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Equity and health regionalization in the countercurrent

Equidade e regionalização da saúde na contracorrente

Equidad y regionalización de la salud a contracorriente

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The structural limits of regionalization in SUS imposed by the current stage of capitalism, marked by the primacy of the financial sphere of accumulation under the hegemony of the neoliberal doctrine, are portrayed quite accurately in the article *Confronting Health Inequalities: Impasses and Dilemmas in the Regionalization Process in Brazil*. After identifying the advances and limits in the regionalization of the SUS, intensified since the first decade of the 21st century, Ana Luiza d'Ávila Viana & Fabíola Lana Iozzi suggest a new agenda for Brazil's health regionalization reform.

In the unpostponable task of contributing critically to this necessary debate, so well outlined by the authors, I have chosen to point out some aspects – still explored little by the authors – related to the Brazilian political economy in 1988-2019 and that reinforce the arguments advanced in the article.

It is a fact that the SUS was born in the countercurrent of the hegemonic neoliberal paradigm on a global scale beginning in the late 1970s. Health policy reflects (with specificities) the trajectory of Brazilian social policy in recent decades, crisscrossed by two movements heading in opposite directions. The idea of the SUS began to mature in the mid-1970s, inspired by the "Golden Age" (1945-1975), an unprecedented cycle of regulated capitalism, marked by the consolidation of Social Welfare systems [1].

Therefore, when the SUS was consecrated legally by the 1988 *Brazilian Federal Constitution*, it was already in the countercurrent to the hegemonic global paradigm.

The neoliberal ideology began gaining momentum in the international scenario in the late 1970s. The movement created favorable conditions for the break with the commitments established from 1945 to 1975. One target of the market backlash was the Welfare State, whose ideals were exorcised in favor of the ideals of the Minimum State. In this scenario, the idea was to impose targeting on "the poor" (those earning up to two dollars a day) as the only possible social policy. The ideological tactic extolled the supposed virtues of these programs to pave the way for reforms that would deconstruct universal policies, opening the door to privatization of services. That is, whoever is not "poor" would have to buy services on the market.

A favorable consensus for liberalizing reforms was also formed in Brazil since 1990. The state's material and financial foundations were destroyed by privatizations, low growth, high interest, overvalued exchange, and growing public indebtedness that demanded obtaining a high primary surplus (non-financial expenditures). In this scenario, social protection began to experience tensions between two opposing paradigms: the values of the Minimum State versus the values of the Welfare State.

These tensions remained high from 1990 to 2019, except for 2007-2013, when they were attenuated, especially due to economic growth, which regained some central role on the agenda after 25 years [2,3].

Health equity and regionalization were counterhegemonic from 1990 to 2019, because there was generally an antinomy between macroeconomic strategy and state reform and the possibilities for development and social inclusion. "Austerity" policies are imposed by the macroeconomic "tripod", whose institutionality places limits on the economy's growth. Inflation, fiscal surplus targets, Fiscal Responsibility Law, caps on expenditures, and golden rule on issuing public debt all curtail investment and current spending, since the purpose is to balance the budget, avoid growth of the public debt, and preserve resources for interest payments. Under these rules, the generation of primary surpluses to pay for a portion of the financial expenses is the only "sacred" item that must be complied with.

Thus, there is no fiscal room for financing the necessary investments to expand the supply and availability of infrastructure, resources (physical, financial, and human), services, and activities for health. When the SUS was born in 1988, the supply of services was mostly private. Its functioning required investments to expand the public supply. But the "austerity" blocked this requirement, which is reflected in the structural deficits in the supply of services, asymmetrical in the scenario of Brazil's profound regional heterogeneity.

As a result of the limits imposed by economic policy, financing of the SUS has always been limited, starting with the Organic Health Law (LOS, 1990), followed by the decision by the Itamar Franco government to use employees' and employers' payroll tax contribution exclusively to finance Social Security, by the policy of Decoupling of Federal Revenues (DRU, 1993), by the ongoing process of granting tax exemptions and capturing constitutionally bound budget funds to finance Social Security, by the creation of the Provisional Contribution on Financial Transactions (CPMF), "bound" to the SUS but captured by the economic area (and extinguished in 2007), and by the long and difficult passage of *Constitutional Amendment n. 29* (2002). This was followed, especially since 2016, by the adoption of various mechanisms focused again on limiting the financial base for the SUS, featuring *Constitutional Amendment n. 95*, which sets the "ceiling on expenditures" for non-financial expenses.

Health equity and regionalization were counterhegemonic from 1990 to 2019, because in general, throughout this period, while decentralization and regionalization of the SUS advanced gradually, in parallel and contradictorily there was a progressive depletion of the Federative Pact established in 1988. This process is perceptible first because the fiscal power of the Federal Executive branch was reinforced since 1989, when the economic area reacted to the fiscal decentralization provided by the *Constitution*. Revitalization of fiscal centralism proceeded over the course of the decade, when the tax burden increased from 25% (1994) to 33% of the Gross Domestic Product – GDP (2002).

Secondly, the federative pact of 1988 was dismantled because economic policy disrupted the states' and municipalities' financial structure. The states' and municipalities' indebtedness increased due to the high basic interest rate (reaching 42% a year during moments of international crisis in the 1990s). Once indebted, the states and municipalities were forced to accept the terms imposed by the federal government in the process of renegotiating their debts. The following measures were implemented, among others: Program to Support States' Restructuring and Fiscal Adjustment (1997), followed by the Fiscal Responsibility Law and the Fiscal Crimes Law (1999).

This largely explains the asymmetries identified by the study between the different spheres in Brazil's federal system, leading to low development of relations between these different government levels, which are unable to "*overcome the various conflicts arising from attempts to strengthen an integrated system*" (p. 7).

Health equity and regionalization were generally counterhegemonic from 1990 to 2019 because in the structuring of the SUS since 1989, the privatization of health advanced at a forced pace. Incentivized by the federal government and backed by Congress, beginning in 1990 various modalities of commodification were widely disseminated at the three levels of government for various social sectors.

The SUS emerged as the antithesis to the privatist system adopted by the military dictatorship. It was expected that the democratic governments after 1990 would block privatization. But in practice there was a growing process of commodification of healthcare. There are numerous manifestations of this fact: permission for the so-called "double door" to healthcare (reserved beds for private health plans in public hospitals); use of health plans in the SUS network for high-cost procedures (unreimbursed); establishment of Public-Private Partnerships for the operation and management

of public hospitals, backed by public monies for investment and costing; formidable expansion of action by the so-called "Social Organizations" (OS) to manage hospitals and health units throughout the country; and enormous gaps in government regulation of private health plans (self-management, medical cooperatives, charitable hospitals, group medicine, health insurance) (Brazilian National Health Agency) [4].

It is also important that in order to circumvent the Fiscal Responsibility Law, which limits earmarking of payroll expenditures, various mechanisms were engendered for hiring personnel through Nongovernmental Organizations (NGOs) and so-called Public Interest Civil Society Organizations (Oscip), whose spending is written up as "outsourced services" rather than "payroll expenses".

The challenges of the new health regionalization reform agenda in Brazil are not trivial. The period from 2016 to 2019 may represent the end of the brief cycle of building social citizenship that began in the mid-1970s and that spilled over into the 1988 *Constitution*.

The liberal project's radicalization has advanced in three main directions. In the first place, in the sense of forcing to the extreme the state reform initiated in the 1990s.

Secondly, in the bolstering of "austerity" policies via deepening of the macroeconomic "tripod".

Thirdly, in the destruction of the Social State of 1988 and implementation of the liberal Minimum State. This design, harbored since 1989, gained force after the coup in 2016 and has advanced at forced pace in 2019. The correlation of forces favorable to implementation of the ultraliberal project in Brazil successfully spread the false view that in order to obtain fiscal adjustment, "there is no alternative", in the sense of making society believe that it is indispensable to put an end to the model of society agreed upon in 1988, via destruction of the Social Security system and the resulting cut in "mandatory" expenditures on universal social policies enshrined in the "Social Order" under the country's 1988 *Constitution*.

The ideological thesis of an "ungovernable country", flaunted in 1988 by then-President José Sarney (1985-1990), is once again dictating the debate imposed by market representatives that have proclaimed that "democracy's social demands do not fit in the GDP". In other words, in the Brazil of the neoliberals, the poor do not fit in the budget. In this scenario, how does the country advance the interrupted process of expanding equity and regionalization of the SUS?

Additional information

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