United Nations Research Institute for Social Development

Working Paper 2014-20

Political and Institutional Drivers of Social Security Universalization in Brazil

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prepared for the UNRISD project on
Towards Universal Social Security in Emerging Economies: Process, Institutions and Actors

December 2014

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Acronyms

CGU	Comptroller of the Union (*Controladoria Geral da União*)
COFINS	*Contribuição para o Financiamento da Seguridade Social*
CPMF	Provisional Contribution on Financial Transactions (*Contribuição Provisória sobre Movimentações Financeiras*)
CSLL	*Contribuição Sobre o Lucro Líquido* (contribution on net profits)
GDP	gross domestic product
INAMPS	Social Security Health Care Institute of the Social (*Instituto de Assistência Médica da Previdência Social*)
LAPOP	Latin America Barometer
OECD	Organisation for Economic Co-operation and Development
PFL	Party of the Liberal Front (*Partido da Frente Liberal*)
PMDB	Brazilian Democratic Movement (*Partido do Movimento Democrático Brasileiro*)
SUDS	Unified Decentralized Health System
SUS	Unified Health System (*Sistema Unificado de Saúde*)
UK	United Kingdom
US	United States

Abstract

This paper discusses the political and institutional factors that shaped the emergence and consolidation of a universal health system (SUS) in Brazil after the transition to democracy in the late 1980s. The paper argues that a combination of political incentives and political, fiscal and institutional capacities have been at the root of the process of creating such a system. First, the political incentives have been associated with a competitive political system leading a race to serve poor constituencies and to the policy communities and activists within and outside the state. SUS benefitted from this political dynamic and thus became politically sustainable. Second, fiscal capacity and sustainability have been secured by a massive increased taxation and earmarked social expenditures. Third, the system's success stems from the institutional capacity to run a complex decentralized system. The system appears to reach its limit in terms of the capacity to extend coverage in a context where there is universal formal entitlement to health, but some 30 per cent of the population has access to private insurance. Despite many improvements, many challenges continue to beset the delivery of health care in Brazil, and addressing them adequately will require significant policy changes, not only additional resources. However, finding resources has proven increasingly costly politically and improvements will have to be achieved through efficiency gains. Politically, this is a situation of a zero sum game rather than that of the positive game typical of coverage expansion. Most importantly, the perceived increased personal risks are leading citizens to support creating new resources for the system and for policies to improve the quality of care. A new window of opportunity thus seems to have been opened.

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Introduction

In Latin America, 19 countries have included the right to health in their constitutions. The question is, however, not the mere rhetorical adoption of the right to health in constitutions and political discourse but the actual implementation of this ideal. The case of Brazil is of particular interest because it seems to be the country where this constitutional ideal has been implemented most forcefully and has made a significant progress to universal social security by establishing a system to provide universal access to health care to its citizens.

Reformers in Latin America and elsewhere have recently drawn inspiration from the Brazilian case in the wake of unprecedented recognition of the international development agenda that universal systems are crucial to overcome poverty and reduce inequality (Editorial 2012). While the organization and structure of the Brazilian social security system and its achievements and constraints are relatively well known, less attention has been given to explaining the institutional and political drivers for the universalization of health security in this country. Although its accomplishments have been widely acknowledged, the system has been under considerable stress recently. How did this system come to enjoy such legitimacy and what makes it politically and institutionally viable? Several contributions have described the historical conditions leading to the establishment of the Unified Health System (*Sistema Unificado de Saúde* or SUS) and many focused on the role and the contribution of the *Movimento Sanitário*, a movement of health professionals, as the origin of the system (Faletti 2010). The governance mechanisms and the role of civil society in the workings of the health councils have also been investigated in the literature (Faletti 2010). The institutional factors have indeed been well analysed in the scholarly literature. This paper reviews the institutional and political drivers of universalism focusing on the factors that made the system currently in place politically and institutionally viable: the nature of political competition in the country; a shared belief in social inclusion and universalism; issues such as institutional and organizational capacity; and the creation of fiscal capacity for the operation of the universal health system and more generally of a universal social security system.

The paper is organized as follows. First, I present some contextual information on the evolution of SUS in Brazil in the context of the broader transformation of the social security regime from the late 1980s onwards. In section 1, the focus is on the democratization process and the new Constitution of 1988 and its impact on the system of social protection. I summarize the main institutional innovations and describe the underlying political process. I show how the universalistic principle was socially constructed during the process of transition to democracy and argue that the principle of universalism was an overarching ideal that can be found in health care, social security and social assistance. It is part and parcel of a deeper transformation within the Brazilian society. Section 2 provides a concise evaluation of the SUS reforms with a focus on how the formal entitlement to health care was translated into effective access to health care. I provide some basic information on the progress achieved in health care and on the constraints affecting the system.

Section 3 focuses on the institutional and political drivers of the reform process and of social policy making in the 1990s and its sustainability in the 2000s. The first factor that is discussed is political competition in an environment characterized by a strong coalition government and relatively robust checks and balances that prevented the system from degenerating into personalistic rule. Competition for the median voter and a shared belief in fiscally sustainable social inclusion shaped social policy making in

ways that partly explain the success in building a relatively successful inclusive social security regime. Strong executives guaranteed that the reform agenda was implemented and the commitment to inclusion translated into effective policies. This unprecedented outcome contrasts with earlier predictions about governability problems and Brazil's inability to implement a reform agenda.

The second factor discussed in section 3 is the macroeconomic environment that guaranteed fiscal capacity and a significant increase in taxation that allowed a rapid and impressive increase in social spending. This section also considers the underlying politics of financing social security expansion over the last two decades. Section 3 concludes by discussing institutional capacity, which I argue is a precondition for effective implementation of such complex innovations, in a vast country marked by regional heterogeneity and striking territorial inequalities. Without a strong bureaucracy and effective audit systems, the programme of fiscal decentralization and devolution to lower levels of government that Brazil embarked upon would have failed.

Throughout this paper universalism[1] is used liberally to indicate impersonality, coverage, non-conditionality and formal entitlement to free-of-cost services depending on the issue area discussed: pensions; social assistance; or health. In the case of health, which is the focus of this paper, it means that people have a formal entitlement to free health care provided by the state.[2] How this formal entitlement translates into actual practice is conditional on a variety of factors, including health facilities, which may reflect inequality in other relevant dimensions. In pensions, universalism is a commitment to eliminating inequalities and privileges of various types, while in the realm of social assistance it is a commitment to eliminating any conditionalities in accessing publicly provided goods and services. In this paper, in general, universalism refers to the absence of discretionary criteria replacing need as the basis of entitlement.

1. Toward Universalism: Democracy, the Constitution of 1988 and the New Social Contract

Universalism in social security was part and parcel of the Brazilian developmental process whereby it became a foundational principle. Indeed, it is enshrined in the constitutional principle that health is a right of citizens and an obligation of the state (Constitution of 1988, Articles 6 and 196). In this section, I show that the right to health

[1] It is interesting to note that the notion of universalism has been subject to considerable conceptual "overstretching" and is cause of great confusion. In addition to a lack of clarity, the notion of universal access or coverage in the area of health care, pensions and social assistance tend to have a different meaning. In the area of pensions, it is typically understood to mean that all people have access to universal flat pensions irrespective of past contributions (administrative or actuarial universalism). This is the strong version of universalism in pensions, which in practice means that additional coverage beyond a certain limit would be provided by private insurance. A weaker version of universalism in social security is that pensions are granted according to the same rules irrespective of occupational status—which for middle-income countries such as Brazil would require the equalization of benefits across rural and urban groups and within urban groups across public sector employees and other special categories—but are conditional on past contributions. In this version—a Bismarkian or corporatist model—labour market inequalities are reproduced in the pension system but this would be the only acceptable inequity in the system. Thus, the level of the ceiling, in practice, determines the private/public mix or the extent of "de-commodification" in the system. In social assistance, the language of universalism is typically associated with the extent of coverage and access for the poor, the elderly and those excluded from the labour market. The key element in this case is impersonality and non-discretion. Thus, this definition does not restrict universalism to policies that are not conditional on the beneficiary meeting certain requirements—a usage usually found in the social policy literature. Universalism in this literature describes a situation where the entire population is the beneficiary of welfare benefits as a basic right, as opposed to targeting, which involves some kind of means-testing to determine the "truly deserving" (see Skocpol 1991; Antonnen 2002; Mkandawire 2005; Antonnen et al. 2012).

[2] The World Health Report 2010 defines the principle in *prima facie* similar fashion: universal health coverage as a target in which "all people have access to services and do not suffer financial hardship paying for them" (World Health Report 2010:Ix). But this definition involves a consideration of capacity to pay that is absent from the former definition. As demonstrated in this paper, this has produced some perversity in SUS.

stipulated in the Constitution has far deeper implications than simple access to goods and services provided by the state. The adoption of universalism in many areas of welfare provision is intertwined with the transition to democracy in the country. The development of Brazil's welfare regime, therefore, can be explained as a process where welfare and democratic regimes are interlinked. The empowerment of large electorates and a level playing field have indeed created strong incentives for the expansion of health care and social transfers.[3]

Dubbed as "transition by transaction" in the literature on democratic transitions, Brazil's transition to democracy was a protracted process characterized by extensive intra-elite bargaining. The political process of the transition was intertwined with the fiscal crisis of the developmental state in the 1980s. Having achieved unprecedented growth rates under the military during the so-called Brazilian miracle (1967–1973), the Brazilian economy lost dynamism in the late 1970s, and in the 1980s entered a period marked by macroeconomic imbalances. High public deficits and balance-of-payment problems ushered in a period of hyperinflation (Frieden 1992). The regime began to liberalize as a result of the loss of legitimacy arising from the deterioration of economic performance and as a consequence of the extensive mobilization of a heterogeneous coalition of forces, including opposition parties, civil society organizations, trade unions and business groups.

Brazil formally started its transition to democracy in 1985 when military rule gave way to civilian rule amidst intense political mobilization. In the wake of a protracted transition process, which contrasted with other countries in the region, a complex bargaining process took place in which reformist political elites played a crucial role. Democratization was made possible as a result of an inter-elite pact. A coalition of centre-Left and centre-Right political forces dominated the transition agenda. The former, represented in party politics by the Party of the Brazilian Democratic Movement (*Partido do Movimento Democrático Brasileiro* or PMDB), enjoyed a hegemonic position in this coalition in which the Party of the Liberal Front (*Partido da Frente Liberal* or PFL)—a dissident faction of the pro-regime Social Democratic Regime—was the junior partner. In the centre-Right political forces, the military retained veto power in matters concerning the armed forces and other key policy areas.

The new democracy's policy agenda was shaped by a policy-making process in which the legacies of the bureaucratic authoritarian military regime (1964–1985) and a long tradition of political opposition was characterized by a collective endeavour and consistent criticisms that were largely from (but not exclusively) opposition circles—and, in particular, from the professional and intellectual elites. In this process, the opposition groups regarded the country's so-called "social debt" as a result of excessive bureaucracy, an extremely centralized decision-making process, the permeability to sectoral interests and a tendency of public policy toward excluding the needs of the poorest. For the new reform agenda, social inclusion and redistributive issues became key priorities. At a more specific level, this agenda addressed an array of issues related to the modus operandi of public policies and proposed changes. Lack of participation and "transparency" in policy making were viewed not only as having caused a structural bias in favour of middle–income groups, but also as having contributed to the business groups' capture of resources allocated for the provision of public goods and services. Gigantic bureaucracies were seen as groups pursuing only their narrow organizational interests and dissipating public money. Decentralization and participatory practices

[3] Rudra and Haggard 2005; Ross 2006; Mares and Carnes 2009.

were thus proposed as a means to overcome these problems. A new political coalition was formed, consisting of the urban middle class, the Catholic Church, trade unions, civil society groups, business groups and alliances between the PMDB and the PFL.[4]

Reformers advocated a number of *idées forces*: democracy and popular participation; decentralization; and above (all) giving priority to the social agenda and inclusion, which meant in practical terms universal coverage of social security. A strong consensus among social actors emerged, leading to what could be called a new social contract in this context. Although the concept of a social contract implies a "choice" by each country regarding the way of organizing itself, it is in effect the result of a process of social choice that aggregates individual preferences in the context of specific political institutions, which are in turn endogenous to the social contract. In other words, the social contract determines the institutional choices made (Alston et al. 2013). The Brazilian social contract is encapsulated in the new Constitution of 1988, which was a critical juncture in the evolution of the Brazilian system of social protection. One of the most important innovations in the Constitution is the move toward what is called in this paper a special type of "universalism" in the sense that coverage is extended to reach all members or at least very large groups in the population as opposed to being targeted at specific clienteles, such as certain occupational groups or privileged groups. To argue that universalism has been an underlying leitmotif of the Constitution does not mean that the system of social security currently in place in Brazil is without certain privileges or inbuilt inequalities in terms of processes and particularly outcomes. As discussed in various sections in the paper, although privileges within the system have been gradually eliminated, certain categories of beneficiaries—public servants and specific categories of workers—have continued to receive special treatment.

Prior to the 1980s, the system for social protection was highly fragmented. In its formative years, it provided social protection—pensions and health care—to a few urban occupational categories. Under military rule, the system was overhauled and was partially consolidated. The systems of pensions and social assistance were fragmented and the rural poor and the urban informal workers were excluded from social protection, although some initiatives extended coverage to rural labourers in the 1970s. Access to health care was even more limited. Workers in the private formal sector of the economy with health insurance had very limited access to health care through private and public hospitals. The first attempt to rationalize health care under the social security system involved the creation of the Social Security Health Care Institute of the Social (*Instituto de Assistência Médica da Previdência Social* or INAMPS) in 1977, a public organization under the jurisdiction of the Ministry of Health, which took charge of managing health care provision. However, the system was chronically underfunded, restricted in coverage and mainly limited to emergency care (ER).

The reform agenda in the 1980s reflected a widespread recognition of the extant system's clear failures in many senses. Reformers consisted of a loose coalition of academics and professionals (some of whom were elected as members of Congress), civil society activists and government officials who pushed for an agenda based on three pillars.

First, a number of constitutional provisions extended care to the previously excluded social groups to guarantee universal access. The Constitution contained a strong statement that recognized health as a universal right of citizens, and obliged the government to provide universal and equal access to actions and services for health promotion,

[4] The PMDB was the main opposition party under the dictatorship and the PFL was founded by a group of defectors from Arena, the party that supported the military regime.

protection and recovery (Brazilian Constitution of 1988, Chapter 2, Article 196). The Constitution mandated the equalization of the rights and benefits of rural and urban workers in the social security system. Based on this, for the first time rural benefits were upgraded to the level of urban pensions (Melo 1991, 1993; Barrientos 2013). Not only the minimum pecuniary value of pensions was set at that of urban pensions and benefits and scaled up to the level of the minimum salary, but a whole range of benefits that had only been available to urban workers was also extended to rural workers. As a consequence, for the first time rural benefits were upgraded to reach the minimum salary. For health care, the main practical implication was that access to the system would be granted to all citizens irrespective of previous contributions or occupational categories or urban/rural status.[5] The new Constitution also resulted in the massive extension of effective health care coverage to rural workers through various mechanisms of primary care.

Second, unifying the system was seen as a precondition for the implementation of these constitutional provisions because there was a consensus that a fragmented system could not be a basis for universal coverage. In practical terms, this required the organizational overhaul of the system. For the pension system, it meant that the existing stratification of benefits and eligibility criteria should be equalized. The major organizational innovation was the phase-out of INAMPS, with its function transferred to the Ministry of Health. In unifying the fragmented health system, the government gave priority to preventative care measures, with all the decisions made based on the epidemiological profile of the population.

The third pillar was a growing consensus on the lack of resources, unsustainability of a purely contributory system and the necessity to allocate resources from the earmarked taxes for the guarantee of the universal component of social security, which required the overhaul of the funding mechanism. In addition to workers' and individual payroll contributions, new sources of finance were introduced. New taxes—the so-called social contributions—were created. They included a new tax on total revenue or turnover—the *Contribuição para o Financiamento da Seguridade Social* (COFINS)—and a new social contribution on net profits—the *Contribuição Sobre o Lucro Líquido*. This innovation had a symbolic importance because it signalled the break with the contributory principle informing the functioning of the extant system.

Although the new democratic Constitution embraced the principle of universalism and extended social rights significantly, it also confirmed existing privileges. It maintained a dual pension system with a pillar for private sector workers and the salaried and a separate subsystem for public employees. Inequality in the provisions of pensions in the two systems remained intact. Public employees also managed to secure privileged civil service status in the pension system and the benefits of civil servants (a full replacement rate for pensions and tenure status, among others) and 300,000 workers with contracts in the public sector (the so-called CLT contracts) were increased. This resulted in a significant actuarial deficit in the system because it created a disconnection between past contributions and current pensions and a potential gap between the insufficient current contributions and future pensions.

Several important changes in the welfare system accompanied the transition to democracy and even preceded the promulgation of the Constitution. The new civil government of

[5] Interestingly, most urban unions—along with senior bureaucrats in the planning and finance ministries—opposed this move with the argument that it might jeopardize the financial basis of the system, but it was strongly supported by the Confederation of Agricultural Workers (Contag) and by reformist legislators and bureaucrats.

José Sarney (1985–1990)[6] created the Unified Decentralized Health System (SUDS) and introduced several changes in the health-care subsystem, including the elimination of barriers to entry for the non-affiliated poor.[7] However, the crucial move was the creation of SUS in the Constitution, which aimed at universalizing access to health care and improving its quality, for example, through a more decentralized and participatory delivery of services. The constitutional provisions affecting the social security systems included a number of far-reaching measures (Articles 201 and 202), which, however, were implemented by a host of organic laws, including the Health Organic Law (Law 8080/1990) and the Social Security Organic Law (Law 8212 and Law 8213/1991).

In sum, the implementation of SUS occurred in three phases. First, before the formal creation of SUDS (the system that preceded SUS) in 1985, some initiatives were implemented selectively in a number of municipalities under the Integrated Health Activities (AIS) (a federal programme). This involved a shift toward increased outpatient care, more efficient use of INAMPS facilities and some degree of decentralization. Interestingly, this was a time of intense social mobilization by health professionals, experts and professional unions known as the *Movimento Sanitarista*. This movement was highly successful in transforming grassroots support into policy and institutional change. The apex of this mobilization was the 8th National Health Conference, when a motion calling for health as a citizens' right and a public responsibility was approved, opening the way for the approval of a similar proposal during the workings of the Constituent Assembly (1987–1988). In the second phase, INAMPS was converted from a dual financer/provider role to solely a financing agency; access to INAMPS funding was universalized and INAMPS staff and facilities were transferred to state health secretariats. These changes occurred during the 1988–1989 period before the promulgation of the Health Organic Law. The last phase essentially involved the transfer of public responsibility for health care to the municipal level (Paim et al. 2011). This was accompanied by the creation of municipal and state health councils with broad representation from health-care users, providers and workers, and strong connections to policy makers. Weak at the beginning, these councils mushroomed across the country and over the last two decades have been strengthened and become key actors in health policy making and implementation.

It should be noted that these processes were far from linear and met resistance from a myriad of actors. During the Sarney presidency (1985–1990),[8] conservative sectors associated with vested interests and patrimonial politics were very influential and were able to offer some resistance to changes. However, the balance of forces in Congress led to the progressive implementation of the reform agenda. Thus, the changes called forth by the Constitution of 1988 and the subsequent organic laws reflected not only the new universalistic democratic demands, but also the interests of small groups and clientelistic influence in policy making. This was exacerbated because of the overall fragmentation of the coalition during the conservative government of Sarney that made the transition to democracy possible. This ushered in a period of clientelistic degeneration, which affected the nature of the new legislation. However, despite the protracted period of implementation of the new agenda, many of the constitutional provisions have been put in place.

6 Elected as vice-president, Sarney was inaugurated following the death of President-elect Tancredo Neves.

7 Previously, patients had to produce proof of an employment relationship prior to being admitted to the system.

8 Sarney, a former member of the military's party Arena, was elected vice-president in the election of 1985 that brought Tancredo to power and became president following Tancredo's unexpected death. A minor figure overshadowed by powerful political figures from the historical opposition, Sarney used the political resources of the government machine to forge a clientelistic alliance with conservative groups, leading to some delay in the implementation of the reform agenda.

President Fernando Henrique Cardoso (1995–2002) changed the Constitution so as to exclude several provisions that benefited public employees, but not private pensions, in an attempt to equalize the rules and entitlements. This was the first important reform of the system put in place as a result of the Constitution (Melo 2003). These parametric reforms made the system marginally more equitable and were approved as Constitutional Amendment (20/1998), which eliminated many distortions regarding replacement rates, special privileges and minimum age requirements for private sector salaried workers.[9] In addition, it eliminated the use of time spent at school and several other situations in the calculation of "contribution time" required for retirement. More importantly, it eliminated the "retirement for time of service system" by passing the proposal for the *fator previdenciário*—a mechanism similar to the Swedish notional accounts system allowing for the automatic adjustment of contributions to rising life expectancy.

Nonetheless, it was up to the Lula (2003–2010) government to introduce ceilings in public sector pensions (Constitutional Amendments 41/2003 and 47/2005). The Rousseff government (2011–2014) further provided the enabling legislation that made the new complimentary system—the *Fundo de Previdencia do Servidor Público* (FUNPRESP)—effective (Law 12618/2012). By doing so, the move toward universalism has finally been completed. Confirming the argument that only Left-wing reformers are politically able to implement structural reforms that adversely affect a democracy's big constituencies such as public sector workers ("the Nixon goes to China argument") (Mares and Carnes 2009), the Workers' Party (*Partido dos Trabalhadores* or PT) has been able to finally conclude a cycle of reforms of the system that started in the late 1980s and was a product of a much broader coalition. The ongoing existence of separate subsystems for public sector and private sector workers means that the goal of a universal contributory system has not been achieved.

Current debates on the social security system focus on the financial sustainability of the system and on some equity issues resulting from the existing rules due to the stock of current pensions rather than on the rules applicable to new entrants.[10] The main innovation in social protection in the last decade, however, has been the rise of conditional cash transfer programmes. Notwithstanding the fact that it is conditional and targeted—therefore, *prima facie* belying the ideal of universalism, the scope of *Bolsa Família* now reaching over 50 million people—makes it universal in the sense discussed before: it is non-discretionary and needs based. The *Bolsa Família* is part of a new generation of programmes that are cross-sectoral combining social assistance with health care and educational conditionalities.

Having succinctly described the main innovations in social security that accompanied the move to democracy, I now turn to the analysis of the implementation of SUS over the last two decades and to an assessment regarding to what extent its main objectives have been achieved and, in particular, to what degree universalism has been attained. The following section is rather descriptive and focused on the available empirical evidence in the current literature. I then explore the factors that might explain these

[9] Amendment 20 eliminated the so-called *aposentadoria proporcional* by which early retirement was granted to private and public sector workers at a replacement rate supposedly proportional to the beneficiary's contribution time. Other changes included severe minimum time for eligibility to new public servants' pensions who had participated before in the private sector pension regime and the delinking of public sector pensions and current pay (for the same occupational status) (Melo 2002, 2004).

[10] These developments are leading the two systems to converge in terms of new pensions, despite the fact that the current stock of pensioners carries most of the pre-existing inequalities in terms of eligibilities. The fact that the system is relatively mature and the present value of future pension expenditures is so high makes it extremely difficult to radically reform it, for example, by introducing a capitalized pillar; thus, parametric reforms are likely to be implemented along these lines.

developments focusing, in particular, on SUS' political sustainability over the last two decades. I consider the factors that explain why such a system has emerged and persisted and the political incentives of the universal social security system along with its institutional, economic and fiscal underpinnings.

2. Has Universalism Paid Off?

This section presents empirical evidence on the performance of SUS in terms of providing effective access to health for all as a preliminary step to its political and institutional underpinnings. It is because the net balance of the evidence is largely positive that it makes sense to investigate the factors that made SUS feasible and sustainable. Universality is the founding principle of SUS and, therefore, it is expected that the population would have full access to health care as needed. The relevant question here is to what extent the formal entitlement to free health has actually materialized. According to a recent comprehensive World Bank assessment of the SUS reforms, the answer is largely positive, but with some mixed findings.[11] Undeniably, there have been great improvements over the last two decades in a variety of indicators, including more resources devoted to health care, a significant increase in the number of medical facilities, explosive growth in the number of family health units, diminished variation in the density of hospital beds across regions and states, massive decentralization in health care and a change in the mix of public/private hospitals toward more public facilities (table 1).

Public spending on health has risen significantly, especially in the last decade, to around 4 per cent of gross domestic product (GDP), a level broadly comparable with the average of countries at similar levels of development, and has been increasingly redirected to financing primary health care. Government spending on health increased 224 per cent in real terms between the first half of the 1980s and 2010 (a 111 per cent increase in per capita terms) (Gragnolati et al. 2013). This impressive growth in government spending on health reflected not only economic growth, but also the enhanced centrality of health, in particular, primary health care. Government spending on health as a share of GDP has increased significantly since 2003 although as a share of social spending it has stabilized (more on this in section 3).

Table 1: Indicators of changes in the health-care system under SUS

	Circa 1989	Circa 2009
Number of health-care facilities	22,000	75,000
Number of hospitals	6,342	6,875
Family health units	4000	31,6
Hospitals/municipal (per cent)	11	50
Hospitals/public (per cent)	22	35
Federal transfers for primary care (per cent)	11	20
Municipal share of hospital beds (per cent)	11	50
Federal share in public health care financing (per cent)	85	45

Source: Author's tabulation with original data from Gragnolati et al. (2013).

The last 20 years also saw an impressive reorganization of service delivery. The capacity of the system has expanded significantly as a result of the expansion of the outpatient network due to the new emphasis on primary care; despite the fact that the network of hospital facilities remained relatively unaltered. The meteoric growth in the number of

[11] Gragnolati et al. 2013; Couttolenc and Dmytraczenco 2013; see also Paim et al. 2011.

family health units (teams) led to an expansion of coverage that reached over 100 million people (roughly over 50 per cent of the population). This was accompanied by a dramatic transfer process of responsibility for service delivery to the municipalities, whose share of hospital beds quintupled between the late 1980s and 2010. The system also improved in terms of regional disparities in access to health care and facilities. The convergence was essentially caused by the improvements in the poorest regions of the country—the northeast and the north—rather than a worsening of conditions in the most developed states and regions. The change that occurred regarding the mix of public-private hospitals in the system was not a goal when SUS was implemented.

Has the formal entitlement to free health actually been translated into better observed access? According to data compiled in the World Bank authoritative report, the answer is a qualified yes. In 1981, 49 per cent of the population reported that Social Security or INAMPS was their "regular source of care", while another 19 per cent reported that they relied on the public system or free philanthropic care. By 2008, only 58 per cent of individuals reported being regular users of SUS. As the report concluded, "if measured based on self-reported 'regular sources of care', the goal of bringing a larger share of the population into the public health system has not been achieved. However, other evidence suggests that nearly all Brazilians use SUS services at some point, including a recent study indicating that nearly 90 per cent of the population uses SUS exclusively or in combination with the private sector" (Gragnolati et al. 2013).

The World Bank report also considered other metrics for the assessment of access, including the volume of services provided by the system. By this metric, the expansion of the system has been impressive: the number of medical consultations per capita increased by 70 per cent between 1990 and 2009. If the emphasis is put on primary care procedures, then the expansion was even more remarkable. However, hospitalizations in SUS or the INAMPS system remained stagnant during that period at around 11.5 million. Evidence from survey data shows the same positive increase in access: "the share of individuals who reported seeking some form of health care in the last two weeks increased by nearly 30 per cent between 1986 and 2008" (cited in Gragnolati et al. 2013). This reversal of the previous pattern, which was centred on hospital care, suggests that SUS significantly increased access to primary care, as envisaged by reformers when the system was put in place. Other indicators arrive at the same conclusion: the type of services used by households changed over time, with preventive visits and dental consultations accounting for a growing share of all visits. There has been some convergence in utilization rates across states and socioeconomic groups. Although geographic disparities in utilization have declined to a certain degree, a significant income gradient remains in average utilization rates across states. There is a significant differential across income groups, with higher levels of utilization among high-income groups: "household survey data indicate that utilization rates are around 50 per cent higher for the top two deciles than for the bottom two" (Gragnolati et al. 2013).

However, there is evidence that the system has failed in several aspects, an outcome that was partly unanticipated. Despite the much-enhanced coverage, it remains uneven and inequitable. About one-third of the population does not receive even one consultation per year and SUS covers a smaller share of health costs in the lower decile than in the middle and upper deciles of the income distribution (Ter-minassian 2013). Richer households resort to SUS services for the more costly specialized treatments, while using supplementary private health insurance for basic consultation and exams (Medici 2003; Mobarak et al. 2011). A non-anticipated outcome of the constitutional right of the right to health is that citizens increasingly have resorted to the judicial system to ensure

costly treatment that is rationed because of the universal and free-of-charge nature of the system (Menicucci and Machado 2010). Richer patients are more likely to know about new procedures and drugs and, therefore, have the resources to seek legal injunctions. This has caused considerable financial stress on SUS. While there appears to be no figures on this issue for the whole country, in the state of Rio Grande do Sul, Biehl et al. (2009:2183) found that in 2006 alone 6,800 medical–judicial claims reached the Attorney General's Office, an increase from 1,126 in 2002. By 2008, an average of 1,200 new cases were reaching the office per month. This study found that "in 2008, $30.2 million[12] was spent by this state of 11 million people on court-attained drugs for about 19,000 patients". This represented 22 per cent of the total amount spent on pharmaceutical drugs that year and 4 per cent of the state's annual projected health budget—one-third of which is for high-cost drugs not provided through the public health-care system (Biehl et al. 2009:2183).

This means that this perverse mechanism ends up reproducing inequality in the system. The source of the problem is the inconsistency between an open-ended service package and the reimbursement of a limited list of services within the system. Patients litigate to have access to services not on the SUS list. Providers seek injunctions against private insurers in court with the requirement to reimburse SUS for the cost of services provided to SUS patients, based on the principle of universal coverage. As Gragnolati et al. (2013:47) argued: "However, as a mostly political process, the decision to grant universal and free coverage to health care was not accompanied by a discussion of the resources needed to support it".

Ter-Minassian (2013) argued that the "universal and free-of-charge character of the system entails rationing through queuing, resulting in late diagnoses and substantial delays in accessing treatment (estimated to average 76,113 days for different types of treatment)". Not surprisingly, therefore, surveys show high levels of popular dissatisfaction with public health services. Quality control of the services provided by the system is widely considered inadequate. There is a need to extend and strengthen accreditation procedures for the whole range of health providers, develop and keep up-to-date appropriate protocols for the treatment of endemic diseases and better integrate diagnostic and curative services.

3. Explaining the Political, Institutional and Fiscal Sustainability of Universalism

Brazil's transition to democracy was associated with an important change in mass beliefs. As argued in Alston et al. (2013), inclusion and universalism became part of the language of politicians and the organizing principle of political life. The Constitution encapsulated these new beliefs, but this has also been true for other constitutions in the Latin America region.[13] What factors explain the emergence and the sustainability of these beliefs and ultimately, one decade later, the widespread universalistic outcomes? Many countries have introduced innovations in social policy only to discontinue them later.[14]

A crucial question then is what explains the viability of the reforms that were undertaken. In this section, I argue that there are three crucial factors: political incentives; fiscal capacity; and state capacity. Savedoff et al. (2012) made the point that all countries that

[12] All references to $ are to United States (US) dollars. All references to R$ are to Brazil reals.

[13] Beliefs are shared mental models mapping institutions in the broad sense and outcomes (North 2005). Therefore, they are related to values and preferences, but are distinctive. The belief in inclusion implies that universalism may be causally associated with some desirable outcomes. See also Melo and Pereira (2013) and Alston et al. (2014).

[14] Rudra and Haggard 2005; Rudra 2007; Segura-Urbiego 2007.

successfully managed to guarantee universal health care have combined political mobilization, and pooled compulsorily extracted funds and an increase in incomes. Political mobilization is indeed crucial, nonetheless, this framework fails to take into account the incentives arising from electoral competition in new democracies.

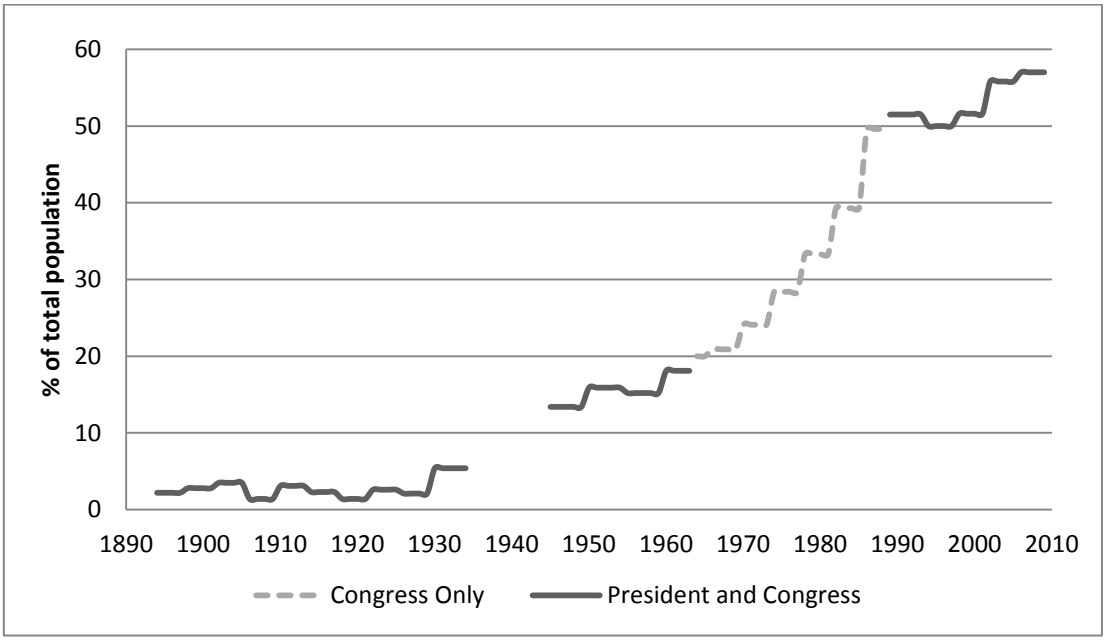
Political incentives for universal social security

A crucial factor explaining the move toward a universalistic welfare regime is the existence of political incentives for power holders. Political competition for the median voter in a new democracy provides a powerful incentive structure. Competitive elections will lead to newly enfranchised citizens to massively support redistribution and inclusion, and social security is clearly a crucial part in this process. Figure 1 shows the rise of a mass electorate in Brazil. It shows the extension of the franchise that took place with democratization and the evolution of the proportion of total population that effectively voted for president and Congress from 1894 to 2006. Only in 1985 did Brazil authorize the right to vote to illiterates, so the first time that a majority of the Brazilian population voted for president occurred in the 1989 election. The previous presidential election had been almost 30 years earlier and less than 20 per cent of the population voted in that election. Although Congressional elections took place during the 1964–1985 period, these were clearly of a less significant nature. This implies that the political scenario initiated in the 1990s was remarkably different from anything that the country had ever experienced before. Thus, the incentives for politicians were of a vastly different nature than those of previous periods. This is particularly true and relevant for the case of the president given the strong presidentialism that prevailed after the 1988 Constitution.

The electoral races have been particularly competitive. Out of six presidential elections that took place after the redemocratization, on only two occasions—1994 and 1998—was the decision taken in the first round (by margins of victory of 27 and 22 per cent, respectively) and on four occasions there were very competitive run-off episodes. The margins of victory were 12 per cent in 2010, 20 per cent in 2006, 19 per cent in 2002 and 6 per cent in 1989. More importantly, the presidential race involved two social democratic parties, the Workers' Party and the Party of the Brazilian Social Democracy, which in different degrees were committed to a programme of social inclusion and universalism. During the vote in the Constituent Assembly, legislators from both parties supported universal health care and a generous social security system.

Since the early 1990s, the national political agenda has been dominated by a discourse that has emphasized the expansion of coverage in the system and the need for increased funding for it. In sum, the political market has been very competitive and equally important elections have been fair and transparent. Universal social security is an outcome that is consistent with theoretical expectations about competitive democratic elections in contexts of high exclusion, inequality and poverty. Because the mean income is higher than the median voters' income, it follows that strong pressure will emerge for redistribution (Melo et al. 2014). This pressure is a key point of the political viability and sustainability of universalism as a programmatic goal. Electoral institutions with integrity and political competitiveness are crucial in assuring this outcome. If the system is competitive, then politicians converge on the need to politically serve the interests of the median voter. The medium and long-term consequence of this convergence is that the process becomes path dependent. A large clientele of social security beneficiaries, ranging from old age and survivors pensioners to end users of medical facilities, makes up a formidable interest group with much political clout.

Figure 1: Per cent of total population that voted in presidential and congressional elections, 1894–2010



Notes: Data are for the total number of voters that actually voted and not the number eligible to vote. Data for congressional elections are for the period after 1933 and is very close, but not identical, to that for presidential elections. Source: Alston et al. (2013).

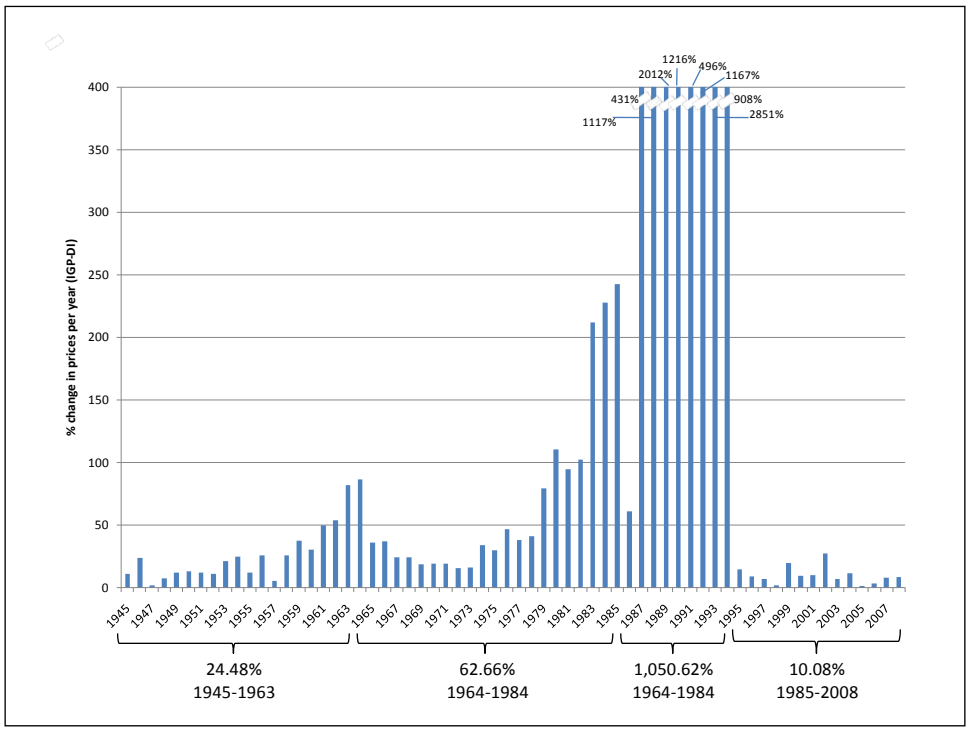
There is robust empirical evidence that electoral pressure from SUS users are correlated with the number of clinics (affiliated with SUS), doctors and nurses per capita. All three inputs are higher in counties with a higher percentage of poor people in the population (a higher Gini coefficient, holding per capita income constant) and a higher percentage of citizens favouring redistribution (as measured by the share of votes going to candidates favouring explicitly redistribution in the 1998 presidential election). They are also higher in municipalities with higher per capita incomes since this increases the public budget constraint. Mobarak et al. (2011) found that the importance of political factors depends on the health inputs examined. The percentage of the population that votes and the mayor's vote share in the 1996 elections correlated positively with the number of clinics and the number of consultations in the municipalities, a finding also present in terms of per capita health budget. However, the same is not true for less salient health indicators, namely the number of SUS doctors and nurses per capita. Kuhn (2012) reached similar conclusions in a study of local health spending: partisanship and electoral competition matters for the proportion of health expenditures at the municipal level. Political competiveness matters: regardless of voter's preference, if there is a strong partisanship and fierce competition, health expenditure increases.

Another key factor explaining the sustainability of universalism is political stability. Indeed, this is as crucial as political competition in providing a stable institutional environment, in the absence of which policy reversals take place and policies and programmes are discontinued. Since 1989—the year of the first presidential election—the country has elected six presidents, impeaching one in 1993 for corruption, and has witnessed peaceful power alternation at the national level. Two large coalitions have dominated the national political landscape. The crucial test for institutional stability was indeed the victory of the Workers' Party in the presidential election of 2002. There was also significant policy continuity in macroeconomic management and social policy making despite power alternation, which suggests some deeper consensus and shared beliefs among the relevant political actors.

Creating fiscal capacity for universalistic health spending

A crucial factor underpinning the universalization and expansion of the social security system (including health care and social assistance) is fiscal capacity, which in the case of a new democracy with a long history of balance-of-payment problems and high inflation essentially requires macroeconomic stabilization. Figure 2 provides information on inflation rates in Brazil over the long period of time from 1945 to 2008. Shortly after the promulgation of the Constitution, the country embarked on an unstable path characterized by hyperinflation and fiscal crises. Some of the constitutional provisions exacerbated existing fiscal problems. The most significant one was the increase in the number of civil servants as 300,000 government employees acquired civil servants status, which was tantamount to an external shock to the system.

Figure 2: Inflation in Brazil, per cent per year, 1945–2008



Source: Ipeadata. www.ipeadata.gov.br

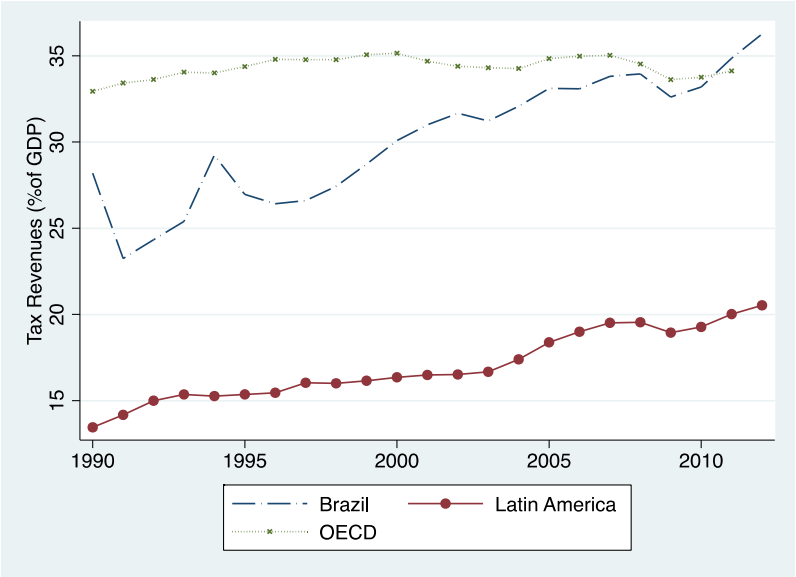
The fiscal imbalances were monetized and paved the way for the hyperinflation of 1988–1993 (see figure 2). This deterioration menaced the expected social gains from the generous social provisions introduced by the Constitution. It was only when inflation was tamed from the mid-1990s onwards that the regressive impact of hyperinflation on citizens welfare started to be effective. This occurred under Cardoso's first administration (1995–1998), when the Real Plan was implemented. Unlike previous plans, which were associated with the so-called shock therapy, Cardoso's plan was extensively publicized prior to its implementation. It called for the introduction of a new currency pegged to the United States dollar and generated short-term gains in terms of real income for the population, which explains its popularity. These characteristics made the Real Plan unique and distinct from previous stabilization efforts. Economic stability was again under threat following the run against the real in 1999 in the wake of the Russian Crisis and Asian Crisis. However, macroeconomic stability was accomplished as a result of the implementation of a flexible exchange rate system, a regime of inflation targets and the policy prioritizing the goal of fiscal surplus.

As Savedof et al. (2012) argued "many countries legally establish a right to health care without having policies or resources in place to guarantee that people who need care can obtain it without financial hardship". The massive expansion of SUS required the creation of significant fiscal space and the governments in the 1990s were able to create that needed fiscal space. Since 1990, the tax burden (central government tax revenue) as a percentage of GDP has increased from 25 per cent to 35 per cent, placing Brazil as an outlier in Latin America. As figure 3 shows, Brazil's tax burden is double the Latin American average, which is 17 per cent. Controlling for Brazil's income level, the tax burden is much higher than comparable countries. This has been accomplished by an impressive increase in indirect taxation and social contributions.[15] It also has allowed an equally striking increase in social spending. Figure 4 shows that it reached $1,400 in 2009—nearly the highest in Latin America, shortly below Argentina and Uruguay, which boasts higher PPP per capita incomes—$16,000 and $14,440, respectively, compared to Brazil's $11,200. Although the tax system has inbuilt inequities and inefficiencies, it has allowed fiscal sustainability and the expansion of social spending. A significant part of social expenditures is allocated to public sector pensions, but social expenditures have helped reduce poverty and allowed funding of universal health care.

The creation of fiscal capacity for social security was a protracted and conflict prone process that involved the approval of two constitutional amendments due to the detailed nature of the Brazilian Constitution. The constitutional amendments can be interpreted as attempts to hardwire institutional innovations as a pre-commitment device to ensure that they are preserved. Once the Constitution guarantees a certain social service, the key issue for the executive was to secure the resources for the service delivery. The Constitution of 1988 created a unified budget for pensions, social assistance benefits and health care—the so-called social security budget. This was part of the demand for a universalistic social protection system advanced by the opposition parties during the military regime and an important banner during the Constituent Assembly. Sources of funding were sought in diversified forms. The social security budget was made up of the contribution on net profits paid by corporations or CSLL, the corporate tax on sales (COFINS) and the employers' and employees' payroll contributions. This institutional arrangement was viewed by the groups supporting the idea as a mechanism that would delink contributions and access to the system, making it more democratic and redistributive. It was what the Constitution intended in establishing universal access to health care through the newly created SUS. The Constitution also introduced generous social assistance benefits, such as three months maternity leave.

[15] Tax revenues from personal income taxation in Latin America and Brazil have been historically low because of a variety of factors, including elites' resistance to taxation (see Melo et al. 2014).

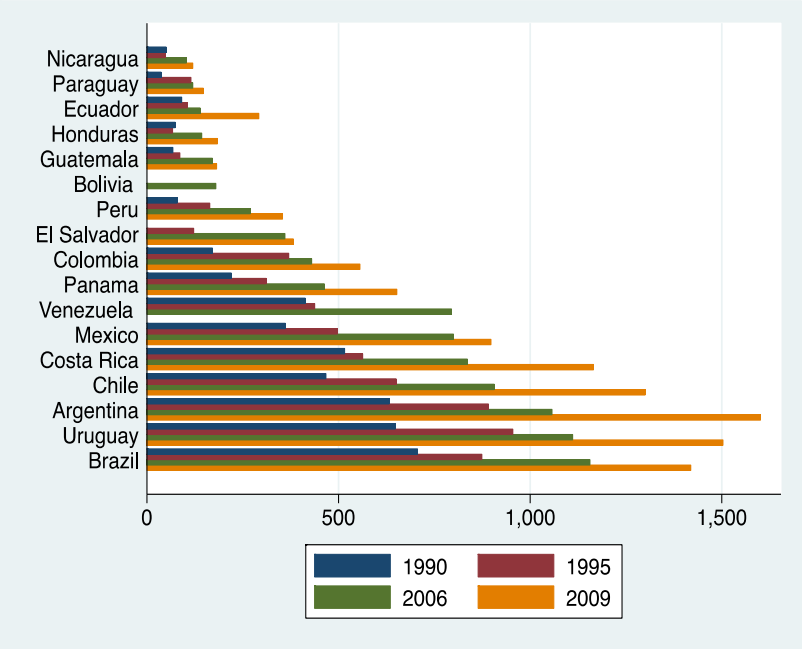
Figure 3: Central government tax revenue as percentage of GDP, 1990–2010



Sources: Stats.OECD.org; CEPALSTAT (http://estadisticas.cepal.org/cepalstat/WEB_CEPALSTAT/Portada.asp?idioma=i).

The fusion of expenditures for health care and pensions in the same budget over time produced a dynamic that was paradoxically highly detrimental to health care. This resulted from the fact that pensions are contractual disbursements and are not compressible. They are a flux of future commitments that ends only with the death of the pensioners. By contrast, health expenditures are mostly current expenditures that can by definition be changeable. However, prior to the Constitution of 1988, it did not become problematic since the fiscal imbalances in the pension schemes were not very significant and, more importantly, pensions were not indexed. This resulted gradually in the sharp reduction in the real values of pensions. By mandating that pensions were to keep their real value, the Constitution of 1988 prohibited the erosion of the real value of pensions and benefits that prevailed up until 1988. In addition, it dramatically expanded the mass of workers under the civil service regime (Regime Jurídico Único, in which benefits are related to the average of last pay checks), upgraded rural non-contributory pensions and social benefits to the level of urban pensions, and finally set the lowest value of pensions at the minimum wage level. This produced a shock in the system and caused the crowding out of health expenditures shortly after its implementation.

Figure 4: Per capita social spending in Latin America, 1990–2009



Note: In 2005 United States dollars. **Source:** CEPALSTAT (http://estadisticas.cepal.org/cepalstat/WEB_CEPALSTAT/Portada.asp?idioma=i).

The mechanism described took place while the decentralization of health care was being implemented. In the mid-1990s, while efforts toward macroeconomic stabilization were undertaken, the policy priority primarily became the control of inflation and fiscal stability. However, the problems in the health sector acquired increasing saliency in the public discourse as a result of the implementation of SUS. The recurrent crisis of SUS enhanced the visibility of health financing in the country. At the same time, Brazil exhibited infant mortality rates that were far above countries at the same level of development.[16] Revamping the health system along the lines of a universalistic welfare state compatible with the conditions of a developing country was also a key priority for the government. In 1996, Health Minister Adib Jatene made strong efforts to secure more resources for health care, and many proposals were made for earmarking resources for the health sector. These proposals were criticized by the finance and planning ministries as a move backwards that would cause more fiscal rigidities in a context of rapidly declining degrees of liberty in the budget. The argument that more resources needed to be secured for the health sector was used in negotiations leading to the creation of the social emergency fund (*Fundo Social de Emrgência* or FSE) in 1994. This fund would consist essentially of "de-freezing" 20 per cent of taxes and contributions that could then be freely allocated by the executive to allow more discretion in fiscal management. The government's strategy consisted essentially of supporting these proposals, which yielded political dividends to its coalition, considering that they would not conflict with its primary objective of fiscal stability. The measures to secure financing for the health sector culminated in the proposal to reformulate the Provisional Contribution on Financial Transactions (*Contribuição Provisória sobre Movimentações Financeiras* or CPMF) and earmarking part of it to the health sector. The CPMF was created by Constitutional Amendment 3 in 1993 and was a "sunset provision" that would be valid for only two years. Constitutional Amendment 12 reinstated the CPMF and earmarked it for the health sector in 1996.

[16] Brazil was behind all Latin American countries with a similar level of development. In 1995, Brazil's mortality rate (per 1,000 inhabitants) was 11.3 compared to 5.7 in Colombia, despite the fact that Brazil's per capita income was considerably higher ($8,350 compared to $5,100).

Nevertheless, ensuring a steady source of resources for the health sector was not enough considering the vicissitudes of Brazilian federalism. The implementation of policy depended on subnational governments and on the bureaucratic echelons situated at the periphery of the organizational structure of the social ministries—such as their regional offices, individual departments and divisions that were basically controlled by the conservative coalition partners. The key element, however, were the actions of mayors and governors. The recognition that their power was an impediment to the effective use of health resources, the federal government introduced major institutional changes. In this case, then-Health Minister and Cardoso's future presidential candidate, José Serra, played an important role. He proposed Constitutional Amendment 29 in 2000 that stipulated minimum values for investments in the health sector for the three tiers of government. For the federal government, the budget for 2000 was set at the 1999 level plus 5 per cent. For the period 2001–2004, the value of health expenditures was to be readjusted by the annual variation of the nominal GDP.[17] Of this amount, 15 per cent should be transferred to the municipalities for basic health care and distributed according to their level of population. In the case of the states, 12 per cent of their revenue (after legal transfers to the municipalities) was to be spent in the health sector. In turn, the municipalities were required to spend 15 per cent of their own budget on health care. The states and municipalities that had expenditure levels lower than those stipulated in 2000 were expected to reduce the difference at the ratio of 1:5 per annum. Non-compliance would allow federal intervention in the subnational governments. The law stipulated that all transfers would be channelled to a fund and subjected to auditing. Interestingly, the resources were hardwired for health as a percentage of current revenue for states and municipalities and in proportion to the previous year's GDP for the federal government.

Piola et al. (2013) estimated the impact of Constitutional Amendment 29 as very positive, leading to a jump in the amount of resources allocated to health that was equivalent to 1 per cent of GDP. It rose from 2.9 per cent in 2000 to 3.9 per cent in 2011. Mounting pressure to find more resources for health care led to the discussion of new legislation, which until today has not been approved. Because the amendment left many loopholes regarding the categories of expenditures that could be classified as falling under the bracket of health expenditures, the government passed Complimentary Law 141/2012. The CPMF's share in the total amount of resources in the area of health was significant, reaching 32 per cent in 2007 when it was phased out.

Originally designed to be a temporary tax with a rate of 0.38 per cent on financial transactions earmarked to SUS, the CPMF lasted as a provisional contribution for about 12 years. It was finally extinguished on 13 December 2007 in a historical roll call when the executive's bill requesting its extension until 2011 was defeated in the Senate. It was an upsetting result for Lula's government because its majority coalition was able to obtain only 45 of the 49 votes needed for a majority. With this political defeat of Rula's government in Congress, SUS lost about R$ 40 billion in revenue according to the 2008 government's budget proposal. There are several reasons for this political defeat.

First, the government took its approval for granted without any policy concession. Later, when the government realized that it would not be easy to obtain Senate approval of the extension of the CPMF, it suggested a smaller rate of 0.36 per cent in 2007 and greater reductions in the following years up to 0.3 per cent. Without success, the government promised to allocate part of the CPMF to education. Anticipating that it

[17] This was an attempt to link the size of health expenditure to overall economic growth.

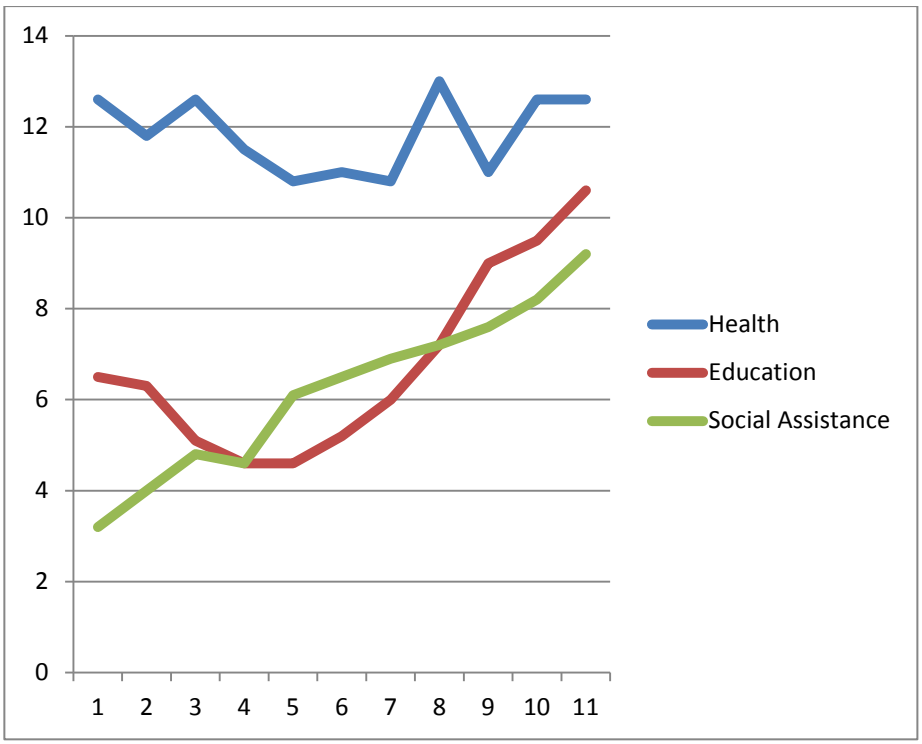
would be defeated, the government, as a last resort, sent a letter signed by the finance minister that the CPMF would be entirely allocated to SUS. But this last move was not successful either.

This episode represents a signal and a remarkable mobilization of several different sectors in society (media, interest groups, business sectors, etc.) and of opposition players demonstrating that the leverage of the federal government to keep increasing the tax burden was running out. One of the most important criticisms the CPMF from those sectors was the lack of transparency in its allocation. In fact, the CPMF was never fully allocated to the universal health care system as it was originally intended; rather, it was deviated to other ends, for example, for raising the budget surplus. The resistance against the CPMF from the Federation of Industries of the State of Sao Paulo (*Federação das Indústrias do Estado de São Paulo* or FIESP), which was composed of more than 200 unions and associations (www.contraacss.com.br/), was able to gather more than 1.5 million signatures from all over the country against the CPMF and at the same time supporting the idea of a comprehensive fiscal reform. Actually, this movement continues to be active as a kind of "vigilante" against any further government's attempts to bring the CPMF back in and to mobilize the society in opposition to additional tax increases.

These two initiatives to secure more resources for health—Constitutional Amendments 12 (CPMF) and 29 (earmarking budgets for health expenditure in the total budget)—were key to securing more resources for the sector. However, the system has become more expensive and complex, resulting in considerable financial stress. Despite the considerable absolute increase in resources, the share of resources devoted to health has stagnated, engendering great tension. As figure 5 shows, the share in 2002 was the same as in 2012. This partially reflected the fact that the spectacular expansion of conditional cash transfers has had a crowding out effect on health. Costing slightly more than 1 per cent of GDP, the *Bolsa Família* and smaller transfer programmes have absorbed part of the additional resources to universal social security as they share the same source of funding. *Bolsa Família* has become the flagship programme of the Workers' Party's governments (since 2003 to the present), and has certainly dwarfed the political saliency of other issue areas for the government agenda (Melo 2007a, 2007b).

The episode involving the extinction of CPMF points to the fact that the tax burden has reached a plateau. At 35 per cent of GDP, it is slightly lower than the Organisation for Economic Co-operation and Development (OECD) average. More importantly, the political feasibility of raising additional taxes in Brazil has declined rapidly. Considering that coverage of SUS has also reached a plateau of 100 million people, it means that quality improvements in SUS would have to be achieved by efficiency gains rather than by funnelling more resources to the system (although that might be necessary in many municipalities across the country as well). However, since 2012, and particularly following a wave of street protests in 2013, there has been strong social mobilization for more resources for health care.

Figure 5: Percentage of social spending in net current revenue by sector



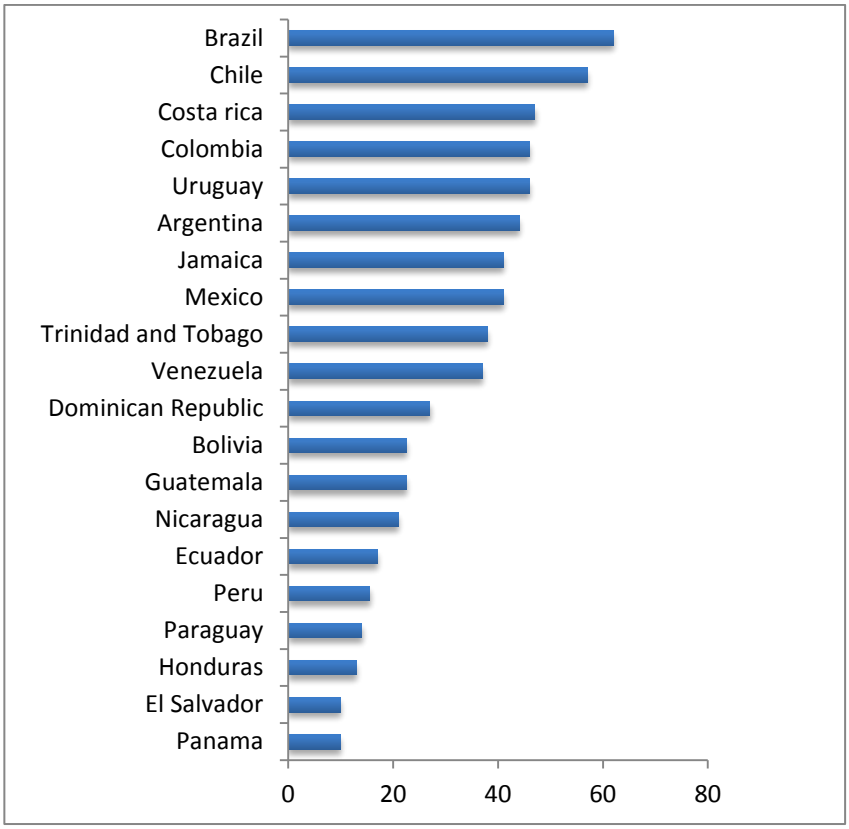
Source: Original data from the Brazil National Treausury. www.tesouro.fazenda.gov.br.

State and organizational capacity for universal social security

In addition to fiscal capacity, an effective welfare regime requires state capacity. In fact, the latter is also a precondition for fiscal capacity: extracting resources from corporations and families is a complex task and in a democracy it requires a capable state machinery. The sophisticated social security system Brazil built over the last two decades was made possible because the country had already created an effective bureaucracy prior to its massive expansion. However, concomitantly with the expansion of the system there has been an extensive overhauling of the so-called social ministries.

Prior to the 1990s, the ministers in charge of the social ministries were typically clientelistic politicians. In sharp contrast, from the mid-1990s onwards the ministers of social security and health have been economists or health policy experts. More significantly, a number of careers have been created within the federal government, including experts in public policy and public management and social policy analysts. Over a thousand new experts have been hired on a meritocratic basis for key posts in the line ministries, two-thirds of them are currently staff in the social ministries. According to the Inter-American Development Bank, by the mid-2000s, Brazil boasted the most professionalized bureaucracy in Latin America (Longo 2006) (see figure 6). Another crucial development within the social ministries was the strengthening of external control and internal audits. In the past, the ministries of health and social assistance along with education were the organizations where corruption tended to concentrate.

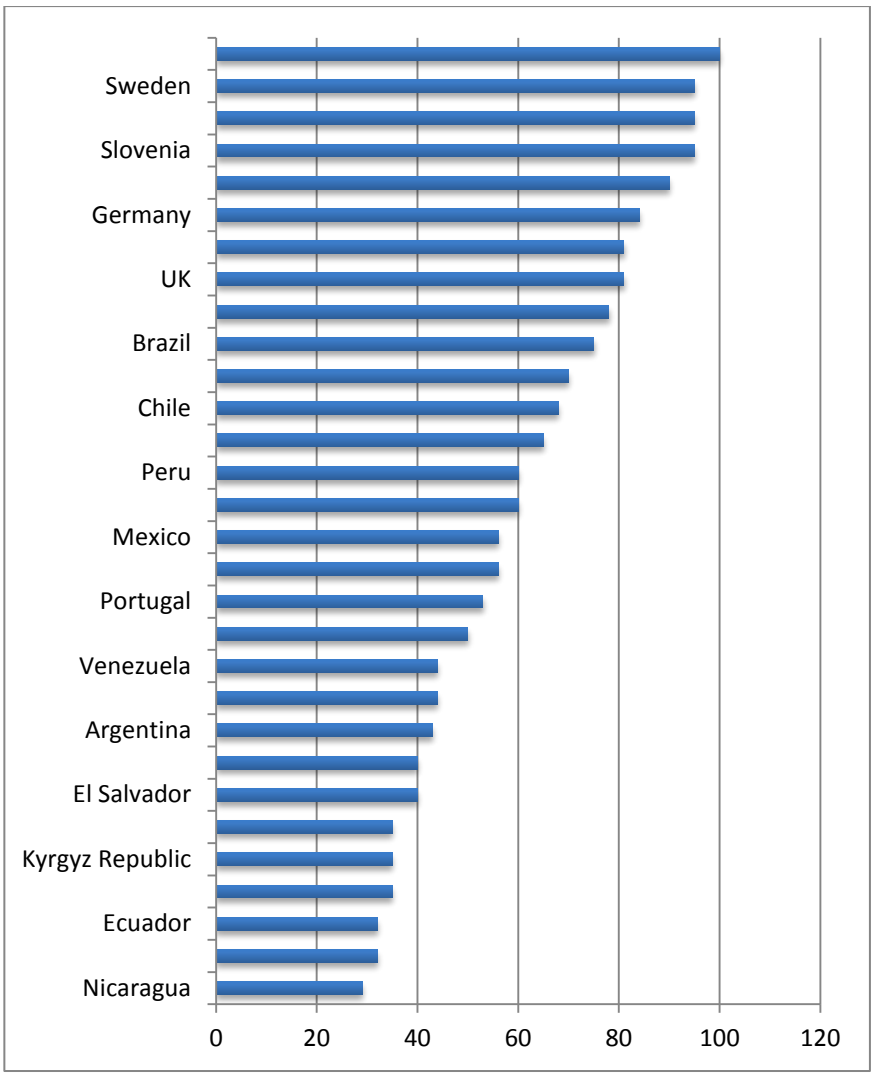
Figure 6: Quality of public administration in Latin America, per cent



Source: Longo (2006).

Following the strengthening of the Audit Tribunal to the Union in the 1988 Constitution and the creation of the Secretariat of the Federal Comptroller, both external and internal audits have improved considerably, leading to the professionalization of these ministries, and the creation of a modern new Ministry for Social Development in 2003. In the wake of the creation of SUS, the decentralization of health in Brazil involved transferring 1 per cent of GDP to subnational governments in a scale unparalleled in Latin America (Ferraz and Finan 2011; Leite 2010). Massive decentralization of funds is associated with high risks of agency losses, making it necessary to put oversight mechanisms in place. In 2002, the Cardoso government transformed the existing *Secretaria Federal de Controle*—the internal audit body in charge of monitoring public expenditures and making sure that financial rules were followed in the public sector—into the Comptroller of the Union (*Controladoria Geral da União* or CGU). This measure was complimentary to the enactment of the Fiscal Responsibility Law or FRL 2000, which imposed a host of requirements for transparency, monitoring and reporting for subnational governments in Brazil. With a mandate to fight corruption and ensure compliance with transparency and administrative procedures, the CGU has improved the professionalization of state machinery in the social sectors. Using data from randomized municipal audits, it was found that 27.8 per cent of municipalities had serious irregularities in the use of health funds (Melo et al. 2012; see also Leite 2010), whereas the corresponding figure for education was 25.1 per cent, despite the fact that the value of funds for health is significantly greater than in education. Local corruption in health services is rampant, but there is evidence that CGU audits have had an important deterrence effect (Zamboni 2012).

Figure 7: Quality of audit institutions in Latin America and OECD countries, per cent



Source: Data processed from Open Budget Partnership. http://internationalbudget.org/what-we-do/open-budget-survey/.

Figure 7 shows comparative data on the quality of public sector audits in OECD and Latin American countries. Brazil comes first in the Latin American ranking and compares favourably with some European countries. In sum, institutional capacity was crucial for the overall performance of the social sector in the Brazilian context.

This is not tantamount to say that health and social assistance has been performing very well, but that there is a new sectoral dynamic, which is politically and institutionally driven, that has put the sector on a track that was promising. Much of the relative improvements in social development stems from the new incentive structure that was put in place in the first decade of SUS and the operation of the political markets under a vibrant democracy.

Political and institutional challenges to universal health care

Under the SUS model, wide-ranging reforms have taken place over the last two decades that undoubtedly contributed to significantly improving basic health indicators, such as life expectancy and infant mortality in Brazil. These reforms involved, among other things, a substantial expansion of coverage (with a stellar expansion of outpatient care), with growing emphasis on preventive services, such as vaccinations and family health along with a reduction in regional disparities in access to care. Previous sections show

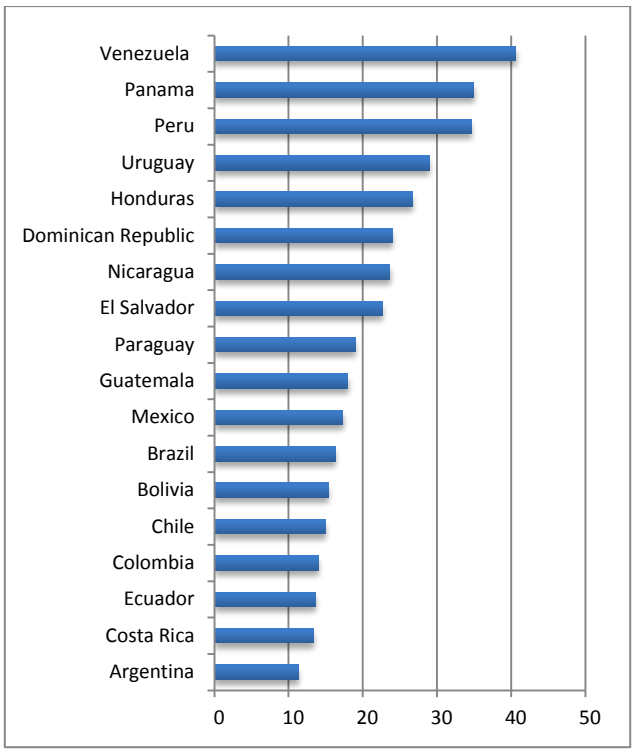
that this was made possible because of a combination of institutional and political factors. Although SUS continues to receive strong support as a political priority, there is widespread dissatisfaction with the quality of the services it provides. This is also found in other areas, including educational services. The subjective evaluation about the quality of public expenditures is very low: 15 per cent of respondents in Brazil replied positively when asked in 2012 about their trust in the quality of spending—a figure much below the Latin American average (see figure 8).

The level of satisfaction with public services has reached very low levels—in fact, the lowest score in the sample of countries in the available Latin America Barometer (LAPOP) datasets. Only 40 per cent of respondents was satisfied with public services (see figure 9). A LAPOP survey carried out in 2012 found that 72.8 per cent of the population was unsatisfied or very unsatisfied with medical and public health services in 2012 (see figure 10). In turn, a study by the National Confederation of Industry found that 61 per cent of the population considered public health services to be bad or very bad and that 85 per cent of respondents saw no change or worsening services over the previous three years (CNI 2012:9). The problems that are most commonly reported are delays in access or treatment and lack of doctors. The main criticism raised against public hospitals, which were rated worse than private hospitals, is waiting times for consultations and exams.

Interestingly, in the LAPOP 2012 survey (figure 9), Brazilians and Chileans—citizens of the two countries with the most successful economies in the region—were the least satisfied with the quality of public services of all citizens in Latin America and the Caribbean. The economic progress of recent years and the emergence of a new middle class have raised expectations, and many Brazilians and Chileans say they now want social progress too. Issues of quality of services came forcefully to the fore for contextual reasons in Brazil. People protested against the government's decision to overspending on the construction of new and/or renovating old soccer stadiums for the 2014 FIFA World Cup. Criticisms that the final cost will exceed significantly the initial budgets and the perception that little has been done to improve the urban infrastructure triggered protests everywhere. Reacting against the "FIFA-Standard Soccer Stadiums", demonstrators carried signs in the streets asking for "FIFA-Standard Hospitals". Even before the July 2013 events, there was mounting social mobilization for increasing resources for health and a new movement was created, the *Movimento Nacional Em Defesa da Saúde Pública* with the motto *Saúde + 10*.[18] Thus, the saliency of health care for the current agenda may be a window of opportunity for policy change. As Carnes and Mares (2012) have argued, dissatisfaction and perceived increasing risks have led citizens in Latin American to support the health-care policy reforms toward universal care. Recent developments in Brazil suggest that the reversal of expectations in the wake of the commodity boom increases the demand for improvements in health care coverage.

[18] *Saúde + 10* is a proposal for health expenditures to be earmarked at 10 per cent of federal current expenditures.

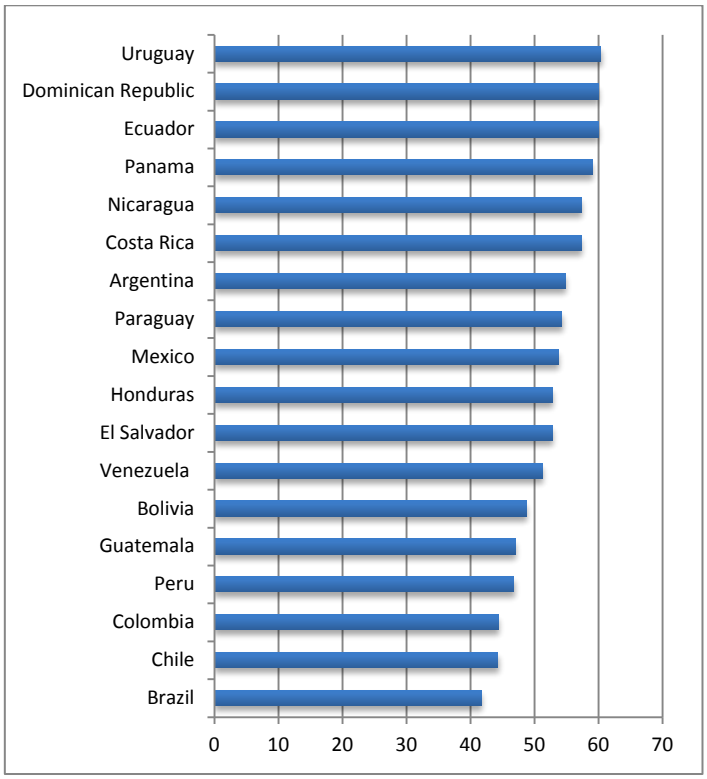
Figure 8: Trust in the quality of public expenditures



Note: Per cent of respondents that trust in the quality of public expenditures. Mean values for surveys in 2003, 2005 and 2011.

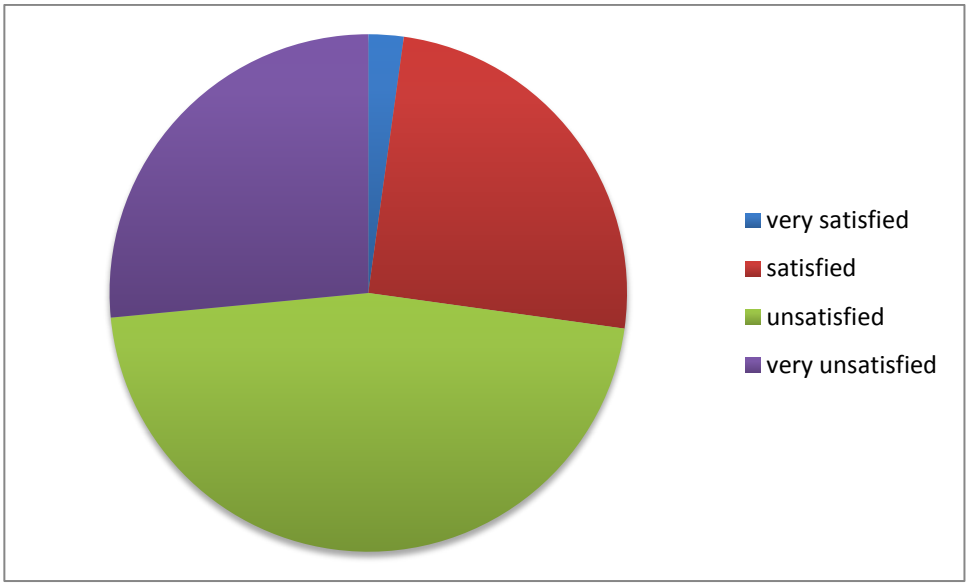
Source: 2012 LAPOP survey. www.vanderbilt.edu/lapop/.

Figure 9: Satisfaction with public services



Note: Per cent of respondents satisfied with public services. **Source:** 2012 LAPOP survey. www.vanderbilt.edu/lapop/.

Figure 10: Brazil—satisfaction with medical and public health services



Source: 2012 Latin American public opinion project. www.vanderbilt.edu/lapop.

Conclusion

Over the last two decades, Brazil has built a relatively successful universal health system. Its success was made possible by the combination of three factors:

- Political incentives arising from electoral competition in a competitive institutional environment that resulted in a race to serve poor constituencies, which were introduced by policy communities and activists within and outside the state. SUS benefited from this political dynamic and thus became politically sustainable.
- SUS' fiscal sustainability, which was secured by the great extractive capacity of the Brazilian state, was the product of a massive increase in resources in the form of social contributions partly earmarked for pensions and social assistance and health care.
- Part of the system's success stems from the institutional capacity to run a complex decentralized system. The system's enormous expansion and great coverage has led to a plateau—over one hundred million people are now benefiting from the system.

Unlike developments elsewhere—for example, Asian countries (Mares and Carnes 2009)—Brazil has expanded its universal health care, while eliminating the blatant distortions in its two contributory pension subsystems (for civil servants and public sector workers) and extending its non-contributory subsystem. While the system has become more universalized in health care, it has been reducing regressive elements in the contributory systems.

The system appears to reach its limit in terms of the capacity to extend coverage in a context where there is universal formal entitlement to health, but some 30 per cent of the population has access to private insurance. Coupled with the costly judicialization of access to health care and pharmaceutical drugs, which disproportionally benefit the richer groups, SUS has engendered a perverse incentive structure that is inbuilt in the system, leading to great inequities. Despite many improvements, many challenges continue to beset the delivery of health care in Brazil, and addressing them adequately will require significant policy changes, not only additional resources. However, finding resources has proven increasingly costly politically and improvements will have to be achieved through efficiency gains. Politically, this is a situation of a zero-sum game rather than that of the positive game typical of coverage expansion. Most importantly,

the perceived increased personal risks are leading citizens to support creating new resources for the system and for policies to improve the quality of care. A new window of opportunity thus seems to have been opened.

References

Alston, Lee, Marcus André Melo, B. Mueller and C. Pereira. 2014. *Beliefs, leadership and development: Brazil 1964–2012*. Princeton University Press, Princeton.

____. 2013. "Changing social contracts: Beliefs and dissipative inclusion in Brazil." *Journal of Comparative Economics*, Vol. 1, pp. 4–22.

Antonnen, Anneli. 2002. "Universalism and social policy: A Nordic femininsit reevaluation." *Nordic Journal of Gender Research*, Vol. 2, No. 70, pp. 70–84.

Antonnen, Anneli, L. Haikio and K. Stefansson (eds.). 2012. *Welfare State, Universalism and Diversity*. Edgard Elgar, Cheltenham.

Barrientos, Armando. 2013. "The rise of social assistance in Brazil." *Development and Chang*e, Vol. 44, No. 4, pp. 887–910.

Biehl, J. et al. 2009. "Judicialization of the right to health." *The Lancet*, Vol. 373, No. 27, June, pp. 2182–2184.

Carnes, Matthew and Isabella Mares. 2012. *Risk and Reversals: Explaining Individual-Level Support for Public Social Insurance Expansion in Latin America*. Paper presented at the annual meeting of the American Political Science Association, New Orleans, 29 August–2 September.

CNI (Confederação Nacional da Indústria). 2012. *Retratos da Sociedade Brasileira: Saúdepública*. Pesquisa CNI-IBOPE. CNI, Brasilia. www.cni.org.br/portal/data/pages/FF80808134CE91AD0134D2267E4E09D3.htm.

Couttolenc, Bernard and Tania Dmytraczenko. 2013. *Brazil's Primary Care Strategy*. World Bank, Washington DC, January.

Editorial. 2012. "Universal health coverage: The third global health transition?" *The Lancet*, Vol. 380.

Faletti, Tulia. 2010. "Infiltrating 'the state': The evolution of health care reforms in Brazil, 1964–1988." In James Mahoney and Kathleen Thelen (eds.), *Explaining Institutional Change: Ambiguity, Agency, and Power*. Cambridge University Press, New York, pp. 38–62.

Ferraz, Claúdio and Federico Finan. 2011. "Electoral accountability and corruption in local governments: Evidence from audit reports." *American Economic Review*, Vol. 101, pp. 1274–1311.

Frieden, Jeffrey F. 1992. *Debt, Development and Democracy: Modern Political Economy and Latin America 1965–1985*. Princeton University Press, Princeton.

Gragnolati, Michele, Magnus Lindelow and Bernad Couttolenc. 2013. *Twenty Years of Health System in Brazil: An Assessment of the Sistema Único de Saúde*. World Bank, Washington DC.

Kuhn, Diane Marie. 2012. *Health Care Reform in Mexico and Brasil: The Politics of Institutions, Spending and Performance*. PhD thesis. Harvard University, Cambridge.

Longo, Francisco. 2006. "Análisis comparativo por índices." In Koldo Echebarría (ed.), *Informe sobre la Situación del Servicio Civil en América Latina*. Inter-American Development Bank, Washington DC, pp. 573–592.

Mares, Isabella and Matthew Carnes. 2009. "Social policy in developing countries." *Annual Review of Political Science*, Vol. 12, pp. 93–113.

Medici, A. 2003. *Family Spending on Health in Brazil: Some Indirect Evidence of the Regressive Nature of Public Spending in Health*. Technical Paper Series. Inter-American Development Bank, Sustainable Development Department, Washington DC.

Melo, Marcus André. 2007a. "Unexpected successes, unanticipated failures: Social policy from Cardoso to Lula." In Peter Kingston and Timothy Powers (eds.), *Democratizing Brazil Revisited*. University of Pittsburgh Press, Pittsburgh.

____. 2007b. "Policy bandwagoning, political competition and antipoverty programs in Brazil." In Tony Bennington and William McCourt (eds.), *Statecraft in the South: Understanding Policy Success in Developing Countries*. Palgrave Macmillan, London.

____. 2004. "Institutional choice and the diffusion of policy paradigms: Brazil and the second wave of pension reforms." 2004. *International Political Science Review*, Vol. 25, No. 3, 320–341.

____. 2003. "When institutions matter: A comparison of the politics of social security, administrative and tax reforms." In Ben Ross Schneider (ed.), *Reinventing Leviathan: The Politics of Administrative Reform in Developing Countries*. North South Center Press at the University of Miami, Miami, pp. 211–251.

____. 2002. *Reformas Constitucionais no Brasil: Instituições Politicas e Processos Decisó*rios. Revan, Rio de Janeiro.

____. 1993. "Anatomia do fracasso: Intermediação de interesses e a reforma das políticas sociais na Nova República." *Dados Revista de Ciências Sociais*, Vol. 36, No. 1, p. 119–164.

____. 1991. "Interesses, atores e a construção historica da agenda social do estado no Brasil, 1930–1990." *Ciências Sociais Hoje—Anuário de Sociologia, Política e Sociologia*. Vértice/Anpocs, São Paulo.

Melo, Marcus André and Carlos Pereira. 2013. *Making Brazil Work: Checking the President in a Multiparty System*. Palgrave Macmillan, London and New York.

Melo, Marcus Andre, Armando Barrientos and Andre Canuto. 2014. *Taxation, Redistribution and the Social Contract in Brazil*. Working Paper. Brooks World Poverty Institute, Manchester.

Melo, Marcus André, A. Leite and E. Rocha. 2012. *Competitive Corruption: Evidence from Randomized Municipal Audits in Brazil*. Paper presented at the annual meeting of the American Political Science Association, New Orleans, 29 August–2 September.

Menicucci, Telma M. G. and Jose Angelo Machado. 2010. "Judicialization of health policy in the definition of access to public goods: Individual rights versus collective rights." *Brazilian Political Science Review*, Vol. 4, No. 1.

Mkandawire, Thandika. 2005. *Targeting and Universalism in Poverty Reduction Social Policy and Development*. Programme on Social Policy and Development, Paper No. 23. UNRISD, Geneva.

Mobarak, Ahmed, A. A. Rajkumar and Maureen Cropper. 2011. "The political economy of health services provision in Brazil." *Economic Development and Cultural Change*, Vol. 59, No. 4, pp. 723–751.

North, Douglas. 2005. *Understanding the Process of Economic Change*. Princeton University Press, Princeton.

Paim, J., C. Travassos, C. Almeida and J. Macinko. 2011. "O sistema de saúde brasileiro: História, avanços e desafios." Série Saúde no Brasil 1, *The Lancet*, 9 May, pp. 11–31.

Piola, Sérgio, A. B. Paiva, E. B. Sá and L. M. S. Servo. 2013. *Financiamento Público da Saúde: Uma História à Procura de Rumo*. IPEA Texto para Discussão 1846. IPEA, Brasília.

Ross, Michael. 2006. "Is democracy good for the poor?" *American Journal of Political Science*, Vol. 50, No. 4, pp. 860–874.

Rudra, Nita. 2007. "Welfare states in developing countries: Unique or universal?" *Journal of Politics*, Vol. 69, No. 2.

Rudra, Nita and Stephan Haggard. 2005. "Globalization, democracy and 'effective' welfare spending in the developing world." *Comparative Political Studies*, Vol. 38, No. 9, pp. 1015–1049.

Savedoff, William D, David de Ferranti, Amy L. Smith and Victoria Fan. 2012. "Political and economic aspects of the transition to universal health coverage." *The Lancet*, Vol. 380, pp. 924–932.

Segura-Ubiergo, Alex. 2007. *The political economy of the welfare state in Latin America: Globalization, democracy and development.* Cambridge University Press, Cambridge.

Skocpol, T. 1991. "Targeting within universalism: Politically viable policies to combat poverty in the United States." In C. Jencks and P. E. Peterson (eds.), *The Urban Underclass*. The Brookings Institution, Washington DC, pp. 411–436.

Ter-minassian, Tereza. 2013. "Improving social spending for a better life for all in Brazil." Vox LACEA. www.vox.lacea.org/?q=brazil_social_spending.

World Health Report 2010. 2010. World Health Organization, Geneva, p. Ix.

Zamboni, Yves. 2012. *Avaliando o Avaliador: Evidências sobre um Experimento de Campo sobre Auditorias da CGU*. PhD thesis., Getulio Vargas Foundation, Brazil.