Decentralising the health sector: issues in Brazil

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Abstract

The health sector in Brazil has undergone important changes, particularly with the development of the Unified Health System (SUS). Decentralisation is an important principle of SUS and advances have been made in transferring responsibilities and resources to the local government units, known as municipios. This article describes the changes introduced, focusing on the system of municipio classification and the funding mechanisms introduced through the basic operating rule (BOR) of 1996. The paper then moves on to analysing three key issues of decentralisation in Brazil that are related to the policy process, the system of decentralisation and the output of decentralisation. Firstly, the formal process by which decisions on health sector reform are made is discussed with particular attention being paid to the negotiated and relatively open policy space. Secondly, the role of the states is discussed within the decentralised system. Thirdly, the impact of decentralisation on equity is discussed with particular reference to the resourcing of the Municipal Health Funds. The article concludes by emphasising the political nature of health sector decentralisation and the need to develop the conditions for effectiveness in decentralisation programmes. © 2000 Elsevier Science Ireland Ltd. All rights reserved.

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1. Introduction

Decentralisation is a ubiquitous feature of health sector reform throughout the world. Its virtues are extolled by those that adhere to the Primary Health Care movement as expressed in the Alma Ata Declaration of 1978 and in the more market driven approaches which have informed health sector reform in many countries, particularly in the early 1990s. Despite its many advantages, there is a growing concern that decentralisation, particularly when inappropriately formulated and implemented, can have negative effects on health and health care development [1–4]. Thus, decentralisation has been linked with increased bureaucratic costs, inefficiency and political manipulation. It has also been associated with increasing organisational fragmentation and constraints on the development of national health policy objectives and strategic planning. The paradox of health sector decentralisation is that, while it is justified in the name of equity, it can quite easily lead to inequity, particularly in devolved forms of decentralisation.

There is a clear need to develop our understanding of the policy processes leading to decentralisation, the appropriateness of decentralisation policies themselves, the conditions leading to effective decentralisation, and to assess the impact of decentralisation on health and health sector development. One way in which this can be done is through developing our understanding of concrete processes of health sector decentralisation. There is a need for a realistic process of international learning in the area of health sector decentralisation, and recent work has sought to develop this [4–7]. This paper seeks to contribute to this process through an analysis of health sector decentralisation in Brazil. Important health sector reforms have been introduced in Brazil and these contrast, at least on paper, with the more market driven reforms espoused throughout the world in the 1990s. They have attempted, at least formally, to break with the traditionally fragmented systems of Latin America, and have been developed as part of a politically explicit programme to draw the country back from two decades of military rule (1964–1985).

In the first part of the paper we shall outline the characteristics of health sector reform in the country and how decentralisation fits into this. We shall then discuss three key and interrelated issues of decentralisation in Brazil:

- the way in which policies on decentralisation are formulated and, in particular, the ‘policy space’;
- the organisational form of decentralisation and, in particular, the role of the states in decentralisation;
- the output of decentralisation with particular reference to equity.

The paper underlines the essentially political character of the decentralisation process and reaffirms the need to link decentralisation to policies on the key political issues of process, content and impact of health sector reform.

2. The Unified Health System (SUS) and decentralisation

Between 1964 and 1985 Brazil was ruled by military governments known for their
political repression, rigid centralisation and strong emphasis on economic growth as opposed to social development. The military had inherited a fragmented health care system based on the public financing of Ministry of Health provision in addition to a number of compulsory health insurance schemes for employees from the formal sectors of the economy. In the late 1960s these diverse social security schemes were brought together under the name of INPS, later referred to as INAMPS. While the Ministry of Health maintained its own facilities and undertook public health programmes, INAMPS operated as a semi-autonomous agency and provided health care to the more urban and formal sector employees. The system continued as fragmented operating within government policies that focused on economic development as opposed to social welfare [8]. Those working in the informal sector and the rural areas were largely excluded from these social security arrangements. As a result, public sector health care tended to be concentrated in the more developed south and south east of the country and exclude the urban and rural poor. A development during the years of the military governments was the growth of the private sector, including private (particularly for profit organisations) provision of publicly financed care through social security arrangements. In addition, government subsidies were given to support private hospital construction.

An important feature of health sector reform in the 1980s was its explicit political character and its relation to the fight against the military regime. Health sector reform became a fundamental feature of the fight to re-democratise the society and the political regime. Of relevance here was the Public Health Reform Movement—a wide ranging and loosely organised coalition of social and political groups emerging from the mid 1970s and dedicated to a democratic reform of the health sector. It included progressive members of health professional and occupational groups along with intellectuals, trade unionists, social popular movements promoting the need for improved health and municipal reformers and held broad links with opposition political parties. Souza [9], points out that the movement’s progress saw it widen its appeal to social movements, women’s groups and neighbourhood associations, although Viana et al. [10] draw attention to the important role played by a professional elite in the reform process. Cohn [11] has signalled out a dual political strategy adopted by the movement: ‘...active participation in struggles to re-democratise the nation, specifically through health issues, and the elaboration and implementation of proposals for the institutional re-organisation of health care, primarily through the strategy of occupying spaces within the State apparatus.’3 This infiltration of the government machinery was accompanied by a whole series of simposia, meetings and conferences supporting the cause of reform [10]. The Movement was able to exert an important influence over the post dictatorial reforms.

The period of political transition in the mid 1980s was marked by a number of reform initiatives: the creation of Integrated Health Activities (AIS) in 1984 and the

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3 NB: State refers to the public sector as a whole, while state refers to the level of government.
Unified and Decentralised Health System (SUDS) in 1987. The major change however, was signalled by the new National Constitution of 1988 and the creation of the SUS in 1990. INAMPS ceased to exist in 1993 and the Ministry of Health’s role in public sector health care was confirmed.

The principles of SUS are those of universality, equity, public financing, decentralisation, popular participation and integrated service provision. The system operates through a three-tier system of devolved government: the Federal level, the states and the municipios (municipal level). Although decentralisation was a key feature proclaimed of SUS from its inception, the mechanism to put it into practice was only issued some years later through the Basic Operating Rule of 1993 (from now on, BOR 93 but known in Brazil as NOB 93). SUS has operated through a complex and centralised payments system whereby provider units, both public and private, throughout the whole country have received moneys on the basis of service provision. This pay for service system meant that the Federal level made monthly payments (preset according to a number of criteria [12]) the bills sent by public (be these state or municipally owned) and private units (to whom payments were channelled through the states).

The federal level, through the Ministry of Health, takes on typical macro functions of, for example, national health policy but has a limited role in the direct provision of curative services. It does, however, operate a number of national programmes relating, for example, to communicable diseases and nutrition. The federal health expenditure for SUS in 1996 was R$14.18 billion (R$1 = US0.9) and in 1997 it was R$18.79 billion, due to a new provisional source created as a taxation on bank transactions involving their use of cheques. It should also be pointed out that the approved budget is not always fully executed, due to cost containment [13]. Federal funds for health care come from general revenues and three ‘social funds’ — FAS, FPAS, and FINSOCIAL which in turn are financed through earmarked taxes. Although attempts have been made to set a clear sum for SUS funding from the social funds, they tend to be somewhat erratic [14,15].

The state level is financed through the State Health Fund, which receives both federal and state sources of income. It runs its own network of health care services, although the process of decentralisation has tended to pass over the state level and pass directly to the municipios. The latter, of which there are 5507 in the country, operate their own Municipal Health Funds which receive both federal and municipal contributions. The municipios also operate their own system of health care activities, although their measure of autonomy depends on a number of variables, as mentioned below. Because the inception of SUS, there has been a gradual process of selective decentralisation to the municipios. The first years of SUS, and particularly during the Collor government (1990–92), however, held little hope for a decentralised system. The municipios appeared more as simple providers existing within a centralised payments system.

Things started changing with the 9th National Health Conference in 1992 which took municipalisation as its key theme. The resulting regulation was Ministry of
Health Basic Operating Rule (BOR) of 1993. This allowed for the grading of municipios in three categories and the subsequent transfer of responsibilities to the municipio according to their respective category. The lowest category was referred to as ‘incipient’ management, followed by ‘partial’ management and ‘semi-full’ management. All categories received public sector health units transferred from the state and federal levels as part of the decentralisation process. In the ‘partial’ category the municipios were given some control over the SUS contracted units of the private sector, although the latter still received payment directly from the National Health Fund. In the ‘semi-full’ category the municipio had a more complete control over the private sector linked to SUS. Resources were transferred directly to the Municipal Health Fund and the municipio took responsibility for resource use. How these figures were calculated varied between states, although the procedure adopted was usually previous expenditure through SUS. By 1996, 3127 or ~ 63% of the total municipios in the country had registered within the categories established in BOR 93, distributed in the three categories as set out in Table 1. It should be noted that although only 144 municipios were put into the highest category, these covered the major urban centres, such as Recife and Belo Horizonte, and occupied 28.4% of the national transfers within BOR 93 [16].

The decentralisation process was taken forward through recommendations of the Tripartite Intergovernmental Commission (see below) in 1996 and the promulgation of BOR 96 in the same year. Those municipios registered under BOR 96 are placed in one of two categories:

- Higher grade municipios are referred to as ‘full management of the municipal system’ in which the municipio possesses full responsibility for municipal health services. This basically means that the more developed municipios have greater autonomy, receiving periodic transfers from the National Health Fund to the Municipal Health Fund and take responsibility for health care through a network of public and private provider organisations. The Municipal Health Fund is made up of the municipios own budget allocation to the health fund and federal transfers.

- Second grade municipios are referred to as ‘full management of basic care’ and have more restricted responsibilities. They also receive periodic (monthly) transfers from National Health Fund to the Municipal Health Fund. However, SUS provider units — be they public or private — in these municipios receive

<table>
<thead>
<tr>
<th>Management category</th>
<th>Number of municipios</th>
<th>Municipios (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incipient</td>
<td>2367</td>
<td>75.7</td>
</tr>
<tr>
<td>Partial</td>
<td>616</td>
<td>19.7</td>
</tr>
<tr>
<td>Semi-full</td>
<td>144</td>
<td>4.6</td>
</tr>
<tr>
<td>Total</td>
<td>3127</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* Source: [16].
payments directly for episodes of more specialised care carried out through SUS. This money does not go through the Municipal Health Fund.

Under BOR 96 the states are also graded: advanced management of the state system and full management of the state system. In both there are many common responsibilities and similarities, the great difference resting on the funding mechanism. In the ‘full management’ type, the state receives its whole financial ceiling regularly and automatically from the National Health Fund to the State Health Fund, exempting just the money already transferred directly to the municipios. In the Advanced type the state receives part of the transfers in this same way, to cover specialised treatments and PAB (see below), with the rest being paid directly to the providers, such as hospitals and outpatient clinics. To enhance decentralisation, one of the basic requirements for the state to be qualified in one of these two types is to present 60 and 80% of its municipios, respectively, also qualified in terms of BOR 96.

A new format for the financing of the municipal health care systems was introduced through BOR 96. Three sources of income and expenditure for health care may be identified, although the importance of these three sources varies according to the municipio concerned.

2.1. Municipal taxes

Municipios in Brazil have their own tax based sources of income and also receive tax transfers from the federal level. Municipios are expected to allocate ~10% of the municipal budget to health. This is not obligatory but a recommendation and is, therefore, not always followed-up.

2.2. Federal transfers

These are made through SUS for payments to providers for instances of care provided and are received by public and private hospitals and outpatient clinics. Some features of this system of transfers and payments may be highlighted. Firstly, the prices paid are the same for the whole country, although it is well recognised that the costs of specific healthcare procedures vary between different regions, cities and towns. This indicates a centralised uniformity and somewhat rigid process of financial management. There is also controversy as to whether the prices paid to the provider units actually cover the costs incurred. Secondly, since 1995 transfers and payments have been made punctually every month, avoiding any extra costs or waste of resources due to delays — a situation which, in the recent past, used to occur frequently. Thirdly, for those municipios not registered under BOR 96 these sums go directly to the provider institutions of outpatient and hospital care. For these municipios registered under BOR 96 as ‘full management of basic care’ (the lower level of decentralisation) these sums are transferred directly only to the private provider institutions for (only) hospital care. It is claimed by the government that these municipios are more likely to have a less developed financial and accounting system for health, which could make them less efficient to plan, assess
and pay for hospitals and complex procedures such as dialysis (in clinics). Those municipios classified under ‘full management of the municipal system’ (higher level of decentralisation) receive a sum calculated by the federal level by up-dating previous sums formerly transferred under the SUS payments — the difference being that these sums are transferred to the Municipal Health Fund, and the municipal authorities are relatively autonomous in how they spend this money on health care.

2.3. \textit{PAB}

This mechanism establishes periodic (monthly) distribution of funds from the National to the Municipal Health Funds of those municipios registered under BOR 96. These sums are made up of a fixed and variable amount. The fixed one is based on a formula of R$10 per inhabitant per year and is designed to cover basic care. The municipal authorities are presented with a list of activities that they can spend the amount on and they determine how they spend it within that list [17]. Paraphrasing the official norm, this includes health education, immunisation, nutritional care, consultation with the doctor in basic specialities, dentist basic attention, home visits by nurse or community health worker, basic emergencies, minor operations in addition to ante-natal care, family planning activities and birth at home by a Family Doctor. The variable element of PAB is made up of five sub-programmes which, establish their own specific areas of activity and criteria for allocation of funds. They are designed to act as an incentive for municipal action in the specific areas set out in the programmes:

- Community Health Worker Programme and Family Health Programme (R$201 million to be distributed in 1998, calculated on sums for each community worker and set of equipment);
- basic pharmaceutical care (R$159 million to be distributed in 1998, the criteria for allocation are under discussion);
- programme against nutritional deficiencies (R$159 million to be distributed in 1998);
- basic actions of public health control (R$42 million to be distributed in 1998);
- basic actions of epidemiological and environmental control (sum not decided for 1998).

The federal level will make discretionary allocations based on requests from the municipios following their own appreciation of health care needs and the manner in which they could be fulfilled by the specific sub-programme. Each one of these sub-programmes has its own criteria for determining allocations and project work. For example, programmes in the Community Health Worker Programme and Family Health Programme have a target of 100 000 community health workers in the country and 3500 family health teams by the end of 1998.

The implementation of BOR 96 was at first slow. The change in the Minister of Health, municipal elections and negotiation over the details of PAB led to a delay and the eventual inauguration of the new rules in December, 1997. During January and February, 1998 a total of 1888 and 144 municipios had their requests approved
to be categorised as full management of basic care and full management of municipal system, respectively.

3. Challenges of health sector decentralisation

The Brazilian experience draws to our attention some of the key comparative issues in health sector decentralisation. We shall focus on three of these:

- decentralisation and the policy-making process;
- decentralisation and the role of the states;
- decentralisation and equity.

3.1. Decentralisation and the policy-making process

The formulation and implementation of health sector decentralisation should not be viewed as a ‘one-off’ act that can be isolated in time. A learning process of re-interpretation and development should be foreseen by which decentralisation takes on its integrated character of change. We refer to the mechanisms by which the programme of decentralisation is developed over a number of years.

The creation and development of SUS has included an explicitly political and relatively open and negotiated system of policy formulation and implementation. This is hardly surprising given the democratic origins of the system. An elaborate network of institutional arrangements have been developed. Health Councils operate at the federal, state and municipal levels. The National Health Council, for example, has a strategic development role and controls national health care policy implementation. It represents government, health care groups and suppliers while service users take up 50% of Council places. The Health Conferences also operate at the three levels of government. The National Health Conferences, which take place every four years, have played an important role in the creation and development of SUS. They are important events attracting between 4000 and 5000 delegates elected in the municipal and state conferences which together gather more than one hundred thousand participants. Intergovernmental commissions also operate: the Tripartite Commission exists at the national level and has representatives of the three levels of government. The Bipartite Commissions are to be found at the state level and include state and municipal representatives. Lastly, the states and the municipios have representative bodies — CONASS and CONASEMS, respectively. This broad network of institutions serves to generate proposals for change, discuss different options, legitimise decisions, represent interests, organise community participation, and secure smooth relations between the levels of government.

The democratic structures for policy-making have played an important historical role in the development of SUS. There are concerns, however, that the political space for health sector reform has been limited since the mid-1980s and the democratic fever in the early post dictatorial years. The extent to which this participative network is able to provide a clear direction for the development of
SUS is mediated by a number of factors. Brazil is not isolated from the international tendencies towards a marketised process of public sector and health sector reform. There are strong pressures for limitations on the role of the public sector in the provision of health care. It would be politically naive to believe that this formal and relatively open form of policy-making will provide the only strategic direction to the reform process. The important political role of the Ministry of Finance has to be taken into account in the development of SUS together with the forms of private political influence exerted, for example, by private interests linked to the medical industry. At the same time, concern has recently been expressed by Misoczky and Ferreira who, in their criticism of the growing centralism in Brazil and its link to inequity (see below), call for a strategic review of decentralisation: ‘This will only be achieved if there is a change in the political context, with social actors committed to the Health Systems principles recovering the important political role they had in the 1970s and 1980s, in order to neutralise anti-decentralisation forces and to counter a centralist tradition.’

3.2. Decentralisation and the role of the states

Generalisations on decentralisation in Brazil are really quite dangerous given the size and diversity of the country. For example, the public sector has an important role in the state of Pernambuco, but not so in the states of Sao Paulo and Parana where private not-for-profit and for-profit organisations are important respectively. We have also seen that, according to BOR 96, there are two categories of states with different responsibilities. However, it may be said that the process of decentralisation in Brazil has tended to avoid the state level and vest responsibility for primary health care at the municipal level. In many respects, the federal level relates directly with the municipal level. The formal list of health care functions attributed to the state level are those of managing specific units (such as tertiary level institutions and laboratories), overall planning, evaluation, supervision and co-ordination of health care within the state area, dealing with the flow of reimbursements from the federal level to the second category municipios, and providing support to the municipios. These roles, however, are not necessarily clear. The words used in describing the role of the state, such as co-ordination, are open to diverse interpretations. As a World Bank report notes: ‘Many functions are ill-defined or over-lap with those of the MoH and the municipios’ [18].

Having made the above points, which suggest an ambivalent but largely reduced role of the state, it should be indicated that the states are still players within the system and there are good arguments for thinking through a policy for developing the state’s role. We have already taken note of the consultative and negotiated form of decision-making system in SUS. The states are represented on the Tripartite Commission where they meet with the other two governmental levels. They are represented at the national level by CONASS and each state operates a State

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4 As presented by the authors to the Decentralisation network (Decentr-L) run by Management Sciences for Health (decentr-l@mail.msh.org), 24th February, 1999.
Health Council. The health care system is also dynamic and there are good reasons to suggest that the state will be called upon, in the future, to take a more active role in SUS.

- The immense size of Brazil and the large number of municipios in the country make it quite impractical to think that the forms of intergovernmental integration can be conducted without a state level intermediary. It should be noted that decentralisation requires a strong level on intergovernmental liaison around resource allocation, planning, quality assurance, technical supervision and human resource planning.

- Concerns over the existing inequity and the potential for increased inequity between municipios in Brazil will be raised in the following section. In order to deal with this, there are grounds for calling upon the state level to take a proactive role in supporting weaker municipios and developing resource allocation with a view to equity through state level health planning systems.

- Many of the municipios in Brazil are really too small to consider them as having the capacity to develop workable municipal health systems. Araújo [19] has listed at least five weaknesses, either political or technical, among the many municipios in order to cope with this process. Basically, they lack sufficient population size, expertise, leadership and resources. There is a role here for the state in not only supporting the weaker municipios but also in promoting inter-municipal consortia for the provision of health care. This would provide a more appropriate resource and population base for the planning, management and provision of health care. It would recognise the fact that the municipio is not, in many cases, of sufficient size to take on those roles internationally recognised for district health systems.

- We would question whether the municipios have the capacity and political will to regulate the private sector. There is a case here for looking into whether the state could co-ordinate the regulation of the private sector with the municipios.

In any process of decentralisation, the central role is that of giving a strategic direction to the health care system through planning and resource allocation, regulating the decentralised system and providing support (including technical supervision) to the periphery. The centre will also be required to take on specific operational functions that require a national perspective and authority. The size of Brazil requires the state level to strongly participate in these key functions.

### 3.3. Decentralisation and equity

The impact of decentralisation on equity is a complex issue. While health sector decentralisation is frequently justified in the name of equity, it can nevertheless lead to inequity [3]. It will be seen that inequity and decentralisation is a matter of some concern in Brazil.

In general terms it should be pointed out that the equitable pretensions of SUS are somewhat in contradiction with the wide social divisions in Brazilian society. Despite the emphasis on universality and equity the health care system faces problems of restricted access and inequity. Thus, Buss and Gadelha [12] point out
that access to health care in Brazil varies with income. The attempt to widen access through SUS has allowed some previously excluded groups, particularly in the rural and semi-urban areas, to improve their access to health services. These groups were largely excluded given the urban bias towards formal employment of the previously structured social security system. There is, however, still poor coverage of those living in semi-urban areas and particularly in the north and north-east. At a different level, service quality in SUS does not satisfy the perceived health care needs of the upper and middle-income groups, which tend to look to the private sector. It is becoming increasingly apparent that organised sectors of the working class, who were previously covered under the INAMPS system, are now looking to private health insurance.

There is an overall concern and debate around the level of resources used to fund SUS. Their unstable character and their link to declining social security funds within the context of a fiscal and financial crisis raises doubts over the viability of decentralisation in Brazil [10]. Should the provision of resources continue to be insufficient to meet the needs of municipal dwellers, then the drift to inequitable systems of private health care will continue.

On a more specific level, the concern here is that decentralisation has the potential to increase the level of inequity in the system. Five discussion points are relevant here.

Firstly, it should be pointed out that devolution, which is the form of decentralisation used in Brazil, is quite susceptible to inequity. As devolution can include local revenue collection for the municipal health care system, this tends to favour the well-off areas with their greater revenue collection capacity. Municipal tax revenue in Brazil depends on local property and service taxes, the income from which varies greatly between municipios. In order to gain a fuller understanding of municipal finances, account would have to be taken also of the regular transfers for the federal and state levels to the municipios and their impact on equity.

Secondly, the impact of transfers through SUS for hospital and outpatient care on equity has to be considered. We have already noted that these payments are made directly to providers in second grade municipios whereas in the first grade and more autonomous municipios sums are allocated to the Municipal Health Fund based on previous sums allocated through SUS. For the 1998 budget this was R$7.8 billion compared with R$2.2 (approx.) billions through PAB. This allocation has tended to be based on where the hospital and outpatient institutions are located, which historically tend to be in the richer areas of the south to south east and in the more urbanised areas throughout the country. This type of transfer has tended to reinforce the unequal allocation of resources in the country. Table 2 shows SUS federal transfers according to monthly per capita amounts to the municipios in poorer states (Acre and Paraiba) and the richer state of Sao Paulo. Municipalities in the state of Sao Paulo receive, on average, more than twice as much as the municipios of Acre.

Having said this, a review of specific municipio allocations of SUS funds shows considerable variation between municipios in the north and north east of the country.
Table 2
SUS federal transfers to the states of Acre, Paraiba and Sao Paulo (February–May, 1998 in R$ per capita)\(^a\)

<table>
<thead>
<tr>
<th>State</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acre</td>
<td>0.66</td>
<td>0.93</td>
<td>0.95</td>
<td>0.95</td>
</tr>
<tr>
<td>Paraiba</td>
<td>1.78</td>
<td>1.87</td>
<td>1.97</td>
<td>1.99</td>
</tr>
<tr>
<td>Sao Paulo</td>
<td>2.28</td>
<td>2.28</td>
<td>2.30</td>
<td>2.20</td>
</tr>
</tbody>
</table>

\(^a\) Source: population in IBGE tabnet, federal transfers in Ministry of Health tabnet.

Thirdly, we have to consider the impact of PAB on equity. PAB is in its infancy and is still limited in its impact. The simple population criteria of resource allocation used in the fixed slice of PAB funds is not necessarily guaranteed to direct resources to areas of greatest need. However, it does represent an important difference in comparison with SUS based funding. As we noted in the preceding paragraph, SUS allocation has been primarily directed to those municipios with existing health care institutions which are usually the richer municipios. The fixed element of PAB has meant that poorer municipios have seen an important increase in the amounts received for health care. Seventy per cent of the 5506 municipios in Brazil used to receive less than R$10 per person per year from federal transfers — these municipios have therefore gained under the new system. The variable element of PAB is not specifically designed to correct inequities and the sub-programmes are limited in their absolute amount of funds and the impact they can have. A great deal will depend on the criteria adopted by the federal level. Will it be based on the health needs of the respective populations or on the municipio’s capacity to present viable and convincing projects to the federal level? If it is the latter, we would expect that municipios more experienced in service delivery may well be more convincing in this respect.

Fourthly, there is an issue about policy direction of local government systems and the extent to which they themselves will develop local health care systems based on equity. Once again, a lot will depend on the way in which local health care systems are based on democratic processes, the type of central policy direction and the extent to which there is policy cohesion around progressive national health polices. An important issue in the PAB allocation mechanism is that of central direction of the Municipal Health Fund. Both fixed and variable PAB allocations come with central strings attached. Calculations suggest that while 3500 municipios used to spend ~ R$5 per capita on the areas covered under the fixed PAB allocation, they now receive R$10 per capita. The idea is to give a greater emphasis to primary health care activities. PAB resources are deposited in a special account in the municipios, the intention being to maintain a certain transparency in the process and ensure that these resources are not used for other purposes. The federal Ministry of Health, together with the states, are supposed to audit the use of PAB funds. The above raises the issue of municipal autonomy: Are the municipios devolved governmental authorities with a clear directive role in the development of
municipal health services? Alternatively, are they really deconcentrated units of central government following strict expenditure controls? Is there a trade-off here between central policy direction and the autonomous development of municipal health systems? Which of the two will produce greater emphasis on primary care is yet to be resolved.

Lastly, Misoczky and Ferreira⁶ have expressed concern over the selective and centrally controlled process of decentralisation and its impact on equity. Since 1994, 144 municipios achieved the higher level of decentralised health management, representing 17% of the national population and 24% of federal health budget. Through a cross-sectional exploratory study the authors sought to assess how this selective strategy to decentralise relates to inequalities in education, poverty, water supply and infant mortality rates. Results showed that regions with the worst conditions tended to have less population coverage by municípios and were in the third level of decentralised management. Where the conditions improve there is a higher population coverage by municípios which tend to be classified in the higher level. This pattern also happens within the regions and even within some states. They concluded that the selective strategy to implement decentralisation is reproducing and reinforcing inequalities. How the findings of the exploratory study are analysed is complex. Do we interpret the better quality of life in the decentralised municípios as the product of decentralisation? Is the better quality of life in those municípios part of a whole set of social and political factors which explain why they were chosen to be decentralised in the first place? This might explain why municípios in the richer regions of the south-east and São Paulo have a relatively high proportion of decentralised municípios — they are in better conditions to meet the regulatory requirements of decentralisation. However, Misoczky and Perreira point to the 22% of decentralised regions from the poorer north-east where political influences are used to gain decentralised status for the municípios. However, we interpret the findings, there is a clear need to conduct further research to understand the impact of decentralisation on equity.

4. Conclusions

Two important themes emerge from the above analysis. Firstly there is the obvious point referring to the political character of health sector decentralisation in Brazil. This is hardly surprising. Decentralisation is a reorganisation of the public sector — it is the product of political relations and conflict and similarly acts as a major determinant of how those political relations are conducted. It is the product of a political process and similarly influences access to the policy-making process. This study serves to underline this political character and provide an insight into the political form taken.

⁶ See footnote 2.
Secondly, by understanding cases such as Brazil heightens policy-making awareness of some of the key issues vital to the effectiveness of decentralisation. This article has referred to three such conditions: the policy-making process, equity and the role of the state. Depending on the policy conditions, decentralisation can lead to either greater equity or inequity. In order to give rise to equity, programmes of decentralisation have to be linked to policies on, for example, national health planning, resource allocation, community participation. Only in this way will the equity credentials of decentralisation be secured. The analysis has also suggested the need to focus on district support through intermediary levels, such as states, regions and provinces. Robust national policy-making systems should be able to assess whether such lessons apply to national programmes of health sector decentralisation.

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References

[16] Secretaria de Assistência à Saúde (SAS), Brasília, 1996.