky, Richard Titmuss and Thomas H. Marshall. For Wilensky, the social programs were built as industrialization radically changed family life, assigning new roles to its members and reducing their capacity for determining the reproduction of the labor force. They were key-elements to social cohesion and integration of the new emerging society, and they could be implemented only because of the surplus generated and accumulated in industrialization. The WS development, in turn, was determined by cultural factors, explaining the existing difference between countries (Wilensky, 1965).

According to Titmuss[3] the social programs were expanded thanks to the increasing work division entailed by industrialization. For Marshall[4], the WS origin and development should be considered a result of the logical and natural evolution of the social order resulting from industrialization. After the initial industrialization stage and with the new living style inherent to it established, the lines of force in the social system would become autonomous, so that it would expand and become consolidated, fostered by its own dynamics.

Among those who view the WS as a response to the needs of accumulation and legitimizing of the capitalist system, are James O'Connor and Claus Offe (O'connor, 1973; and Offe, 1994). Thus, taking into consideration the economic and social conditions entailed by industrialization, the degree of variability of social programs would be low. The WS would perform the duty of correcting/compensating the (de)functionalities created by capitalist accumulation in the social plane. In another light, it would be the required counterpart for the capitalist system to flow smoothly.

Among the authors that emphasize the political conditioning elements, considering the WS to be the result of the gradual expansion of rights, Marshall is once again outstanding, through his work "*Cidadania, Classe Social e Status*". For him, as the *continuum* – from civil to political rights and from political to social rights – is integral part of the process of building the citizenship concept in a capitalist society, public social programs would represent the corollary of that process. Many other authors develop their analyses based on that understanding. Among them, Rosanvallon is outstanding: "The economic and social rights naturally come about as an extension of civil rights" (Rosanvallon, 1981:23). Despite that, he emphasizes that the democratic and egalitarian democratic movement that started in the eighteenth century is the one that lays claim to the expansion in the scope of the idea of citizenship. Therefore, there is little left over that is natural.

[3] See Titmuss (1962; 1976; 1974).
[4] See Marshall (1967; 1967a). The first work is among those that explain the WS emergence as a result of industrialization. The second work considers the WS as a product of the gradual expansion of rights.

Ian Gough and Gosta Esping-Andersen understand the WS as the output of an agreement between capital and organized labor[5]. According to Gough, the WS corresponds to a given stage of development of the capitalist systems and, like O'Connor, he understands that its programs play an auxiliary role in the process of accumulation, of reproducing the labor force and legitimizing the system. However, when he recognizes the lack of automatism in the emergence of laws guaranteeing the performance of such duties, he moves away from O'Connor's position. The same occurs when he says that WS expansion is conditioned to the dynamics of accumulation and the capacity of financing social programs. For that author, the pressure from subordinated classes and other organized groups concerned, as well as their level of organization, is decisive for the introduction of social protection measures and, moreover, for establishing the degree of centralization of social policies. Therefore, WS development can be perceived as an expression of the agreement achieved between capital and labor during the post-War days. Although emphasizing the relevance of financing conditions in regard to maintaining the WS, an analysis of it reveals that the expansion or retraction of social policies is mainly due to the relationship of power among the social agents who have made such agreements.

The importance of the degree of worker organization is successfully understood by Gosta Esping-Andersen. Besides stating that existing differences among protection systems are determined by the diversity of active social weight assumed by workers in each society, he assigns to the leaderships an awareness of the fact that social program implementation stands for, among other things, the possibility of partially (de)commercializing the cost of reproducing labor force.

Among the authors who attach importance to political conditioning elements, there are those who perceive the WS as a result of historical configurations unique to State structures and political institutions. They are: Hugh Heclo, Theda Skopol, Ann Shola Orloff and Margareth Weir *et al*[6]. To them, there is almost no place for other variables than the State. This way of facing the WS leads to an emphasis on the detailed study of each country, thus jeopardizing a broader understanding of the phenomenon.

1.2 The construction of social protection as an universal right in developed countries: from class solidarity to systemic solidarity

Almost all the aforementioned theories make no distinction between social protection prior to the end of World War II and that of the WS, tending to elect an independent variable as the only explanation for that phenomenon. However, at the best, a variable may only assume principality and it would be a mistake to attach importance alternately to economic or political factors. Such a focus does not allow for an analysis of the mutual interaction among the factors, losing part of the richness entailed by the process of constructing and developing social protection.

1.2.1 First stage

The historical setting up of social protection systems is indistinguishable from construction of wage-based society itself. Its origin rests on mechanisms of "mutual aid" support built up by

[5] See Gough (1979); Esping-Andersen (1985; 1985a).
[6] See Heclo (1974); Skopol, (1992); Orloff (1993); and Weir *et al* (1988).

industrial wage earners. Made up of workers in industry, they were aimed at meeting the needs entailed by unemployment, disease, death and old age (Castel, 1995). Those rudimentary and corporative forms of protection were expected to meet two objectives: 1) fill in the gap resulting from the destruction of old forms of solidarity present in trade guilds and rural life, caused by the hastened growth of industry and cities; 2) serve as minimum guarantee to avoid leaving the workers at the mercy of working and wage conditions offered by the capitalists. Therefore, the existence of this kind of social protection, as well as its capacity to provide the expected coverage, were directly dependent on the degree of organization attained by workers, agglutinated by field of activity, during the initial stages of the industrialization process.

Up to that time the only action developed by the State, with the conclusive agreement of private initiative, was limited to the "workers housing" that, far from being a tool of integration or social assistance, represented a powerful tool to rule the labor force (Castel, 1995). Later on, due to the State's omission, some entrepreneurs endeavored to guarantee minimum coverage of the main risks and needs faced by their employees. The actions developed by such entrepreneurs comprised, among others, housing and education for workers. According to some authors, among which Benjamin Coriat is outstanding, this kind of protection allowed the capitalist to fix and rule its labor force (Coriat, 1982)[7].

Only the increasingly independent organizations of workers led the State to take on responsibility for organizing and managing social protection (Esping-Andersen, 1991). That happened in the early twentieth century, which corresponds to the Taylorist labor force management[8]. The only recorded exception to this is the case of Germany where social security legislation dates back to the 1880s. However, that fact just confirms the link existing between the State's emergence in social protection and the degree of worker organization, since if social democracy was deeply rooted anywhere, that place was Germany, where being member of a Party was a way of living (Broué, 1971).

The idea that the State started worrying about organizing social protection systems only under the pressure of workers' organization does not imply disregarding the fact that such systems played a role in building the wage-earning process. "... in a sociological light, nothing proves that individuals affected by the *divestiture* of their condition of using their own work or other conditions of survival [9] spontaneously move to the status of *active* proletarization, i.e., start offering their labor force in labor markets" (Lenhardt and Offe, 1984: 15-16). Among other things, they could have recourse to begging, stealing and emigration to other lands. The wage-earning work only becomes attractive when the associate risks are covered.

The uneven development of industry and workers' organizations meant that State participation started at different moments in different countries. In turn, incorporating risks took place in a somewhat similar way in all countries, with clear prevalence of work accidents, oldness and disability, over the others. Actually, the granting of benefits resulting from work accidents is the foundation of our current protection systems.

[7] Ford, in his book "My Life and Work", is clear about this intention (Ford, 1925).
[8] Taylorist management stands for a set of procedures introduced in the productive processes and that allowed for management to determine the pace of work and how it should be performed. It gaves Birth to the "scientific" treatment of work.
[9] Offe refers to the divestiture of production means and the destruction of rural way of living.

Coverage was restricted to urban workers and financing was based on the contributions paid by employees and employers. The defrayment regime was that of collective capitalization, i.e, the fund revenue was used to pay pensions and retirement benefits to eligible beneficiaries, according to the cash available resulting from its assets profitability. Therefore, there were no fixed benefits. In that protection organization, the solidarity was of compulsory nature and established among the active workers (Olivennes, 1992).

1.2.2 The second stage: the *Welfare State*

The second stage of protection systems construction starts by the end of the 2nd World War, when the Fordist system of accumulation became hegemonic worldwide [10]. Despite national differences, its basic features are the gradual expansion of coverage to new segments of workers or populations, and the incorporation of new risks and social affairs on its agenda of actions. Therefore, universalizing coverage to the population at large and the expanded concept of protection are inherent to the WS. In the field of social security, collective capitalization was replaced by single sharing, meaning the introduction of solidarity between generations and the abandonment of solidarity among the active workers.

Universalizing coverage implied overcoming that social protection directed only at urban wage earning workers, and the election of citizenship as the guiding principle in awarding rights. A consequence of such deep change was the increasingly significant use of fiscal revenues within systems basically dependent on the contributions collected from the payroll. The guarantee of income and services, regardless the beneficiary's contributing[11] capacity, and the employment of public resources to finance protection systems, softened the divide between protection and social security.

Economic and social conditions at the time of universalizing social protection: the historical moment of its implementation.

The 1950's and 1960's were marked by strong changes in economic and social structures. According to Hobsbawn (1995), that period corresponds to an outstanding, even unique stage in the history of capitalism. Increased Gross Domestic Product (GDP) in developed countries surpasses all previous figures, and industry is expanded all over the world, including the Third World. The world economy becomes internationalized, significantly expanding trading relations among nations. Accelerated growth in investments sustained by high profit rates allows for expanding employment in an unprecedented way, despite the productivity gains ensured by technological innovations that are a landmark of that period. There is such a need for labor that, after all traditional reserves have been exhausted, women are definitively incorporated into labor market. In developed countries, salaried employment with rights becomes the rule.

[10] The Fordist regime comprises changes in work process that sustained the serial production and measures that allowed for massive consumption, among which the universalization of granted replacement income and actual wage increase.

[11] The introduction of minimum benefits based on previous contribution stood for the weakening of security logic. That is so because some security payers would not be entitled to that amount if they were to rest only on their individual effort.

In regard to the State, governments of all sorts of political trends adopt planning — although with different focuses — and consider lawful the State's intervention in economics and in establishing the living conditions of the working class.

The nations (except for African and Asian countries) become mostly urban, experiencing a steep reduction in the number of rural workers. The level of education is raised, with an outstanding increase in the number of youths attending universities. Mortality rate drops and life expectancy increases all over the world, thanks to advances in chemistry and the pharmaceutical industry. The combination of new materials, inventions, techniques and massive production cheapened industrialized products and introduced some goods and services that used to be considered as luxurious articles, into average consumption patterns. To that should be added the number of brand new products launched on the market, and the significant increase in agricultural production. The range of inequalities is significantly reduced and, although the poor continued to exist, the average individual now lived much longer and better than prior to the Second World War. Endemic hunger was vanishing from the Earth, except for that entailed by wars and political madness, as Hobsbawn says when referring to China's situation in 1960/1.

At the political level, which is elemental to the decision-making process, the then Soviet Union played a decisive role when it defeated Nazi Germany. Similarly relevant were the emergence of other socialist States in the East and the political representation of workers in many governments (Przeworski, 1989; Hobsbawm, 1992). When taking into consideration this last factor, the WS is also considered as a protection against the intensification of social struggles in Western countries after the 2nd World War.

The interaction of the Welfare State with the pattern of accumulation.

According to some schools of thought, the benefits and actions awarded by social protection and the policy of actual increase of salaries, in addition to expanded credit for consumers, were the required counterpart to generalize the productive rules that allowed for serial production[12]. Simultaneously, the WS is a key element for that stage of capitalism; it assists the implementation of a particular way of managing the labor force, one of the Fordist accumulation bases.

In the general plan, it was one of the factors that helped in breaking the workers' resistance to the Fordist methods and avoided greater conflicts. In the productive unit, the labor force management was characterized by job stability and awards of factual wage increases[13]; in the social field, it was characterized by the guarantees awarded by the WS, work regulation and acknowledgement of trade unions as the genuine representatives of the working class. It is worth mentioning that there was no legal device to actually grant stability. The stability was effective just because the economy was working with almost full employment.

Due to the relatively expressive value of benefits and the incorporation of new social risks, wages were no longer the single element of income for the waged population. The worker reproduction cost started then to comprise social benefits awarded to families or workers, both as services and through pensions, allowances and expenses reimbursement. In some cases, such as

[12] The main school that interprets the post-war social protection development in this way is the regulation French school. On this matter, see Aglietta (1979) and Coriat (1982).
[13] Which meant that the productivity increase was shared among workers.

in France in 1990, the participation of income transfers by the WS represented over 30% of the families' available income (D'intignano, 1993, p.55).

Thus, during the stage of WS consolidation a peculiar link was forged between capital and work. In regard to the enterprises, the agreement rested on one hand on the guarantee of job and actual salary increases and, on the other hand, with production at high productivity rates ensured by the implementation of the scientific organization of work. In the social field, the agreement comprised the generalization and deepening of social protection coverage.

The trade unions and traditional workers' parties played a crucial role in that agreement. If on one hand, their participation meant that the State and capital perceived them as genuine representatives of workers, on the other hand it allowed for channeling the claims of those organizations. That granted some predictability and control over the relationship with workers.

The control became even sharper when they started privileging the actual income increase, through direct or indirect salary. There would be no major problems between capital and work, provided that accumulation expansion was followed by actual salary increases and expanded coverage of social risks.

Therefore, social protection was completely adequate to the Fordist accumulation interests. Besides fixing the worker in the company and allowing massive consumption, it provided some predictability of the relationship with workers.

2. The Adoption of Universality as an Expression of the Will to Build a Democratic Society: the Brazilian Case.

2.1 The Unified Health System and social security

In the second half of the 1980's, the debate on and elaboration of a new Constitution totally absorbed attention in Brazil, since what was at the stake was the definition of the grounds that would sustain the development of the new regime. Among such grounds, social issues played a core role because the country had to recover a huge social debt inherited from the military era. With that spirit, the constituents introduced in the 1988 Constitution the guarantee of basic and universal citizenship rights, establishing the right to public health, defining the scope of social assistance, regulating unemployment insurance and advancing social security coverage. Such guarantees were the subject of a specific chapter on Social Security, symbolizing a rupture with past.

The principles that guided the progressive sectors of the constituent assembly were: coverage expansion, reaching segments that were unprotected; equal treatment for rural and urban workers; implementation of health and care policies with decentralized management; participation of stakeholder sectors in the decision-making process and in the control of policy execution; definition of safer and more stable financing mechanisms; and, guarantee of a sufficient volume of resources to implement social protection policies, among other objectives. In the field of Social Security, those principles have resulted in the establishment of a minimum benefit value corresponding to the minimum wage and the abolishment of differentiation between rural and urban workers, concerning the kinds and values of benefits awarded. The 1988 Constitution maintained separate, security for workers in the formal sector, in the private sector of the economy and that of Federal, State and Municipal civil servants.

There were some advances towards universalization, expanding coverage and reducing inequalities, prior to the 1988 Constitution. In the field of social security, specifically from 1985 to 1987, during the government of José Sarney, the minimum urban benefits were increased[14], the grace period reduced and some benefits were expanded to rural workers. In what concerns the establishment of the Unified Health System, which was introduced in the new constitutional wording of 1988, it clearly is the result of a long process of discussions among several civil society sectors that, since the 1970´s, a movement of increased expansion of access to health services has been experienced, although in a "fragmented and selective" way (Draibe and Aureliano, 1989). Since the 1980's, the issue of health system decentralization had been introduced as a priority on the public agenda, through the formulation of the National Program on Basic Health Services, the so-called PREV-SAÚDE. And basically through the strategy of Integrated Health Actions emerges, primarily as just a program of INAMPS (National Institute for Preventive Medical Care) and later enhanced during the New Republic through the creation of the Unified and Decentralized Health System SUDS, that decentralization and universalization of access gradually become feasible, since they strengthen, within the scope of the Public health reform, the public players who are crucial to consolidating this process: initially the state governors and, after that, based on the sectoral "municipalization" movement, the mayors of several municipalities.

However, despite having resulted from that long-process, SUS establishment represents a final rupture with the previous model, since: 1) the introduction of universal and integral right to health abolishes also the historical characteristic of segmentation of clients in the Brazilian social protection system; 2) it also breaks the previous financing model which was basically drawn on individual contributions; 3) it constitutionally promotes a deep political-administrative reorganization, since according to the Constitution, "public health actions and services are part of a regional and hierarchical network, and compose a ***unified system"*** organized pursuant to ***decentralization, integral care*** *and* ***community participation*** principles (our bold) and, moreover; 4) the participation of private services providers in this new system is defined as ***complementary.*** Therefore, such a hard process of implementing a change of that nature and dimension necessarily requires not only political-institutional, organizational, cultural and financial changes, but also changes in the concepts of the health care model.

The establishment of universal access to health as a right inherent to citizenship was coherently followed-up by the insertion of the Health Sector in the Social Security System, in addition to sectoral financing through the Social Security Budget and Federal, State and Municipal Treasuries. The Social Security Budget composition, with no binding sources for each specific area, contemplated the different nature of the benefits and services it financed. In order to award financing to social protection-related expenses, expanded by means of the Social Security adoption, and also to make financing less dependent on cyclical economic variations (mainly concerning jobs in formal labor market), the constituents defined that such resources would be based on the wage (employees' and employers' contributions), earnings (incorporating the Social Investment Fund [15] and the Program on Social Integration and Formation of Civil Servants' Assets - PIS/ Pasep), net profits of corporations (new contribution introduced by the Constitution, named Contribution over Net Profit - CLL) and the revenue from contests and lotteries. Additionally to those sources, Social Security would also count on resources from taxes collected by the Federal

[14] The previous legislation set forth different minimum values, depending on the kind of risk covered.
[15] In 1991 the Finsocial was replaced by the Contribution to Social Security Financing (Confins).

Government, States and Municipalities[16]. Moreover, the establishment of a unified budget aimed at rationalizing the OSS (Social Security Budget) resources allotment, thus avoiding pulverization in the use of revenues from previous funds. On the other hand, a complementary law set forth that 30% of the Social Security Budget resources would be allotted to SUS. According to the Constitution, those federal resources would be enhanced by revenues from the State and Municipal Treasuries, so as to allow for implementing the system.

The constituents also defined that such resources would be exclusively assigned to Social Security. That is so because the trajectory of social protection during the military era was replete with examples of misuse of resources, such as for the construction of the Itaipu hydroelectric plant, and the Rio-Niterói Bridge, among others. Unfortunately, all governments that took office after the 1988 Constitution have failed in complying with such provisions[17].

Another aspect of Social Security financing approached by the constituents, and which is closely related to the social protection concept thought out at the zenith of Brazil's democratization process, is the perception that a link between source and use within the Social Security would be senseless. That perception resulted from the holistic concept of social protection, where coverage of one risk could not exist without guaranteeing the coverage of the other. Therefore, during the yearly discussion on the budget, the sharing of the set of revenues foreseen for the different branches of Social Security[18] would be defined.

The universalization of rights and community participation in the definition of social policies were based on the baseline principle of overcoming the meritocratic character and adoption of citizenship as the access criterion. Citizenship is easily acknowledgeable in the health field. *From a situation where public service was orientated only to taxpaying workers in formal market, it was converted into a guaranteed right for all.* Concerning Social Security, that criterion overlaps with the previous one: simultaneously, the taxpayer workers with retirement benefits basically calculated based on their contributions co-exist with rural workers and individuals with very low salaries, which is guaranteed by the minimum benefit equivalent to one minimum wage.

2.2 The movement that led to SUS

> "The establishment of a Unified Health System (SUS) has been considered as the most successful reform in the social area undertaken under the new democratic regime. In its genesis can be identified the organization of an expressive sanitary movement in the middle 1970´s, in a context deeply marked by social and political resistance to the authoritarian regime. The health issue, as well as other demands from Brazilian society for

[16] The 1988 Constitution, however, did not define how States and Municipalities would participate in Social Security financing. In 1997 the Provisional Contribution over Financial Transactions (CPMF) was created and its revenues were added to those set forth in the Constitution. The Constitutional Amendment # 29 was enacted only on September 2000, setting forth how the Federal Government, States and Municipalities would be inserted in the Unified Health System.

[17] There are countless examples, from 1989 to 2006, on the misuse or attempted misuse of Social Security resources. For detailed information, see Uga and Marques (2005).

[18] The only binding link foreseen was that for the PIS/Pasep, which is oriented to the unemployment insurance program and to the payment of PIS/Pasep allowance, where 40% of its collection is allotted to BNDES loans to the enterprises.

civil freedoms and collective goods capable of reducing income inequalities, and access to public services, was one of the axes of the social and political fight during the 1970's and 1980's" (Lima *et al*, 2005, p.15).

Brazilian literature is rich in documents and analyses on the emergence and role played by the sanitary movement in the fight for universalization of public health services and actions. Among the several authors who have worked on such topics, we stress the synthesis of Escorel, Nascimento and Edler (2005). Those authors, reinforcing the idea expressed in the quotation above, call attention to the fact that the sanitary movement was structured simultaneously when other social movements started to be re-articulated, still during the military dictatorship period. During the Geisel government the trade unions of different categories of health workers, particularly physicians, academics and researchers, started to debate several aspects of the Brazilian people's health and public health and/or social security services. This movement resulted in several seminars and the setting up of work groups. In the organizational plan, the Brazilian Association of Post-Graduation in Collective Health (Abrasco) was created in 1979, supported by the Departments of Preventive Medicine of the medicine courses. Ideas and concepts were tried out and proposed in health secretariats, where the movement's representatives were present.

Upon Brazil's democratization, still under the Sarney government, movement leaderships take key-offices in institutions in charge of defining and carrying out the country's health policy. Under this influence, the 8th National Health Conference was convened in 1986, considered the most significant moment of the sanitary movement, when the Sanitary Reform strategies and platform were defined. Among several objectives there were: the access to health services and actions for the entire population.

However, the introductory paragraph of the aforementioned book *Saúde e Democracia – História e Perspectiva do SUS*, organized by Lima *et al* (2005), also provides a clear idea on the differences between the process and environment of implementation of the right to public health universalization in Brazil, as compared to developed countries. Such differences are partially explained by the fact that Brazil guaranteed that right only when the "citizen" Constitution was enacted, in 1988. In comparison wit developed countries, the adoption was considered "late" both in regard to the time and to the historical moment on which it was founded. Let us analyze the differences.

2.3 The world was no longer the same

Contrary to what happened during the three decades after the end of the 2nd World War, industrial capital no longer governed the capitalist process. Since early 1980's, there was no longer any doubt about the long-lasting nature of the reappearance of interest-producing capital and that it would determine the economic and social links of our contemporary form of capitalism. Such capital aims at "making money without leaving the financial sphere, in the form of loans interests, dividends and other earnings resulting from the possession of shares and profits ensured by successful speculation" (Chesnais, 2005: 35).

Several factors determined the reinvigoration of financial capital power. Outstanding among them is the United Sates' and Great Britain's decision to implement free capital transactions, promote deregulation of their financial systems and implement measures to promote centralization

of corporations' and families' net funds [19]. To those "institutional" factors should be added the fact that, by the beginning of the crisis (which became evident to all in the middle 1970's), the American corporations working abroad employed their non-reinvested profits in the City of London, so giving birth to the Euro-dollar. The broad availability of capital was then increased by that from petroleum, the "petro-dollars", which served as basis for the loans granted to so-called Third World countries and, therefore, for the Brazilian foreign debt.

The prevalence of capital holding interests had great impact on the social protection arrangement known as WS and on the capital/labor relationship. Since the early stages of the crisis, the fight against, and challenging of the WS were intensified. Many countries introduced devices to hinder access to retirement benefits, increased the user's participation in the defrayal of health actions and services, and limited the list of free medications, among others (Mesa-Lago, 2000). Simultaneously, the labor market presented significant changes as compared to its previous reality. Unemployment, which used to be restricted to problems resulting from the imperfect information system between demand and supply (the so-called frictional unemployment) registered high rates in the developed world. Wage labor or self-employment, with no social or labor laws coverage that used to characterize the labor work in the Latin America and Africa, became a structural component of the developed countries' reality. Since the middle 1970's, the actual salary increases — which characterized the golden years — were forgotten and replaced by adjustments that promote loss in purchasing power. Exclusion and poverty are significant once again.

Productive capital – suffocated by the domination of the financial side — is then compelled to work on the "weakest link", i.e., the workers. Reducing the cost of labor then became primordial, given the size of the bite that interest holdings would take out of production surpluses[20]. Productive capital then imposed reduction in salary levels and advocated for the abolishment of social charges and significant reduction in taxes, which are the elements that support social protection financing in many countries. However, to keep salaries reduced it would be necessary to maintain high unemployment: that is why productive capital is not interested in promoting something like a full employment situation (Husson, 2003).

While unemployment became part of the workers' lives again, the mass movement (mainly that of workers affiliated to trade unions) that had sustained the post-war agreement between capital and work was successively overthrown. Just to have an idea about its impact on the workers' capacity to remaining advocating for rights and achievements, one should recall the emblematic defeat English miners by the Thatcher government, and the symbolic and concrete meaning of the fall of the Berlin Wall, and the dissolution of the Soviet Union.

Somewhat quickly, depending on the country, trade unions that used to be extremely active experienced a sharp reduction in the number of associates, even among those with jobs relatively stable. For most of the workers, increasingly precarious working conditions are the rule, and an increase in part-time jobs for fixed-terms, with no rights (Mattoso, 1994).

[19] The centralization of net funds started in the United States in the 1950's, during the "glorious years", i.e., when productive capital undoubtedly prevailed. On this topic, see Chesnajs, 2005.

[20] According to Plihon, the minimum profitability required by financial capital is 15% (Plihon, 2005).

2.4 Brazil in the face of new constraints: from a developmental State to a State held hostage by internal and external debt

The increase of the American interest rate promoted by the Federal Reserve from 1979 - 1981 brought drastic consequences to the so-called Third World countries, notably the Latin American ones. Those countries had been induced to take advantage of credits associated to petro-dollar recycling and, all of sudden had their debt service multiplied by three or even four. That situation gave birth to the debt crisis, which was first manifested in Mexico, in 1982, when that country declared a moratorium.

The rise of American interest rates happened when Brazil was endeavoring to counterweight external accounts by promoting a recession (the very first in post-war times). Due to increasing difficulty in financing current transactions, which became evident in 1979, the Figueiredo government constricted effective demand through, among other measures, control over public expenses and state-owned enterprise debts; abrupt shrinking of credit grants (except for credit to agriculture); raising of income tax and tax on imported products. Such measures led to a 3.1% drop in the Brazilian GDP and a positive balance in our commercial balance, followed by an increase in exports and reduction in imports. However, international interest rates increased by almost 4%, so that the debt interests alone accounted for 40% of the Brazilian exports. The Mexican moratorium worsened even more the Brazilian situation abroad, and the reserves were negative to the amount of over US$ 2 billion.

The scope of this paper does not allow for tracing Brazilian economics from 1980's on. Here, what matters is to stress that since the debt crisis Brazil started experiencing a restriction that called for (and calls for) all of its attention.

The Brazilian State change dates back to 1982, when the country had to formally appeal to the International Monetary Fund (IMF), through successive Letters of Intention (when it was inclined to comply with the conditions imposed by that organization), passing through several attempts to cease the galloping inflationary process that followed all the Brazilian economic crises, the signing of an agreement with the IMF, the privatization of state-owned enterprises and the fomenting of the entry of foreign capital, through the maintenance of high interest rates (which, among other reasons, converted the internal debt into a problem). That developmental State — which had been a key-element in the industrialization process, invested in infrastructure and established state-owned producers of essential raw material, besides having developed the public social protection system — was then reduced to a very few functions. Containing public expenditure, which is the first requirement in the 1990 Washington Consensus, aimed at fighting inflation and creating primary surpluses (revenues – expenses), not taking into consideration the interest on internal debt), diverted the State from its former duties, associated to the 'developmentalist' period — 1930 to 1979 (Mantega, 1984).

Within this scenario of new constraints to the Brazilian economy and a handcuffed State, the 1988 Constitution established that public health is the right of all and an obligation of the State. Contrary to what happened during health universalizing in European developed countries, Brazil was no longer growing in a long-lasting way, the State shrank *vis-à-vis* its past, unemployment rates were very high and labor informality was growing, taking the place of occupations with social security and labor rights.

2.5 Inequality as an indelible feature of Brazil

Another difference between Brazil and the countries that have implemented health universalization in the post-war days is the permanence of high levels of inequality. Such inequality takes on different forms.

2.5.1 Income inequality

The United Nations Development Programme (UNDP) 2004 Report highlights that, in regard to income concentration, the country loses only to Sierra Leone, Swaziland, Namibia and Botswana. Income concentration in Brazil is so high that, while the richest 10% hold 46.7% of income, the poorest 10% survive with only 0.5%.

In the light of families, the richest family incomes (monthly family income, in 2000, higher than 10,982.00 Reals as of September 2003), totaling 1.162 million, correspond to 75% of the total national income. Among them, the 5,000 richest families absorb 45% of the national income (Pochmann, 2004). This situation, which is structural in the Brazilian society, got worse from 1980 to 2000 for several reasons. In 1980, the average income of the richest population was 10 times higher than the average income of the Brazilian population as a whole. Twenty years later, that ratio was 14 times higher, and 80 times higher if compared to the poorest 20%.

However, according to data from the 2004 Household National Survey (PNAD), from 2001 to 2004 the participation of the poorest 10% in the total national income increased from 12.4% to 14.1% and the richest 50% dropped from 47.3% to 44,3% (IBRE, 2005).

2.5.2 Poverty size

In addition to that picture of extreme inequality, a large contingent of the Brazilian population lives below the poverty line. It is widely known that defining the poverty line is an extremely polemic issue and generates very different estimates. According to the Brazilian Economics Institute (IBGE) of the Getúlio Vargas Foundation, when analyzing data from the 2000 Demographic Census and adopting the criterion of monthly R$ 60.00 *per capita* as the definer for poverty line, 35% of the Brazilian population (57.7 million persons) would be living below the poverty line. According to that institution, the poorest regions in Brazil would be the North and Northeast ones, where 13.8 million individuals live in extreme poverty; 26% of the Brazilians in that situation live in rural zones. In the Northern region's rural zone, for example, the average income would be R$ 19.67, the lowest in the country.

According to the Hunger Zero Project-a Proposal for Food Security for Brazil, the population whose income is below the poverty line[21], which should be subject to priority attention, comprises 44.043 million individuals, involving 9.32 million families. Absolute poverty accounts for 27.8% of

[21] Lula government's team employed, in that calculation, the World Bank criterion of poverty line (US$ 1.08/ day), adjusting for the different regional levels of cost of living and for the existence or inexistence of self-consumption.

the total population of Brazil; 19.1% of the population in metropolitan regions, 25.5% of non-metropolitan urban areas and 46.1% of rural population. Concerning families, it would correspond to 21.9% of Brazilian families.

However, in 2005 the data publicized by the 2004 Household National Survey (PNAD) pointed out, according to IBRE/FGV, that the share of Brazilians below misery line had dropped from 27.6% (2003) to 25.8% (2004), recording the lowest value since 1992, when the survey started. Furthermore, when the FGV adopts the monthly *per capita* income of R$ 115.00 as the misery line, it shows that the drop in the percentage of the destitute population is a reality from 1992 to 2004 (IBRE, 2005). Nonetheless, the number of individuals in that situation is enormous.

Despite the existing differences in the aforementioned methodologies, the absolute poverty in Brazil clearly reaches an extremely significant share of its population. The size of that poverty turns the use of the expression "focused" into a problem to policies oriented to that population. Obviously, in its restrict sense, these are not universal policies, but the target-population size is "immeasurable", very far from that idea of exception advocated for by the defenders of welfare and charity (*assistencialistm*) bound to the neo-liberal thought.

2.5.3 Inequality among regions [22]

Brazil is a country that registers huge differences among its regions. Among such differences are: demographic density; prevailing economic activity; education levels; life expectancy.

The Northern region occupies most of the Brazilian territory (45.27%) and its area is almost entirely taken by the Amazon River basin. It has the country's lowest population density (3.31 inhabitants per sq. km and the life expectancy of its population is 67.34 years. Most of the population (69.9%), lives in urban zones. In 2003, the average number of years of schooling of the population over 10 years old was 6.4 years. The economic activity there is based on vegetal and mineral extractivism and on large-scale ore exploitation, mainly iron and manganese.

The Northeast region comprises 18.26% of Brazil's total area. Its economy is mainly based on sugar and cocoa agro-industry. Also outstanding are export-oriented fruit-growing in the São Francisco River valley, oil exploration on the coast and the continental platform, in addition to tourism development. 28.9% of the Brazilian population lives in that region, and that is where Brazil records the lowest life expectancy (64.22 years). Its demographic density is 28.73 inhabitants/sq. km and most of the population is concentrated in the urban zone (69.1% - the lowest in the country). The average years of schooling of the Northeast population, in 2003, was five years.

Southeast is the most important region in Brazil, in economic terms. It comprises only 10.85% of the Brazilian territory, but concentrates 42.63% of its population, with life expectancy of 67.53 years old. The average years of education of the Southeast population, in 2003, was 7.1 years. Its demographic density is 72.26 inhabitants/sq. km and 90.5% of its population is concentrated in the urban zone (the highest urbanization rate in the country). The two major national metropolises, the cities of Sao Paulo and Rio de Janeiro, are in this region. Its economy concentrates over half the Brazilian production, and is strongly industrial. However, it also harbors the largest heard of cattle

[22] This part is based on information from the Brazilian Institute of Geography and Statistics - IBGE (Synthesis of Social Indicators for 2004 and IBGE Teen).

and significant agricultural production, including sugar cane, oranges and coffee, with good technical standard and high productivity. Furthermore, it has reasonable amounts of iron, manganese and oil reserves.

The Southern region comprises only 6.75% of the Brazilian territory, with a demographic density of 40.74 inhabitants/sq. km. The life expectancy of its population is 68.68 years old, the highest in Brazil, and 80.9% of its population lives in urban areas. In 2003, the average years of schooling of its population over 10 years old was 6.9 years. This region rests on high hydroelectric potential, and the Itaipu plant is located in it. Its economy, traditionally based on agriculture, developed an important industrial park over recent decades. Agricultural production employs modern cultivation techniques, where wheat, soy bean, rice, corn, beans and tobacco, are outstanding among the major products traded.

The Mid-West region comprises only 18.86% of the Brazilian territory, with a demographic density of 6.51 inhabitants/sq. km. The life expectancy of its population is 67.8 years old, and most of it (86.7%) is concentrated in urban zones. In 2003, the average years of schooling of the population over 10 years old was 6.6 years. Its economy was primarily based on the exploitation of gold and diamond, but has gradually been replaced by cattle farming. The transfer of Brazil's capital from Rio de Janeiro to Brasilia, in 1960, and the construction of railways that facilitated the access westward played an important role in its occupation and development. This region has the biggest reserves of manganese in Brazil but they remain little exploited.

2.5.4 The Brazilian regions' and states' HDI

Information concerning the Human Development Index (HDI) for the Brazilian regions results from the methodology adopted by the United Nations Programme up until 1998[23], before the correction for the effect of income on the population's welfare.

Furthermore, the information employed herein reflects the regions' situation in 1991 and, for the states, that of 2000. Despite such limitations, the results recorded are an additional descriptive element of Brazilian inequality.

That is what the results for the Brazilian states disclose: states with high level of human development are right besides other with extremely low level. The states reporting highest levels are: the Federal District , Santa Catarina, Sao Paulo and Rio Grande do Sul, respectively located in the Mid-West, Southeast and South regions. The states with the worst ratings are all in the Northeast region (Table 2). These results are compatible with those reported in the 1991 HDI concerning the Brazilian regions (Table 1), where the Northeast once again registers the worst performance.

Table 2 discloses the ranking of Brazilian states by the HDI in 2000.. One can observe that the ranking according to that index is normally different from that based only on the *per capita* income. According to the latter indicator, Sao Paulo, for example, is ranked second but, according to the HDI, it is ranked third.

[23] According to the old methodology, when a country's *per capita* income was lower than the global average (of US$ 5,990.00, in 1995), a short increase in income would have great impact on the index, and when the *per capital* income was higher than the global average, even a great increase in income would have low impact on the index. The new methodology maintained the principle according to which an income increase presents decreasing earnings to the population welfare, but "smoothened" the curve that is now logarithmic.

Table 1
Ranking of Brazilian Regions by HDI * — 1991

Region	HDI
South	0.844
Southeast	0.838
Mid-West	0.826
North	0.706
Northeast	0.548

Source: IPEA (1996).
* The methodology employed to calculate the HDI was as follows: life expectancy at birth is used as the as longevity indicator; adult literacy rate and the combined rate of enrollment at basic, high, and higher schools are employed as education level indicators. The rates are then gathered in one single indicator through weighted average technique using weights two and one. The *per capita* income is computed as an indicator of access to resources.

Table 2
Brazilian Regions Ranking by HDI * — 2000

States	HDI	HDI	Ranking GDP per capita	Life expectancy	Education
Distrito Federal	0.844	1	1	5	1
Santa Catarina	0.822	2	5	1	2
São Paulo	0.820	3	2	3	5
Rio Grande do Sul	0.814	4	4	2	3
Rio de Janeiro	0.807	5	3	9	4
Paraná	0.787	6	6	7	7
Mato Grosso do Sul	0.778	7	8	6	10
Goiás	0.776	8	10	8	8
Mato Grosso	0.773	9	9	10	11
Minas Gerais	0.773	10	11	4	13
Espírito Santo	0.765	11	7	12	12
Amapá	0.753	12	14	14	6
Roraima	0.746	13	13	19	9
Rondônia	0.735	14	12	20	14
Pará	0.723	15	20	11	16
Amazonas	0.713	16	18	18	17

Table 2
Brazilian Regions Ranking by HDI * — 2000 (continued)

States	HDI	HDI	Ranking GDP per capita	Life expectancy	Education
Tocantins	0.710	17	19	21	15
Rio Grande do Norte	0.705	18	17	16	19
Pernambuco	0.705	19	15	15	22
Ceará	0.700	20	23	13	20
Acre	0.697	21	16	17	23
Bahia	0.688	22	22	22	18
Sergipe	0.682	23	21	24	21
Paraíba	0.661	24	24	26	25
Piauí	0.656	25	26	23	26
Alagoas	0.649	26	25	25	27
Maranhão	0.636	27	27	27	24

Source: (UNDP, 2006).

2.5.5 Inequality in the supply and allotment of federal resources in public health services and actions

In the first years following health universalization in the Constitution, Ministry of Health (MoH) resources[24] were allotted based on the production of outpatient and hospital care services. Therefore, it enacted inequality in supply which is concentrated in the richest regions and capital cities. From 1997 onwards a process was begun towards achieving a more balanced allocation of resources for primary care actions and services, based on the *per capita* remuneration mechanism, called Minimum Basic Care (PAB)[25]. For that purpose, a minimum value (equivalent to the average national expense) and a maximum value (for the municipalities with historic expenditure higher than the national average) were defined. The strategy was complemented by financial incentives aimed at developing specific programs, wherein the Family Health Program is outstanding. According to PORTO *et al*, such changes in the system of financing primary care have resulted in more balanced resource-sharing, improving the situation of the neediest regions. Nevertheless, that action has not been enough to change the picture of inequality in the primary care field. Among other reasons, the adopted criteria failed to take into consideration that populations presented different compositions in different regions. (Porto *et al*, 2003).

[24] In 1996, federal resources used to finance 53.7% of health public expense in Brazil (Piola and Biasoto, 2000).
[25] In 1998, the Ministry of Health issued several Administrative Rules that deeply changed the content of the 96 Basic Operational Rules. Among them, the original concept of PAB - established in 1997- was changed and it was converted from a Minimum Basic Assistance to a Minimum Basic Care.
See the Ministry of Health Administrative Rule 3925, of 11.13.1998, which approved the Manual to Organize Basic Care in the Unified Health System.

On the side of services production, a glance at the number of medical consultations and hospitalizations reveals the persistent differences among regions (Tables 3 and 4), despite the reduced level of inequality[26].

Table 3
Number of SUS Consultations by Inhabitants

Region / Brazil	1996	1999	2003
Brazil	2.2	2.2	2.53
North	1.4	1.5	1.86
Northeast	2.0	2.0	2.33
Southeast	2.6	2.6	2.86
South	2.0	2.0	2.36
Center-West	2.1	2.0	2.41

Source: MS/SE/Datasus – SUS Out patient Clinic Information System (SIA/SUS)

Table 4
Numbers of Hospital Admissions (SUS) by Inhabitants

Region / Brazil	1997	1998	1999	2003
Brazil	7.37	7.24	7.29	6.50
North	7.17	7.15	7.61	6.53
Northeast	7.70	7.66	7.74	6.91
Southeast	6.84	6.60	6.55	5.81
South	8.30	8.11	8.14	7.16
Center-West	7.58	7.72	7.84	7.61

Source: MS/SE/Datasus –SUS Hospital Information System (SIH/SUS).
Note: Hospital Admissions by place of residence.

Brazilian researchers, among whom the team headed by Porto is outstanding, have tried to develop methodologies that allow for more balanced distribution of resources.

The methodology proposed by Porto takes into consideration both “health needs” and “supply”, resulting in a distribution of resources to hospital and outpatient care within the MoH network that is very different from that effectively done. For example, instead of granting 47.02% of the MoH resources, in 1999, to the Southeast region, it would be granted only 39.31% and the Northeast region would expand its participation from 24.89% to 33.52%. (Porto *et al*, 2003).

In regard to that methodology, it is worth mentioning the emphasis placed on the users’ difficulty in gaining access to health services in the country. That is why when defining “health

[26] Concerning hospitalizations, the strong presence of non-SUS supply is expected to contribute in the south Region, which is the richest and the country and reports the lowest number of hospitalization/100 inhabitants.

needs" those researchers use a set of socio-economic and epidemiological indicators, such as: illiteracy rate; average number of individuals living in the domicile; share of rural population; ratio of poorly defined child deaths and those from diarrhea /deficiencies, malnutrition; rate of mortality from cardiovascular diseases, neoplasias and infectious and parasite-transmitted diseases; mortality rate in the 1 - 64 years old population and in those over 65 years old; child mortality coefficient; and, percentage of adolescent mothers.

2.6 SUS in the face of economic constraints

The SUS' fight for resources dates back a long way, and its first content may be found in 1993[27]. For the purposes of this article, however, what matters are those situations where economic constraints, mainly those resulting from the effort towards achieving primary surplus, are reflected in actions (successful or not) that would result in less availability of resources for public health. However, the situations described and reviewed herein refer almost always to the Federal sphere, although many events are similar to those happening in other governmental spheres [28]. The objective is to highlight that Brazilian society has experienced a situation where the social area, notably health, is being held hostage by economic goals and guidelines, and suffers an appropriation of its resources that may be jeopardizing its development.

a) Enforcement of the provisions set forth in the Constitutional Amendment (CA) 29/ 2000 - - The basis for computing Federal Government resources.

In 1993, when the Ministry of Health was not granted the resources foreseen in the Federal Government budget originating from employees' and employers' contribution, leading it to make a loan with FAT, the Deputies Eduardo Jorge and Waldir Pires prepared the Draft Constitutional Amendment 169 (PEC 169) that, in brief, established the conditions for allocating resources to health. After that, many other binding proposals were prepared and discussed at the National Congress, but the constitutional amendment (CA 29) was enacted only in 2000. Pursuant to the CA 29, the Federal Government should allot for the first year at least 5% more than the amount committed in the previous year and, for the following years, the amount settled in the previous year, adjusted according to the nominal GDP variation [29].

The Ministries of Economics and of Planning, in charge of preparing the Federal government's budgetary proposal and for enforcing the country's economic policy, understood that the base year would be 1999. For the Ministry of Health however, and all

[27] For further details, see Medici, Soares and Marques, 1994.

[28] Several aspects evidence the initiatives and measures against public health financing that were employed by different governments after the 1988 Constitution enactment. Outstanding among them are: the use of a share of Social Security resources for other purposes than those of its area from 1989 to 1990; the specialization of the source of contributions by employees and employers to the Social Security; the establishment of mechanisms- Emergency Social Fund (FSE), Fiscal Stabilization Fund (FEF) and Separation from Federal Government Revenues (DRU) - that allowed the Federal Government access to Social Security resources and, therefore, their undue use. For further details on these situations and even of those described herein, see Marques and Mendes (2005).

[29] For States and Municipalities, the CA 29 established the allotment of, at least, 7% of its tax-related revenues, comprising constitutional transfers for the first year, and the percentage should increase every year until reaching at least 12% for the states and 15% for municipalities in 2004.

other public health organizations, the base year over which the additional 5% would be applied was 2000. The different interpretations led to a reduction of R$ 1.19 billion in the MoH Budget for 2001, which amount could have doubled the resources spent on the Community Health Agents Program in 2000. To the Government economic team, this was another victory towards achieving the primary surplus with the International Monetary Fund.

b) Non-compliance with concepts of health actions and services in states and municipalities.

To comply with provisions set forth in the CA 29, some states have unduly included as health actions and services expenses those incurred with health services for inactive workers, sanitation firms, urban housing, water resources, school meals, prisoners' meals and hospitals to "closed clients" (like hospitals of State civil servants.) Such undue usage occurred despite the previous standards established that defined which actions and services could be considered as SUS expenditure. Such parameters had been agreed on by the Ministry of Health, the States and their Courts of Accounts[30].

The same happened in some municipalities, where expenses incurred with inactive workers were considered health expenses and the 15% established in the CA 29 as being the minimum applicable, when it was in fact exactly the percentage to be applied even if needs demanded higher expenditures.

c) Attempts to reduce the Ministry of Health budget.

The Budgetary Directive Law (*Lei de Diretrizes Orçamentárias - LDO*) on the 2004 budget set forth that the Federal Government social security expenses (EPU), debt service and resources allotted to the Fund to Combat and Eradicate Poverty should be accounted as SUS expenditures in the Ministry of Health. However, the National Health Council and the Health Parliamentary Front strongly reacted against that and asked the Executive Power to send a message to the Brazilian National Congress establishing that, for the purposes of health actions, the EPU and debt service should be deducted. In regard to the Poverty Fund, the message was missing, and this resulted in a reduction of R$ 3,571 million in the Ministry of Health's SUS budget.

Despite the many and intensive debates between entities bound to SUS and the Ministry of Planning, nothing was changed here. Only after the Federal Office of the Attorney-General (*Ministério Público Federal*)[31], issued a report against the Presidential decision asking President Lula to suspend the veto to the provision that clarified that the revenues of the Fund of Poverty Fight and Eradication could not be accounted as health expenses, otherwise the approved budget could be considered unconstitutional, did the Government draw back. That was how Law # 10777, of November 25, 2003 included in its Art. 59, second paragraph, a provision that EPU, debt service and the MoH expenses with the Fund to Combat and Eradicate Poverty should not be considered as public health actions and services.

[30] Resolution # 322 of the National Health Council, dated May 8, 2003, enacted by the Ministry of Health.
[31] The decision of the Federal Public Prosecution in the technical opinion of Minister Cláudio Fontelles was given on the basis of a representation put before it by Federal Deputy Roberto Gouveia (PT-SP), by former Federal Deputy Eduardo Jorge (PT-SP) and by the then of the Brazilian Association of Health Economy, Áquilas Mendes.

d) The binding of CA 29 becomes object of attention in the economic field.

By the end of 2003, the Federal Government submitted a document concerning the new agreement with the International Monetary Fund [32], expressing its intention of preparing a study on the implications ensued by constitutional binding of social expenses – health and education – to Federal, States and Municipal government budgetary revenues. The justification was supported by the idea that making public resources allocations more flexible could furnish a way towards growth for the Country (ME, 2004: 3).

Within SUS, the government intended to release the MoH from the obligation of expending the same amount as the previous year, plus the nominal variation of the GDP; for States, 12% of their tax revenue, comprising constitutional transfers; and, for Municipalities, 15% as defined in the CA 20.

e) The 2006 Ministry of Health Budget endangered.

The Draft Budgetary Directive Law (LDO) for the 2006 budget, submitted by the Federal Government to the House of Deputies, stated that hospital care expenses with military personnel and their dependents (closed system) should be considered when calculating health actions and services. Should that expense be considered, the resources allotted to the Ministry of Health would be reduced by about R$ 500 million. In face of the MoH public pronouncement, rejecting that interpretation, and in face of the mobilization of health entities, the Federal Government was compelled to draw back and reformulate its proposal.

2.7 SUS and improved health conditions for the Brazilians.

Despite the difficulties inherent to the picture of unbalance and restrictions imposed by the economy, the implementation of the Unified Health System was followed by an improvement in the Brazilian people's health conditions. Noronha et al., when analyzing the information available in the Ministry of Health database (DATASUS), highlight several elements that indicate that improvement. Outstanding among them are:

a) Drop in general mortality rate from 6.26 to 5.6, per thousand inhabitants, from 1980 to 2002;

b) Drop in infantile mortality rate from 45.3 to 25.1 per thousand live-born babies, from 1990 to 2002. According to the authors, the reduction seems to be related to increased basic sanitation coverage, water supply, health services, mother-child health programs, vaccination campaigns and programs on breast feeding and oral re-hydrating. During the last year, the State of Alagoas, in the Northeast region, reported a rate of 52.6 per thousand live-born babies, and the Southern region 16.1/1000 (MS, 2006);

c) Change in the mortality rate profiled by causes. In 1980, among the five main defined causes of death, there were: Circulatory diseases, external causes, infectious and parasite-transmitted diseases and respiratory diseases. In 2000, the infectious and parasite-transmitted diseases directly related to water supply, sanitary sewerage treatment and waste disposal cease to be among the five major causes (Noronha *et al*, 2005).

[32] The document refers to the new agreement with the IMF and is addressed to the Executive Director, Köhler (ME, 2004).

It would also be worth mentioning the increased coverage of the Family Health Program (PSF) and, at the other end of complexity, the internationally acknowledged excellence of the STD and Aids Program.

The PSF was established in 1994, but only after 1998 did it become consolidated as a priority policy of the Ministry of Health. The central axis of that program is to strengthen primary care, and it is composed by a team of at least one physician, one nurse, one nurse assistant and four to six community health agents. From 1998 to 2004, the Brazilian population covered by the PSF jumped from 6.58% to 40%[33]. The coverage level varies among regions and municipalities. Therefore, in 2004, while the Northeast region reported a percentage of 54.85%, the Northern region recorded 34.17% and Southeast 29%, for example. For the Northern region, the coverage is worrisome, since its population, in general is low-income, registering the second lowest HDI, as previously observed.

In relation to municipalities, in 1998 only 9.41% of the population living in municipalities with less than 20 thousand inhabitants was served by the PSF. However, the coverage increased along the years and, in 2004, it had already reached 65.29%. That was not true for municipalities ranging from 20 thousand to 80 thousand inhabitants and with more than 80 thousand inhabitants. Over the last years, the coverage has been 27.5% of the population. Taking into consideration the average family per capita income, one can observe that in 2004 the poorest populations, with average per capita income lower than the minimum wage, reported 58.49% of coverage, and for those with average higher average income, equal to or higher than two minimum wages, the coverage was 24.89% (MS, 2006).

Concerning the PSF impact, let us mention two samples of findings disclosed by the Ministry of Health. In relation to the ratio of deaths for children of less than one year old, from poorly defined causes, the MoH says: "the annual average variation for this indicator discloses that the higher the PSF coverage range for the municipalities group, the sharper the drop in the ratio of infantile deaths from poorly defined causes" (MS, 2006, p. 90). In regard to the infantile mortality rate in municipalities with low HDI, the greater the PSF coverage, the greater the reduction (MS, 2006: 171).

3. Final Remarks

Specifically for Brazil, the introduction of universalizing the right to public health took place in processes and environments other that those of the developed countries. Brazil only adopted that right through its 1988 Constitution, and is a late case both in terms of time and of the historical moment that led to it.

The Brazilian social protection system, grounded on the principle of universality and solidarity among the areas that make up Social Security, have been established at the zenith of the new stage of capitalism, that of financial prevalence. At that moment, the Welfare State in the developed world was subject to criticisms consistent with the new logic of interest generating finance capital, and started to undergo more or less significant reforms. In turn, labor market conditions proved to quite the opposite of that of the "thirty glorious years", i.e., structural unemployment emerged

[33] In 2005, the PSF was based on 23.9 thousand teams spread out among 4.9 thousand municipalities. The national coverage was already 43.4%.

and, even more concerning, the increased precariousness of labor relations. That troublesome picture of the labor market has also affected Brazil, intensifying its precarious historical traces.

As can be learned from this paper, the exhaustion of the Brazilian development model starts in 1980, exactly when contemporaneous capitalism starts to evidence its transformations. Among the different impacts of that new environment on the Brazilian society, one of the most notable ones was the replacement of a developmental State by a State that was a hostage of its internal and external debts. Compelled by the demands of creditors and commitments made during negotiations, many times in the last 25 years, particularly in the latest governments, it reduced its size and tried to reduce its expenses, including those in the social field. Over the last decade, the continuity of that process has converted the primary surplus into the major purpose of the Brazilian economic team.

Therefore, it can be observed that at the same time that SUS was implemented based on a public and universal system, the State fiscal and financial crisis was intensified, leading the Federal and State governments to limit the allocation of resources to health. That environment of shrinking State capacity and lack of economic growth was completely different from the period when universalizing health took place in European developed countries.

Finally, it would be worth adding that the problematic structural heritage of the Brazilian socioeconomic situation has worsened in the last decades, exactly during the consolidation of the universal right to health. Both the permanence of poverty and the high degree of inequality of income and regional unbalances in Brazil, as well as difficult access to health services and uneven supply and allocation of federal resources to health actions and services point out the specificity and difference of Brazil as compared to countries that implemented health universality in the post-war years.

Moreover, the uneven supply, which is briefly mentioned in part 2.3.4 above, is an important obstacle to full universalizing. Such unbalance results from the way the public health system was built up and how the dynamics of industrial accumulation have been spatially located in the country. It is widely known that the equipment available to public health services is composed by equipment belonging to its own network and that available through agreements, and when the public system was born and was still directed at workers in the formal market, the existing private network was permanently raised to the category of auxiliary and/or complementary. And the localization of its equipment and units, at that time and in the subsequent decades has followed the urban and economic development of the nation, which is more present in the coastal regions and the Southeast. The interiorization that took place with the creation of Brasilia was to change that situation. On the public investment side, mainly hospital investment, the dynamics were pretty much the same and many times followed the flourishing of university centers in the main Brazilian capital cities.

This additional aspect of Brazilian inequity is as hard to be overcome as the others, thus becoming a challenge for the continued implementation of public health universality in Brazil. Nevertheless, as previously mentioned, despite the difficulties inherent to this scene of unbalance and restrictions imposed by the economy, the implementation of the Unified Health System has been followed by an improvement in the Brazilian people's health conditions, expanded access, reduced unbalances and regional differences, and relative advances in resource granting. Among its actions in the basic care plan, the development of the Family Health Program is outstanding.

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