The Brazilian health system between norms and facts: mitigated universalization and subsidized stratification

O sistema de saúde brasileiro entre normas e fatos: universalização mitigada e estratificação subsidiada

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Abstract ***This paper will focus on recent changes in the relationships between the public and the private sector within the health assistance network, by analyzing selected information on health services and on legal rules related to supporting the private assistance subsystem. This approach recasts analyses which articulate the simultaneous examination of both the material and political instances that permanently redefine the range of activity of SUS. Considering the limitations of the empirical bases here analyzed, one questions the implied assumptions in the meanings of autonomy sustained both in the public and in the private components, departing from hypotheses on the delineation of independent tendencies toward the expansion of universal coverage and he restratification of supply and demand.***

Key words ***Brazilian Health System, Relationships between the public and the private, Restratification of supply and demand***

Resumo ***As recentes mudanças nas relações entre o público e o privado na rede assistencial são enfocadas com base na análise de informações selecionadas sobre serviços de saúde e normas legais relacionadas com o suporte ao subsistema assistencial privado. Essa abordagem retoma as análises que articulam o exame simultâneo das bases materiais e políticas que redefinem permanentemente o âmbito de atuação do SUS. Considerando os limites de abrangência das bases empíricas analisadas, questiona-se os pressupostos subjacentes as acepções de autonomia dos componentes público e privado, a partir das hipóteses sobre o delineamento de tendências interdependentes de expansão de coberturas universais e reestratificação da oferta e demanda.***

Palavras-chave ***Sistema de saúde brasileiro, Relações entre o público e o privado, Reestratificação da oferta e demanda***

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Introduction

Many studies on the Unified Health System (SUS), both the ones emphasizing its demands, and those concerning characteristics of supply, or even those intent on analyzing the roles and the institutional layering of the intra and intergovernmental relations of its framework, highlight the progresses and dilemmas involving the intensity and speed of implementation of the universal right to health. In a very broad approach, one can say that a significant part of these relations is generated by verifications, in turn generated by the political sciences and by economics, of the problems involved in the extension of democracy from the political to the social sphere[1]. These references inspire considerations on the Brazilian health system, based on the acknowledgement of the sometimes supporting, main role of social policies for the reduction of inequalities[2]. These approaches support powerful and diversified analyses of the national health policies.

However, the usage and reverberation of this vast interpretative repertoire have not propagated evenly. After twenty years, the broadening of the scope of participants in the discussion on the future of health policy, the concepts and above all, the expectations concerning SUS have given way - if not to new versions, at least to remodeled interpretations of the gap between the practiced right to health and that set forth in the 1988 Constitution.

Today, more complex explanatory models concerning the conflicts and interests surrounding health policies coexist with formulations imbibed with a strong prescriptive approach. The latter generate SUS diagnosis-prognosis pairs that, for the sake of clearer explanation, could be arranged in a gradient. On the optimistic side one could place the evaluations guided by the political-institutional "revolution" already molded by SUS. The pessimistic side would group those based on the criticism of the shortfalls concerning the access, coverage and utilization of the services of SUS, and on the idea of a low impact of the participation of progressionist scenarios on the successive administrations of public health institutions, which subject the guarantee of the right to health to a future socialist revolution. Between these extremes, both characterized by the primacy granted to the concept of "revolution", there are countless considerations grounded on the process and reform categories which give a quality of relativity to the progresses and dilemmas of SUS.

The excessively normative classifications of SUS are easily identifiable in the statements: SUS is the world's best health system[3]; capitalism is incompatible with the right to health[4]. These are very distinguished approaches of the same reality. However, they are similar concerning the erasure of the temporal dimension and of the contradictory and multifaceted movements of the construction of the Brazilian Sanitary Reform. The same formula is shared by: the mitigation of tensions or symmetrically, the generic attribution of the singularities of health to the structural contradictions between capital and labor. As for those approaches grounded on the ideas of SUS's construction processes, they attempt to capture the conjuncture alterations, the connections between the change process and the structural patterns of social and economic development.

It is worthy of notice that the popularity of such concepts is very heterogeneous. The premise concerning SUS's low maturation, its incremental advances has many adepts among technicians, governmental authorities and bodies of the civil society involved with the executive levels of public health policies. Whereas explicitly optimistic or pessimistic assumptions circulate mainly in environments whose political or partisan density revolves around defenses for or against governments and rulers.

Whereas the non-inclusion of certain factors and parameters of the discussion concerning the limits and perspectives of SUS can generate an impermeable barrier against the understanding of the dynamics of the decision-making processes and their respective normative expressions, it is necessary to go back to approaches that admit and attempt to reveal convergences between facts ad norms. Under this approach, emphasis falls upon the examination of the changes in the organization of health services, financing and legal support supplies, offers that permanently redefine the scope of SUS.

Knowledge about the disparity between public expenditures and their consequences for the curtailment of access and universal utilization of health services is widespread. The stratified and inequitable pattern that still defines the production and distribution of initiatives and health care was recently confirmed by the estimates of the Brazilian Institute for Geography and Statistics (IBGE). Government's expenses on health, between 2000 and 2005, account for approximately 3.2% of the GDP, whereas those originating from private sources reached approximately 4.8%[5].

The increasing problems generated by the opposition between coverage earnings and equity in access to health services, and the limitations on public expenditures for the universal attention to health are the focus of several surveys carried out by the collective health areas. It is with this same purpose – of making efforts to broaden the knowl-

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edge of the relationships between the material sources and the generation of health policies, that this paper focuses on the current growth / withdrawal trends of the public and private subsystems.

The first section of the article revolves around the recent evolution of the private component of the Brazilian health system. Evidence of irregularities in the growth of the private subsystem leads to a brief survey and analysis of laws and norms concerning its preservation and expansion. These are followed by a brief presentation and questioning about changes in the agendas and the dynamics of the representation of interests. The third section of the paper calls into question given senses of SUS by presenting theories on the recent changes in the relations between the public and the private within the scope of the Brazilian assistance system.

Notes on the evolution of the private component in the Brazilian private health system after the 1988 Constitution

Article 199 of the 1988 Constitution sets forth that health assistance is free to the private enterprise, and dedicates its paragraphs to the regulation of the relations between the public and the private in the health system. Paragraph 1 sets guidelines for the participation of private institutions in SUS. Paragraphs 2 and 3 prohibit the allocation of public resources to assistance or subsidies to private, for profit institutions, and direct or indirect participation of companies or foreign capital in health assistance. Paragraph 4 prohibits the trade of organs, blood and related parts. The inclusion of these principles in the constitution demonstrates an attempt, however precarious, to settle the discussions on the public-private nature of health establishments[6].

The practical effects of these constitutional guidelines have been heterogeneous so far. Soon after its enactments, amidst discussions on the immediate or medium term nationalization of private hospitals and the huge efforts towards its regulation, the fiscal legislation was altered in order to authorize the deduction of expenses with medical assistance and private health insurances from the income tax declaration, and thus expand the discount limits of the calculation basis[7].

Ever since, the issuance of policies to encourage the acquisition of private health plans and insurances and encouragements to the private offer of health services go ***pari passu*** with efforts towards the implementation of SUS. These public policies with conflicting signs have been assigned to the frailty of citizenship[8] or the nature of the government system and the representation capacity of the Legislative Power[9]. The nature of the democratic game and its uncertain results[1] are also used to explain the coexistence between social players and diverging projects[10].

This background generates quite schematic interpretations about the publicization / privatization trends of the Brazilian health system. In the light of the convoluted history of SUS, some of its defenders assume that it is enough for private agents to maintain their privileged social status in order to execute their societarian projects. This idea is supported by the speeches of the representatives of private segments, who actively disseminate their demands in favor of the deregulation of government intervention. Changes in the physical base of the organization of demands and volume and allocation of financial resources for the private subsystem, or in the legislation that legitimated them, though, were neither few, nor obvious.

On the one hand, the installed capacity and the utilization of services of the public subsystem increased. Between 1988 and 2005 the growth of public establishments offering hospitalization was larger than that of private establishments (49.59% and 23.24% respectively)[11,12]. The participation of public service providers in the allocation of federal resources continuously increased (39% in 1987, 37% in 1997 and 47% in 2007)[13]. As for coverage, there was an absolute increase in the number of Brazilians assisted by private health plans and insurances between 1998 and 2003, but the ratio remained unchanged. For that reason the increase in health services usage (71.2% in 1998 and 80% in 2003) and in the ratio of individuals that consulted a doctor at least once (54.7% in 1998 and 62.8% in 2003)[14] points toward an increased public coverage. One should not disregard the increase in procedures such as hemodialysis, which became universally accessible (7.17 sessions per 1.000 inhabitants in 1987, and 52 in 2007)[15,16].

On the other hand, the volume of federal resources allocated to health was drastically reduced between 1987-1997 (considering amounts adjusted by the IPC-A, in 1987 INAMPS assistential expenses reached 50 billion, and in 1997 these expenses incurred by the Ministry of Health corresponded to approximately 13 billion, and approximately 19 billion in 2007)[16,17]. Additionally, there were no signs of the universalization of usage and supply of certain equipments . In 1999, less than 20% of all mammography equipments were public. There were 0.4 mammography systems per hundred thousand inhabitants in the north region, and 1.7 in the southeast region[18]. In 2005 most of

these devices (approximately 85%) were private. The subtle territorial unbalance of mammography systems (0.8 devices per hundred thousand inhabitants in the north region, and 2.2 in the southeast region) does not provide evidence of a more balanced distribution[12].

At first view the expansionist trends of SUS are not opposed to an increased privatization of financing and health services provision. The lack of questioning of the simultaneous, or at least sequential and autonomous increments of public and private segments leaves little space to the visibility of retractionist and interactionist trends. Actually, the acknowledgement of contradictions, and above all of the relationships and intermediations between both subsystems is little attractive, both for progressionist sectors, which are permanently urged to protect SUS against raging criticism concerning its limitations, and for business segments that rejoice in the growth of their investments.

However, it is the very understanding of the complex process of public-private complementarity that enables the elaboration of more realistic analyses of the changes in the production bases and representation of interests of health systems. By taking into account the patterns and changes in the distribution and overlapping of spheres of activity and the correspondences between the stratified segmentation of supply and demand, one can clearly discern two relevant dimensions of the public-private financial assistance flows.

The first dimension concerns the correspondences between financing, supply and demand of public and private services. Higher concentration of clients of private plans and insurances in the south and southeast regions, and the corresponding different assistance provided to them permanently lay the ground for inequalities in the usage of services and in health expenditures. The demands for private health plans and insurances, located in certain cities and neighborhoods, and the formation of financial funds administered by private companies and entities comprise a financial-assistance vector that moves in an opposite direction than that of equity.

Brazil allocates at least twice as many financial resources for those linked to health plans and insurances than for universal initiatives (approximately 740.00 and 350.00 in 2004)[19]. The difference between these amounts increases if we consider only assistance expenses. In 2007 commercial health plan and insurance companies allocated 81% of their entire invoiced revenue for the payment of medical and hospital services[20], whereas expenditures on basic, outpatient and hospital assistance represented 66% of the resources of the Ministry of Health's budget[17].

The difference in revenues has consequences on the adopted service prices. Although comparisons must be relativized due to the amount of procedures, one can infer that the average consultation and hospitalization rates charged by health plan and insurance companies are 3 to 6 times those of public institutions. For the sake of exemplification, the average amount paid per hospitalization in 2007 by health insurance self-management companies associated to the Confederation of Self-Management Health Institutions (UNIDAS), R$ 6,112.45 was eight times higher than that practiced to pay for hospitalizations in the SUS network (R$ 754.53)[21].

The second dimension concerns the effects of the volume of public-private financial-assistential resources and inflows in the material bases of the work concerning the production of health services. The highest amounts for remuneration of procedures paid by the health plan and insurance companies are usually seen as the main reason to attract clients and health care professionals by the private subsystem: the former receive better payments, and the latter have guaranteed access to quality services. However, the centricity of procedure price comparisons relegates the dramatic changes in labor relations in private and public organizations to second place.

The growth of atypical arrangements, such as the work co-ops and the regulated civil professional societies[22] - formats that do not configure a job relation – lend a peculiar characteristic to the contracts ruling the production of health initiatives and services and sustaining the privatization circuits. Health establishments and health plan and insurance companies started executing agreements between companies directly, instead of with each health sector professional. Actually the "legal persons" and cooperative members can only recover workers devoid of rights involved in wrappings more suitable to the "***short term-ist***" fragmentation / individualization and to fiscal eliminations. However the exclusion of wage relations, even when occurring in a category such as the medical, which maintains self-regulation prerogatives[22], creates the path for the appreciation of the financial aspects at the expense of the productive aspects. The businessmen-workers hybrid position broadens the scope of their activities by means of the individualized inclusion of new procedures in the charts of their third-payers (whether these are the government or health plan and insurance companies), integrating processes that devaluate the collective work and fragment the care.

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In short, the displacement of the relations between the public and the private result from movements of strong growth of the basic network supply, and a comparatively not so strong increase in the number of public hospital rooms added to the growth of private funding and increase of private offer in diagnosis and therapy, and the substitution of traditional hospital rooms for intensive care units. These movements, along with changes in the production and organization of work in health institutions outline relatively new trends, and do not result entirely from unforeseen or collateral effects. In order to shed light on the political mediations related to the source and destination of health resources, the following table summarizes a selected group of public norms aimed at subsidizing the supply and demand of private health plans and insurances (Table 1).

The briefly summarized legislation, despite disregarding several legal devices related to fiscal deduction for the importation of equipments and the granting of credit and loans for the private sub segment, is quite eloquent. The most recent and conspicuous example of the production of public policies for private support is the Ministry of Health's initiative of removing conditionalities for the concession of the philanthropy certificate to a subgroup of "state of the art" hospitals. The initiative is an interpretation of Decree 5.895 of 2006 aimed at assisting hospitals that do not meet the requirements of providing service to at least 20% of SUS's patients with maintaining their fiscal benefits. Controversies surrounding the protectionist measures of the Ministry of Health (by leaders of the sanitary movement[23] and representatives of philanthropic hospitals not encompassed in the new criteria[24]) and disputes of Provisional Measure 446 of November 7, 2008, which provides for the certification of charitable entities of social assistance, and regulates procedures of exemption from contributions to social security[25], provide hints on the intricate regulation ruling the reorganization of the public and private health sectors.

The recent production of norms that intensify the inflows and the volume of public resources for the provision of assistance to the group covered by private health plans and insurances points out that the existence of structural requirements and general restrictions to the universalization has not derogated the need to legitimate the stratification. Therefore, these changes do not represent the non-intentional result of countless spontaneous initiatives performed by separate individuals. They occur under the leadership of business and governmental agents, and professional bodies and associations.

Uneven exchanges: the political bases of restratification

The reconfiguration seen within the sphere of the framework of supply, production and consumption of health services is associated with the redefinition of the profile and the composition of social players and their strategies and organization methods for collective initiatives. Biased conflicts between the public and the private in the pre-SUS period were replaced by an intricate game of open and mobile coalitions disputed in several institutional arenas.

Paim[26] states that during the implementation process of SUS there was a displacement of the bases providing political support to the sanitary movement. After the Constitution the managing bodies, represented by the National Council of State Health Secretaries (CONASS) and by the National Council of Municipal Health Secretaries took charge of the defense of SUS. The adoption of a pragmatic agenda by an increased, institutionalized sanitary movement within the context of growth of neoliberalism and fragmentation of corporativism managed to neutralize several attempts against SUS, but did not prevent the implosion of the constitutional concept of Social Security[27].

Within the scope of organization and representation of private health care establishments and health plan and insurance companies, changes followed the supply and demand restratification process. The Brazilian Federation of Hospitals and the Brazilian Association of Group Medicine both defended the private sector during the Constitution debates, but lost exclusivity of the sectorial representation. The creation of new entities in the 1990s meets the need to differentiate a subgroup of hospital organizations and large plans and insurances.

The National Association of Private Hospitals (ANAHP) and the Institute of Supplementary Health Studies (IESS) were constituted in 2001 and 2006, respectively. ANAHP gathers hospitals, mostly charitable, classified under the first-rate category. It supports debates and initiatives aimed at monitoring the quality and safety of the assistance provided, such as the accreditation and information systems. IESS, which relies on financial support from the largest health plan and insurance companies, intends to become a supporting agent for the sustainability of health plan and insurance companies by means of the production of knowledge concerning the area, and information on supplementary assistance.

The increasing complexity of the representation of interests in the Brazilian health system also

Table 1. Selected Legislation* Related to the Support to the Supply and Demand of Private Health Services and Insurances in the Period after the 1988 Constitution.

Government	Incentives to supply	Incentives to demand
Sarney		Decree-Law 7.713 of 1988 (increases the limits of deduction of health-related expenses from the Income Tax declaration)
Collor /Itamar	Law 8620 of January 5, 1993 (discounts and payment in installments of debts of hospitals with agreements or covenants with INAMPS National Institute)	
FHC	- Decrees 3.504 of 2000, 4.499 of 2002, 4.327 of 2002 and 4.588 of 2002 (alteration of Law 8.212 of 1991, improved flexibility in the parameters for concession of the philanthropy certificate; introduces alternatives: either 60% of hospitalizations to SUS, or investment of part of the gross revenue in gratuity, or classification of the hospital as being strategic to SUS). - Decree 4.481 of 2002 (reduction in the service provision of high complexity systems of charitable entities intended for universal assistance to 20%) - Provisional Measure 2.158-35 of 2001 (deductions of operational expenses from the calculation basis, and technical reserves of social contributions to health plan companies)	Law 9.527 of 1997 (changes article 230 of Law 8.122 of 1990 – Unified Legal System, by introducing the possibility for the assistance to the server's health to be provided by means of an agreement). Decree 3.000 of 1999 (updates articles 17 and 18 of Law 4506 of 1964 which deal with the exemption, from gross income calculation, of medical services, paid, indemnified or maintained by the employer for use of their employees). Law 9.250 of 2005 (expenses concerning health start to be fully deductible from the Income Tax declaration)
Lula	- Normative Instruction of the Federal Income Office 480 of 2004 (promulgates the separation of bills from third party services – among which medical services – and authorizes the deduction of taxes and social contributions for professionals linked to cooperatives and medical associations). - Decree 5.895 of 2006 (introduction of new criteria for the concession of the philanthropy certificate: service supply at the minimum level of 60%, or the execution of projects supportive of the institutional development of SUS in the following areas of operation: 1) technology assessment and incorporation surveys; 2) qualification of human resources; 3) public interest surveys in the health area; 4) development of management techniques and operations in health services). - Law 11.345 of 2006 and Decree 6.187 of 2007 (creation of a source of resources - Timemania - the collection is partly sent to the National Health Fund and allocated to the "***Santa Casas***", non-profit hospital entities and rehabilitation institutions for persons with disabilities, and payment in installments of tax debts). - Law 10.833 of 2004 (maintenance of the reduction system of the tax rate on the Mandatory Contribution to Fund Social Security (COFINS) from 7.6% to 3% for private health care establishments)	Law 11.302 of 2006 (changes article 230 of Law 8.122 of 1990 – Unified Legal System, by introducing the possibility for assistance to the server to be provided in the form of a benefit – reimbursement of the partial amount corresponding to expenses on private health assistance plans or insurances)

* Incomplete and non-systematic survey.

Sources: SICON (National Congress Data System)) http://www.senado.gov.br/sicon and SIJUT (Fiscal-Legal Data System) http://sijut.fazenda.gov.br/

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involves changes in the bodies representing health care professionals and other workers. A considerable portion of the agendas of medical entities is taken by the negotiation of procedure rates with health plan and insurance companies and, to a lesser extent, by claims for more financial resources for SUS.

Another remarkable change in roles is being performed by certain institutions of the three government levels. Proposals for inclusion in agreements with entities representing public servants of private plan and insurance coverage ratify the removal of public bureaucracy itself from the trench of the fight for the universalization of the right to health, and the nearing of entities representing workers and public servants to the private institutions. Transient coverage benefits raised to the level of law, and the several forms of participation of union representatives of public institutions in the administration of funds to finance them redefines the public and private diagram.

Due to the growing thematic importance of health in the discussion forums, negotiation and formulation of policies and governmental agendas, lines of activity were created which articulate representing blocks, the Executive, and the Legislative. The Congressional Health Committee (FPS), created in 1993, consolidated an agenda which compiles public and private interests whose most notable point of contact is the legal statute and remuneration fees for medical-hospital procedures of the Ministry of Health's lists and of that elaborated by the Brazilian Medical Association, which is used as reference by health plan and insurance companies. The increase in resources for the financing of the public and private subsystem attracts both the claims for increased resources for SUS and those related to the broadening of tax exemptions, credits and debt amnesty for private establishments and providers, and producers of supplies for health care services.

FPS's connections with the industrial component of the production complex and learning and research institutions with the formulation and execution of policies comprise a second line of activity, of which the National whose notorious example is the National Medication Policy Seminar is a notorious example. This forum, guided by the assumption of the need to increase public access to medicines, is sponsored by the Brazilian Federation of Pharmaceutical Industry and supported by the Medicine School of the University of São Paulo, by the Brazilian Medical Association, and by the Federal Council of Medicine. It is sought by researchers of the subject, governmental authorities, and entities of pathology carriers and consumers' rights.

The third line of activity of the Congressional Health Committee prioritizes social demands originated from the National Health Council, National Council of State Health Secretaries, National Council of Municipal Health Secretaries, and managers of the Ministry of Health. It is aimed at guaranteeing and monitoring compliance with the rules of allocation of the federal budget for health. The 8th Symposium of the Federal Chamber on National Health Policy, carried out in 2005, held discussions on SUS and the Sanitary Reform.

In addition to joint agendas between members of the parliament and entities representing public and private interests, the bonds established by nominations, intermediated by government-supporting political parties, for positions in the Ministry of Health and regulating agencies establish a direct and permanent political flow between the Legislative and the Executive. The Executive Power also established new arenas for the articulation of interests in the sphere of the private subsystem, among which is the Permanent Workers' Forum, created by the National Agency for Supplementary Health in August 2008, with the aim of convening the trade unions and confederations in order to "enlighten and inform workers and their leaderships on their rights regarding the consumption of health plans"[28].

It should not be disregarded that the activism of the Judiciary and the Public Prosecutor's Office, receiving individualized and collective social claims regarding problems of miscarriage of resources, lack of compliance with the legislation for personnel hiring by health institutions, and obstacles to the access/denial of coverage for medications and medical-hospital procedures, grant its undeniable leadership in redefining the scope of health policies[29].

This survey, despite being incomplete and focused on changes in the political bases of the representation of private assistential interests, proves the strength and renovation of the interest articulation of the market and the State. Sentencing the death of conflicts and declaring a normative citizenship alone will not magically erase the set of political and material supports that foment discrimination and inequality. Private appropriation of public assets was and continues to be present in the construction of the private health system. Political exchanges governing the stratification of access and the usage of services are uneven. Formal solidarity to SUS is necessary in exchange for the attainment of solid benefits in the private health plan and insurance market.

Final considerations

In order to extract considerations from the 20-year historic experience of SUS one cannot assume that the exercise of political movements is determined by any objective conditions, nor that volitions are freely conducted, depending on the conservative, reformist or revolutionary bias of its members. The permanent revision of explanatory landmarks that confer meaning to the social initiative is essential to the analysis and (re)formulation of health policies.

There is more than enough evidence that the gradual increase of public expenditures on health in Brazil (in 1975 the ratio of private expenditures was 33%[30] and 60% in 2005[5])does not correspond to uniform increases or decreases in coverage, nor does it represent the individual payment capacity of the population. We stand before significant changes in the material ad political bases of the Brazilian health system. The combination of the growth and universalization of basic assistance of a small group of high-cost procedures with the increment of the commodization of the supply of private services does not pave the road that leads to the transformation of the right to health in right to citizenship.

Private health plan and insurance companies increased their revenues between 2005 and 2006[20], and reversed the predicted and dreaded ascending spiral of claims volume. Some predictions, such as the willingness of the federal government to increase the coverage base and the values of its consideration for private health plans of its servants, above inflation levels (R$ 42.00 until 2006, R$ 53.00 until now, and R$ 72.00 in 2010)[31], point toward a greater tendency to increase the return rates of the activity. If, from the point of view of the general dynamics of economic growth, the capitalization of welfare is opposed to the increase of job offer and revenue, due to interactions between the profitability of stock and debentures and the increase in interest rates; in the health sector, the concentration of capital and financial appreciation of prepayment funds, integrated by public sources, among others, cause a major decrease in the prospects of establishing harmonious relations between social development and a better quality of life.

The degree of lethality of the financialization of health assistance to the prospects of effective implementation of SUS is extremely controversial, even though the idea of a universal, fair and humanized health system is almost unanimous. Therefore, oppositions between statists and privatizers, when expressed utterly in abstract terms, is far from the discussions on the nature and directionality of the current regulating policies. Concerning the magnitude of collective capitalization funds, the financial devices mobilized by health seem to be relevant, since private pension funds comprised less than 2.5% of the entire amount of Brazilians in 2003[32].

The current process of restratification of supply and demand of the private subsystem consolidates the currently existing differences in socio-occupational status at the expense of public resources and policies. There are two main pillars supporting the restratification of access and utilization of health services are. The first is the dedicated allocation of part of the charitable establishments (those classified as first-rate) to a certain clientele profile, i.e., the privatization of high-cost and complexity philanthropic institutions. The second is the enlargement of health insurance plan coverage with a restricted service menu (by means of selecting small service providers, vertical integration of the activities of health plan companies and the adoption of co-payment) for public servants and segments occupying less-specialized working positions. This State-regulated and subsidized fragmentation intensifies and feeds back the precariousness of work in health services.

Part of the previous hierarchical relations of health organizations lost meaning due to formal and informal agreements established horizontally between companies (especially hospitals and plan and insurance companies with legal entities and cooperatives). The corporate insertion of health care professionals in the service network along with the abysmal gap between the amount defined for payment of the work itself and informal fees or other forms of individual support (such as event funding and trips to scientific congresses) related to the usage or prescription of commercial products, such as osthesis, prosthesis and medications, is evidenced even in the profile of the demand for medical residency[33].

Mere laudatory mention to SUS, or its simple condemnation to the exile of never fulfilled utopias, make it difficult to detect and analyze the coalitions of interests that renew health policies, including those aimed at the expansion of the private subsystem. It is ironic, to say the least, to verify that the Contribution to the Financing of Social Security and the Unified Legal System, created by the Constitution of 1988 with the specific intention of enabling social rights to health, welfare and social assistance, have been adjusted to the requirements of the privatization of health.

Under the tensions of the current worldwide financial crisis and its possible consequences to the

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Brazilian economy, the discussion on the public and the private in health takes new meanings. The need for deregulation is a constant subject. The financial fragility caused by the decrease of safety margins of companies and banks, among which are large underwriters, holds in check the precepts of privatization of social protection systems. It is unknown how the crisis will unfold, but the more speculative financial attitudes that surround the privatization of the health assistance system in Brazil are ***sub judice***.

This scenario, more favorable to the resumption of the State's role in the application of policies for the reduction of risks associated to social exclusion encourage an update in the considerations concerning changes in work relations, in the methods of organization of the production of health care services. Looking at the past loses the capacity of contributing to a better understanding of the present, when the latter is assigned the condition of being the sole alternative of a future. We have ahead of us the challenge of subsidizing knowledge to build SUS and the Sanitary Reform, thus overcoming the rejection for and distrust in politics, expressed in several ways, including the dissociation of relations between democracy and health.

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