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Innovations in intergovernmental financing for promoting equality in the access to social services: Case study of Health and Education in Brazil.

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Introduction

The objective of this work is to present the main changes in education and health financing in Brazil during the 1995-2002 period, which brought important improvements in the recent performance and will continue for the future in these sectors, with utmost importance to the reduction of the inter and intra-regional imbalance.

For each one of these sectors, the analysis was divided in six parts: 1. Institutional and Resources Panel; 2. Objectives; 3. Strategies; 4. Tools; 5. Results and 6. Challenges; this division has the purpose of extracting the primary elements from adopted policies in order to facilitate its understanding and allowing the analysis of implementation possibilities in other realities, or at least, provoke a reflection about design, construction, and alternatives in the implementation of social policies.

The **institutional and resources panel** presents the institutional environment and the availability of resources that existed previous to the implementation of changes, as well as its evolution through time. These are the elements that illustrate the possibilities and impose restrictions on public managing to make decisions regarding the resources destination; in terms of management, these also explain the margin of maneuvers and opportunities available for change, and allow the evaluation of quality and creativity in the adopted policies.

The **objectives** of the policies were extracted from the official documents, which draw the general expectations and the management intentions, whether it is in a general sphere or in the selection of alternatives for financing, resources destination, organization, and management.

The **strategies** represent the management selection of tools of legal or institutional nature to implement policies, to define the priorities and the combination of actions developed to achieve the proposed objectives. In this case it is an interpretation of the events, projects, programs, and government actions, also based in the official documents, but analyzed based on the objectives of implemented policies.

The **tools** portray the operational aspects of the adopted strategies. In one hand, innovative tools are used in legal matter or in spaces among the already existent legal parameters. On the other hand, the already existing financing resources or new resources are used, for the creation of alternative or the reorientation of resources for the desired goals.

In the **results**, it is attempted to present some empirical evidence to show whether the objectives were met. Because the implemented policies are very recent, there are still no existing impact evaluation studies in sufficient quantity and quality. Moreover, there are

several factors that concur for the same results and it is not always possible to determine whether a specific policy created certain effect. Meanwhile, when there is the impossibility to match a goal met directly to an adopted policy, some indicators can show tendencies in the direction of the wanted effects.

I – Health

1- Institutional and Resources Panel

1.1- *Organization and Financing of the Sector*

The Sole Health System (SHS) in Brazil was legally established by the Federal Constitution of 1998, alter a constituent process and regulated by Law n. 8.080 of 1990. The Article 196 of the Constitution established that "health is a right to all and the Government's duty (…)," this establishes the extent of universality of the SHS, guaranteed by the public sector. Moreover, the Brazilian constitution admits and considers the coexistence of a private system acting as a complement to the SHS. This sector, although it is not part of the SHS, can have its services acquired by the public sector, as long as it is convenient and there is a need, having reference table of prices as a base of all hospital and chirurgical procedures.

The private sector, in addition to being a segment where liberal medicine is practiced, has an important sector that acts in supplementary health, made up by the private health plans (engaged with health insurances companies, groups of medicinal firms, cooperatives, etc.) paid individually or together, by firms/institutions that ensure its employees some guarantee of medical assistance, having the monthly installment paid solely by the employer or discounted automatically from the employee's salary. There are different types of plans, which not always cover the totality of the citizen's needs. According to the IGBE, in 1998 24.5% of the Brazilian population, had access to some sort of private health care plan. (BRASIL, IBGE, 1998). 40.8% of the holders of the plans would be responsible for total financing; 46.0% for partial financing and only 13.2% would have integral financing by the firm or employer institution.

Supposing that this supplementary health participation would be maintained in 2003, it would mean that approximately 133.5 million citizens would depend solely on SHS[1]. Another research of the IGBE, the AMS, of 1999 (BRASIL, IBGE, 2000b), shows that out of the total 484,945 existing beds in the country, 88.3% were destined to SHS and among these, 143,518 (33.5%) beds were from the public sector and 284,493 (66.5%) from the private sector, this last one mainly out of the philanthropic segment, which shows the importance of the private philanthropic sector in the provision of health services for the SHS. To have an idea of the size of the SHS, in 2001 some 421 million medical visits were handled (4.2 per person/year), 11.7 million hospitalizations (6.8 per person/year), 2.4 million births, 78 thousand hearth surgeries, 86 thousand oncology surgeries, 7,234 organ transplants, among others, according to data from the Health Ministry, (BRASIL, Ministerio de la Salud, 2002c).

[1] According to IGBE, Brazil's population in 2003 was 176.9 million citizens.

It was estimated for 1998 that the total health expense in Brazil would be 8.2% of the GNP, 3.3% from the public sector and 4.9% from the private sector. (KILSZTAJN et al., 2002). Estimations for 2002 indicated that the public sector expenses reached 3.52% of the GNP. Regarding government spheres, the participation of federal resources for this same year was 53.1%; 21.6% from the states' and 25.3% from the municipal (BRASIL, Ministerio de la Salud, SIOPS).

The fact that the SHS is co-financed by the three spheres of the government opens the possibility to spread it throughout them, but at the same time it implies co-responsibility, which diffuses the responsibility of the successes and failures of the system. The political tendency is that the management attributes the successes to their actions in the sphere that they are responsible for and the failures and mistakes, to other spheres of the government. Regardless, from its conception in the political fight for a public system of universal, free access health, the three government spheres were incorporated in the decision making processes regarding its organization and attribution of responsibilities for assistance, managing and financing.

For this reason the Basic Operational Norms of Health (BONs) were created, being tools by which the advances and the eventual improvements in the system are established. The BONs are the result of discussions and political pacts among all three government levels. These pacts are fixed in the different health councils that are spread throughout all three of the government spheres, with bi or tripartite representation (government, users, and service providers), that go from the Municipal Health Councils, through the State Councils, to the Tripartite (representation of the municipal, state and federal governments) and ultimately reaching the National Health Council (where the tripartite is repeated and the users and health care providers representations are added), maximum deliberation and consultation organism of the SHS, generally presided by the Health Ministry[2].

Currently in the SHS coexist the BON approved in 1996 and a new norm denominated ONHA, Operation Norm of Health Assistance, approved in 2001, with some modifications made creating the 2002 ONHA[3] The 1996 BON, advanced in the attribution of responsibilities in the levels of health care in the government three spheres, brought innovations like the *per capitation* mechanism and the possibility of giving economic incentives to certain programs and actions, like the induction strategy for the sub national layers to assume responsibility in the implementation of a certain program or health action.

The ONHA represents a great induction effort so that the SHS can have a better service organization, with better designed territorial bases, strictly defining the technical bases for assistance in the different levels of technological complexity and system organization, establishing reference mechanisms for the services. According to the ONHA, each state of the country elaborates a Regionalization Master Plan (RMP), around which the Integrated and Agreed Programs (IAP) is prepared – instrument already used by the national health

[2] The Health Councils are contemplated in constitutional legislation. The operational rules are edited through Ministry Doorways and in these rules the different type of councils were created.
[3] The ONHA is a strategy to improve the national health system organization, and will continue to operate as stated in 1996 BON. The access to these rules contents can be gained through www.saude.gov.br .

system, which estimates quantitatively all annual health actions and the places where these are going to happen among each State's municipalities, considering the already existing infrastructure – and a Master Plan of Investment (MPI) to improve the health infrastructure according to the RMP. The ONHA are still in the implementation process, taking some years to fix the regional networks, investment, qualification and training of human resources, as well as the increase of public financing in order to show concrete results[4].

With the 1996 BON, almost all Brazilian municipalities assumed the management of basic health care system, and almost all the bigger municipalities assumed all the management of the municipal health care system. In the first case, the municipalities started to receive *per capita* values for the level of assistance and economic incentives to assume bigger tasks in that field, since these were subjected to the norms and regulations from the system's administrators, with the protection of the Health Ministry. In the second one, the municipalities started to receive, in addition to the *per capita* values of basic health care, almost the totality of economic resources to offer assistance in all the complexity levels in the system, including the resources for hiring chirurgical services, laboratory and hospital of the private service when needed. According to the 1996 BON, when the states started complying with some requirements, they would begin being responsible for the whole state system management, with funding from the Health Ministry for this purpose, in addition to its own resources.

Although the system organization advanced greatly during the 90s, the financing question is still a challenge to the governments. Having to attend approximately 75.5% of the Brazilian population in all the assistance levels, and being increasingly pressured to expand the access of the population to medicines (including judicially), the public health expenses representing 3.53% of the GNP, require the system's management to carry out, in theory, a permanent search for efficiency and destination of the resources, considering the best cost-benefit relationships and based on cost effective values[5]. It is not possible to affirm that these principles are considered in the managing decisions of the system, although it is reasonable to admit that they are empirically assumed, with the probable inefficiencies and problems in priority selection that this form of management can bring. However, with this level of resource and with a demand based in the universal right to health care, there is no other alternative. Although there is no evident chaos in the system, its quality and efficiency are permanently questioned.

1.2 – The macroeconomic restrictions

The problems regarding the resources destined for health care in Brazil are closely tied with the macroeconomic problem that the country has faced throughout the years. At the beginning of the 90s Brazil was faced with a serious fiscal crisis that involved not only the federal government, but also the majority of the states and some of the most important municipalities. Several state banks were also experiencing insolvency problems, especially

[4] The new Health Ministry management that took charge in 2003, decided to reopen the ONHA discussion. With out judging the merit of this decision, it will result in an implementation delay.

[5] There is a tendency in the Judicial System and in the Public Ministry to consider fair and, even more, a population right to have access to medicines.

in terms of the relationships with its governments[6]. The social protection system presented increasing deficit signals. With the arrival of the Real Plan in 1994, – a stabilization plan that substantially reduced the country's inflation – both the fiscal matter and the public bank system, the social protection, plus the funds for room financing among other debts acquired through a long inflation process, became evident[7].

The process of confronting these problems underwent substantial conjecture of the sub national spheres' debts by the Federal Government via a negotiation in profitable conditions of installments and costs for the different states and municipalities; also by introducing federal resources in order to save different state banks and then privatizing them; by the reduction of funds geared towards health care that made up the social security budget to attend the demands of retired individuals and pensioners, and by the absorption of the living funds' liabilities by the National Treasury, among others. Although the negotiations brought immediate economic relief to the states and municipalities, the group of actions increased the federal debt, which continued to be overdrawn with relatively higher interest rates. In short, along with the price stability brought by the Real Plan, the true fiscal situation of the Brazilian Government surfaced, increasing the costs of its financing.

Because the health care resources became scarce – since the social security resources (health, social protection and assistance) had the same tributary base and there was a dispute about the portion destined to each area – the Federal Government was obliged to create the PCEM in 1996 – Provisional Contribution to the Economic Movement, with an aliquot incidental on all economic transactions made within the banking-economic system, destined to broaden the resources for the national health care system[8] Up until then payments made by the Ministry of Health to the state and municipal shareholders and for the payment of the hospital services, suffered from significant delays, creating chaos in the health system, mainly with the stagnation in sanitary assistance of the private hospitals that provided services to the SHS. Although the PCEM brought some relief to the sector, the fiscal stabilization funds created in 1994, and later on, transformed in fiscal surplus goals that remain to this day, involved the general expenditures of the federal government, including those related to health care[9].

The price stability obtained by the Real Plan through a creative and successful des-indexing mechanism was reinforced by an economic policy that valued change, which, according to the authors of the plan, would contribute in maintaining the internal prices by means of imported products' concurrence. This created deficit in the commercial balance and a need for external financing in order to cover the deficit in the transaction balance, increasing the external vulnerability of the country. Although there was external financing and some inflow of external resources from the privatization of state industries, the external

[6] About state finances see LOPREATO, 2002.

[7] A detailed discussion on the Brazilian government's fiscal matter issue in the nineties can be found in GIAMBIAGI e ALÉM, 2000.

[8] The CPMF was created by law n. 9.131 of 10/24/96, initially with a 0.20% aliquot.

[9] In 1994, it was the Social Emergency Fund, modified in 1996 to Fiscal Stabilization Fund and at the end of 1998, via a negotiation with the IMF; it was transformed in a formal compromise of the fiscal surplus acquisition, valid up until today

vulnerability had no effect domestically, although the domestic tax rates were still high in order to secure external financing, which worsens the domestic debt, causing it to increase proportionally with the GNP[10].

Starting in 1997, the successive crisis in the denominated emerging countries, which started in Asian countries, provoked the risk increase in those countries with high external vulnerability, Brazil included, demanding an increase of domestic tax rates to attract external financing, which would worsen, once again, the internal debt[11]. In this context, agreements with the IMF were signed in order to secure the external financing of the economy, and compromises regarding the fiscal surplus were established. To comply with these compromises, the Federal Government stipulated fiscal surplus goals, in addition to having approved in the National Congress of May 2000, the Fiscal Responsibility Law, which demands of the leaders and executives in the three government spheres, compromises with the fiscal rigor in order to avoid a worsening in the fiscal pattern of the Brazilian State[12].

Increased tax rates and goals resulting from agreements with the IMF created a recessive adjustment that began to have a negative impact in the job market and in the employment starting in 1998. In addition to the need to pay the increasing public debt taxes, which reduced the resources for the different government actions, including health care, the low growing rate of the economy and employment resulted in an increase in the demand of public health services. In order to compensate this reduction in the availability of public resources for the government essential expenditure (including internal debt taxes), the Federal Government resorted to several instruments in order to increase the tributary gross charge, that was relatively stable around 29.5% between 1994 and 1998, and that increased in 1999 reaching 35.6% by the end of 2002[13].

1.3 – Evolution of federal resources for public health care

Although there were some fiscal restrictions, the federal resources for the health sector increased in this period, mainly because of the creation of PCEM. This happened despite the federal government, because with the creation of this contribution, the revision of other resources from other sources had been reduced. The tables that follow, 1 and 2, show what happened with the resources destined to the Ministry of Health. Here there is an important observation that must be considered in the evolution of the Ministry's budget. Although the global budget is important, the free resources for the Ministry to execute its policies are the ones in the Affordability and Costs Budget (ACB). The values of the ACB are calculated from the deduction from the Global Budget, the amounts spent on personnel, payment of debts and basic disinfection. The personnel expenses almost do not have any interference

[10] In December 1998, the liquid internal debt in proportion to the GNP reached 41.71% and in 1999, it increased to 48.68% (www.bacen.gov.br).
[11] Complementary Law n. 101 of 04/05/00.
[12] Visit website www.bacen.gov.br
[13] Even though these are listed in the Ministry of Health, they are administered by the Ministry of Planning, which is also the institution authorizing salary raises and eventual hiring of new personnel.

with the actions of the Ministry, because it does not execute any health care actions[14]. The payment of debts are the payment of expenditures already made in previous periods by means of financing or loans and that they integrate the ACB of those periods, therefore they are not part of the Ministry resources. Basic disinfection will not be considered because it does not integrate the actions and health services[15].

Taking these considerations into account, the action of presenting the nominal budget has a reason: every time that it increases, the management's maneuver margin for establishing priorities also increases. This does not mean that this increase is not tied with the increase in expenditures caused by the price increase. However, it is always possible not to sanction some increase in prices and re-allocate the resources for other purposes[16]. In this case, Table 1 shows that the nominal ACB went from R$ 9.7 billions in 1995 to R$ 21.9 billions in 2002, representing a 124.6% increase, enough to open space for new resource destinations in function of pre-established priorities.

Table 1
Global Budget and Affordability and Capital Budget from the Health Ministry
Nominal Values
(1995/2002)

R$ millions

Description	Year							
	1995	1996	1997	1998	1999	2000	2001	2002
Global Budget	14.937	14.377	18.804	19.324	20.338	22.699	26.136	28.293
(-) Personal and Social Responsibility	3.761	3.834	3.996	3.994	4.330	4.825	4.898	5.467
(-) External/ Internal Debt	1.369	499	1.790	2.333	155	153	235	370
(-) Basic Stabilization	65	33	90	142	201	158	1.199	570
Affordability and Capital Budget ACB	9.742	10.011	12.928	12.855	15.652	17.563	19.804	21.886

Source: Subsecretaría de Planeamiento y Presupuesto, Ministerio de Salud

Table 2 shows the evolution of the real values of the budget. Although the ACB shows some instability in the period, the main fact is that it increased from R$ 9.7 billions in 1995 to 13.3 billions in 2002, in other words, it had a real increase of 37%, an important budget increase and of available funds for the management to increase the existing services and establish new priorities[17]. The fact that in 2002 the real resources decreased did not alter the

[14] According to budget techniques, any loan or financing which is expended in one year forms the ACB of that given year. In the following years, when the portions begin to get paid the values will once again be a part in the signature list budget, but will be administered by the Secretary of Treasury.

[15] Regardless of the health effects, basic disinfection by definition does not represent assistance to health care and is not an objective to be discussed in this analysis.

[16] This is the case, for instance, of a decrease from an annual 2.7% in the birth rate, which is the primary component in the Ministry's expenses regarding hospital admissions, in addition to other sustained economies including the medicine sector, a factor that opens up resources for other means.

[17] The fact of using the Consumer's Price Index - IPCA/IBGE to devaluate the health values is more appropriate than using the General Price Index - IGP/FGV, because the health prices, therefore the costs, go hand in hand with the human resources costs, because the sector needs several human resources and the salary

course of the actions implemented up until 2001, and were already underway in 2002. This occurred because the drop was a result of an inflationary anchorage that happened in the second semester of 2002 as a result of the electoral process that compromised the values destined to the Health Ministry. However, according to the ruling legislation, the value correction has to occur again the following year.

Table2
Global Proposal and Affordability and Capital Proposal from the Health Ministry
Real Values
(1995/2002)

R$ millions in 1995 prices

	Year							
Description	1995	1996	1997	1998	1999	2000	2001	2002
Global Proposal	14.937	13.122	16.315	16.490	15.931	16.780	17.944	17.262
(-) Personal and Social Responsibility	3.761	3.499	3.466	3.408	3.392	3.567	3.363	3.336
(-) External/ Internal Debt	1.369	455	1.553	1.991	121	113	161	226
(-) Basic Stabilization	65	30	78	121	157	117	823	348
Affordability and Capital Proposal ACP	9.742	9.137	11.214	10.970	12.260	12.983	13.597	13.353

Deflator: IPCA/IBGE
Source: Subsecretaria de Planeamiento y Presupuesto, Ministerio de Salud

In fact in the year 2002, starting with a political initiative from the Ministry of Health, the Federal Government managed to obtain in the National Congress a constitutional amendment (Amendment n. 29) that foresees the stabilization of health financing in the country, establishing the minimum percentages that the states and municipalities have to use towards health care, it also determined that the Federal Government has to destine each year a percentage equivalent to the variations in the nominal GNP only for health. For states and municipalities, it was established a transition until 2004 that increases those minimal percentages[18]. This initiative was very important for three reasons: i) it secured a real growth of the resources for the Ministry of Health as long as the real GNP grew; ii) it avoided the continuation of a decentralizing process that would transfer the resources to sub-national spheres, which created, mainly in the state governments, a decrease in the resources destined to this sector, process called fund substitution, which resulted in a liquid balance close to zero; iii) it prevented that the fiscal surplus generation policy took funds away from health.

should accompany, in theory, the *IPCA*. This index reached up to 63.9% in the 1995~2002 period while the specific item of health life cost, a part of IPCA, increased up to 61.3% therefore demonstrating its importance.

[18] Constitutional Amendment nº 29, approved in 09/13/2000 sets the minimum resources that the Union, States, Federal Districts, and Municipalities have to destine to the actions and services regarding public health. In regards to the Union, it was determined that the Ministry of Health should apply, in 2000, the values given in 1999 plus a 5%. From 2001 to 2004, the value should be corrected by the nominal variation of the GNP. For the States, it should be applied in 2000 at least, 7% of the tax remuneration, excluding the transferences to the municipalities, until reaching 12% in 2004, with yearly increments starting in 2001 of at least 1/5. In the case of the Federal District and Municipalities, the minimum that should be applied was of 7% in 2000 until reaching 15% in 2004, with the same yearly increments of at least 1/5.

2. Objectives

The main objectives sought by this health policy in the period were: broaden the access to health services, increase supply, improve the quality and resolution, and increase equity[19].

3. Strategies

Faced with the macroeconomic restrictions situation and the demand for public health care services, the maneuver margins for implementing health polices were relatively slim. By examining the actions implemented in the period, the search for the determined objectives was made by means of the following strategies:

- Emphasis in basic assistance[20]
- Decentralization of resources and actions
- Control of medium and high complexity services' offer
- Active policy of resource destination
- Stability in the public sector financing and regulation in the area of medicines and supplementary health care

The emphasis in basic assistance can be demonstrated by the strengthening and extension of resources for this level of assistance and can be justified by the possibility of achieving certain goals at the same time, though some are mid and long-term:

- Demand less *per capita* resources and less technology, in addition to being able to rely more in the drafting of human resources
- Demand less movement of resources
- Facilitate health system access to the most vulnerable part of the population
- Be more resolving, reducing the necessity of heading towards the more complex and expensive levels of the system
- Change the logic of the assistance model, restructuring the organization of it, starting with basic assistance, making it more accessible, more resolving and less expensive in mid-term[21].

The first task was to establish in 1998 a minimum value *per capita* (denominated BCL – Basic Care Level, initially set at R$ 10.00/year) to which all municipalities would have the right to receive directly from the Ministry, with automatic and monthly installments from

[19] A good reference is SERRA, 2000.

[20] The **Basic assistance,** can be comprised as a set of actions, of individual or collective value, located in the first assistance level of the health systems, directed to promote health, prevent disease reoccurrence, treat, and rehab such as: medical visits in Basic specialties, Basic dentistry, Basic care for other health professionals, ambulatory and in-home visits/assistances by members of the family health team, vaccination, pre-natal assistance, minor surgeries, fast assistance, and others, that fundamentally are originated in the Basic units of health. **The Standard and high complexity** consists of both ambulatory and hospital procedures. In the Standard complexity, it is included, among others: specialized ambulatory surgeries, trauma, orthopedic procedures, clinical pathology, radio-diagnosis, ultrasounds, prosthesis, anesthesia, hemodyalisis, substitutive renal therapy, radiotherapy, chemotherapy, MRI's, topographies, and specified medicines. In the high complexity, besides the hospitalizations of any nature, it is included births, and several types of surgeries, from simple ones to very complex ones (like open heart, neurological, and others).

[21] About the advantages of basic assistance see STARFIELD, 2002.

the National Fund for Health to the Municipal Funds for Health[22]. With this measure, close to 3,860 municipalities (70% of the Brazilian municipalities), that received below this value, had an increase in the resources received. Municipalities with *per capita* higher than this level continued receiving the previous values. The most benefited, were the smaller and poorer municipalities, some of which, under the previous system did not even meet basic material requirements to allow the Ministry of Health to compensate for the procedures made[23].

In the following years, BAL incentives (denominated BCL variables) were created; these consisted of *per capita* values aggregated to the fixed BCL value in those municipalities that assumed other responsibilities in basic assistance such as, Sanitary Surveillance (R$ 0.50 *per capita*/year), Epidemic Surveillance (R$ 0.50 *per capita*/year), Nutritional Lack (R$ 0.50 *per capita*/year), Basic Pharmaceutical Care (R$ 0.50 *per capita*/year) and Communal Agents or Family Health Teams or both, as it will be observed later on[24].

It should be emphasized the implementation of the incentive for pharmaceutical assistance, very important for basic assistance, because one of the problems with the Brazilian health system was that the citizen would receive medical assistance and would not have the resources to pay for the medicine recommended or required to cure the disease, which meant the possibility of follow-up appointments, thus overloading the health system and increasing the costs. In this first phase, essential medicines to treat basic health concerns were guaranteed.

The increase in the number of community agents and Family Health Teams made up the Ministry's most active policy and a huge effort in the settlement of bases for a change in the existing health model, giving priority to preventive care, the promotion and rehabilitation starting in the basic units of health care, in a maneuver to make them the foundation of the system. For this, economic incentives were created for the municipalities that implemented family health teams (formed by a doctor, a nurse, an assistance nurse and five or six community health agents, who would be able to take care of approximately 750 families in a limited territory). Initially, these incentives came from fixed values of remuneration for teams installed by the Ministry.[25]

When the growing rate of teams decreased in 1999, the Ministry created an additional economic incentive where the existing teams and the ones that were going to be installed, would receive bigger values according to the population coverage, see Table 3. It can be observed that the value per team almost doubled in the lower level (up to 4.9% of the population covered) and higher level (70% and more of the population covered). As it will

[22] Funds established in the legislation (Law. 8.080 of 09/19/90 and Law. n. 8.142 of 12/28/90), in which all funds from all the sources are deposited for the health sector and where the necessary expenses come from.
[23] Out of a total 5,560 Brazilian municipalities, 582 did not show invoicing and thus did not receive funds for basic health care, 1,842 did show invoicing of up until R$ 5.00/*capita* and 3,860 received less than R$ 10.00/*capita*. (NEGRI, 2002a; COSTA, 2002).
[24] Both the fixed and variable BAL were part of the 1996 BON.
[25] Although the main focus of this policy was the numeric expansion of complete family health teams, it was not allowed to forget about the communal agents hired, particularly by the municipalities with difficulties bringing together all the professionals needed to form the family health teams.

be shown later on, the number of teams doubled in 2000 compared to 1999, showing the success of this incentive policy.

Table 3
Value of the incentive for the installation of family health teams by value of coverage of the population

Coverage Level Classification	Population Coverage Levels (in %)	Value of incentive/team/year (R$)
1	0 to 4.9	28,008
2	5 to 9.9	30,684
3	10 to 19.9	33,360
4	20 to 29.9	38,520
5	30 to 39.9	41,220
6	40 to 49.9	44,100
7	50 to 59.9	47,160
8	60 to 69.9	50,472
9	70 and more	54,000

Source: BRASIL, Ministerio de Salud, 2000

To support this policy, the main decision was to secure the resources for its implementation. Table 4 shows the destination of the actual resources of the Health Ministry in the period 1995-2002. As it was previously said, the only values taken into account are those of the ACP. It is obvious the option and priority of basic care, its resources growing from R$ 1,575 million in 1995 to R$ 2,983 millions in 2002, representing a nominal increase of 89.4%, while the resources for standard and higher complexity care went from R$ 6,687 millions to R$ 7,934 millions for the same period, an increase of 18.6%. With this, the participation of basic care in the ACP of the Ministry went from 16.2% in 1995 to 22.3% in 2002. One can also observe that although the values for the fixed BCL remained relatively constant, the resources of communal agents and Family Health Program grew 917%, whenever the resources for other basic care actions also increased.[26]

There was also great effort in the evaluation of health professionals involved with the Family Health Teams. Family Health Training Centers were created in all states in conjunction with the universities, with the ability to train human resources. Later on, courses in Specialization and Residency in Family Health were created. To these initiatives it was added a training and evaluation program of nursing assistants and technicians, named PROFAE, financed with resources from IBD, which would help in the increase of the working force needed due to the expansion of the family health strategies[27].

[26] It is important to note that both the fixed BCL resources, and those destined to family health teams, share the same level in basic care. The government's option was to bet on a family health model, and for this, it stabilized the resources based in real BCL terms, at the same time that it increased substantially for family health. One can not forget to mention, the inversion and training expenses, and personnel qualification for family health, that were made during the *REFORSUS* Project (SANTOS, Reforsus, 2002).
[27] The data about family health can be found in SANTOS, Reforsus, 2002.

Table 4
Destination of the Resources of Affordability and Costs Budget of the Ministry of Health
Real Values
(1995/2002)

R$ millions of 1995

Description	Year							
	1995	1996	1997	1998	1999	2000	2001	2002
1 – Basic Care	1,575	1,377	1,957	2,225	2,493	2,620	2,889	2,983
Fixed BCL	1,116	1,046	1,223	1,470	1,392	1,276	1,229	1,137
Family Health/Common Ag.	79	101	140	193	254	485	665	804
Nutr Car/ /Meal Plans	129	29	88	50	110	112	117	155
Basic Farm /HBP and Diab				38	97	121	115	101
Vaccinations	105	120	155	162	215	197	228	302
Endemic Prevention	146	81	351	312	425	429	535	484
2 – Standard and High Complex.	6,687	6,713	7,713	7,058	7,603	8,004	8,283	7,934
Ambulatories/Hospital	6,130	6,118	7.098	6,484	7,034	7,494	7,791	7,448
Private Hospitals	557	595	616	574	569	510	492	486
3 – Other Costs/ Inversion.	1,479	1,042	1,542	1,685	2,165	2,357	2,425	2,435
4 – ACB	9,742	9,137	11,214	10,970	12,260	12,983	13,597	13,353

Deflator: IPCA/IBGE
Source: Subsecretaría de Planeamiento y Presupuesto, Ministerio de la Salud

The decentralization of resources and actions had as a goal to leave the economic resources closer to those who actually provided the services: states and municipalities. The payments began to become monthly and automatic, without the pre-requisite of sending all the documents pertinent to the procedures made, although it was still necessary for data registration. This strategy had some goals:

- It eliminated bureaucracy in the system and reduced the cost because of effort reduction regarding preparation, verification and data and information correction.
- It sped up the resource transference avoiding delays, allowing better planning of local actions, organizing resources better (material and human), and reducing the costs because of the security of receiving the monthly installments in pre-established dates.
- It increased local management responsibility by eliminating the possibility of using the delays or lack of federal resources as an excuse for the faults in the local system, although the system of co-financing and possible questioning of values still allow the transference of responsibility as a result of bad management across the government spheres.

The resource decentralization for status and municipalities is done according to the modalities of approved management, resulting from a qualification process of the status and municipalities as established in the 1996 BON, in which they had to fulfill certain pre-requisites of organization and managing abilities of the presented system. In this process it is necessary to say, that there was an initial weakness in the collegiate organisms regarding the approval, particularly of some municipalities that were accepted for complete management of the system and that were not completely capable of achieving that task[28]. Regardless, there are control and evaluation instruments of the Ministry that allow the correction of these distortions. The following Table 5 shows the advance in the decentralization process. In addition to the number of habilitated municipalities (practically the totality) and states that already received resources automatically, the most important data is that out of the total federal resources in 1997, only 24.1% was transferred automatically, and in 2001 it was 66.9%.

Table 5
Decentralization Evolution Indicators
(1997/2001)

Indicators	Dec./97	Dec./98	Dec./99	Dec./00	Dec./01
Number of habilitated municipalities with automatic transference.	144	5,049	5,350	5,450	5,516
Number of habilitated states with automatic transference	-	2	7	8	12
% of the population residing in the habilitated municipalities with automatic transference	17.3	89.9	99.3	99.7	99.9
% total of federal resources transferred to health funds	24.1	52.5	58.1	63.2	66.9

Source: BRASIL, Ministerio de Salud, 2002a

The **Control of medium and high complexity services' offer** was an essential element in the health costs control strategy, because it represented the assistance area drawing the biggest part of resources from the Ministry and the national health system, which allowed the resource liberation for the Ministry priority policy of increasing basic health care. This control allowed the Ministry to create incentives for offering exams, procedures, and surgeries, for which there was an important demand and a restricted supply, in addition to incorporating new medicines of continuous use or high costs (special medicine) to distribute free of cost, to the population in bad or chronic health state.

The principal measure taken, was to eliminate the practice of linear re-adjustments of the procedures tables, based in a previous inflation index. The linear re-adjustments stabilize the relative prices, they froze the demand structure, and created an unfavorable selection of the clientele for ambulatory and clinical services, because it resulted in a higher demand for the procedures with some profit and the ones costing higher than the ones established by the SHS, were decreased. With the differentiated adjustments, it was possible in a way, to line up the prices of some procedures, with their actual costs (task that is impossible to

[28] The management alternatives and the habilitation requisites are specified in 1996 BON.

complete in an administrative cycle and thus it has to be permanent), on the other hand it favored a supply increase of some necessary services for population's health, identified by the Ministry. In some cases, the demands were taken to the Ministry by movements of the organized society[29].

The Ministry of Health owned a list for special or specified medicines, which was updated throughout the years, based on financial availability, always based on a careful study of potential demand and the unit costs of these medicines. The patients requiring these types of medication free of cost are registered in the public health system, in which they receive treatments and medicines. These measures broadened the availability of these medicines to the population and controlled the costs of this policy. Obviously, a lot of medicines need to be added to this list, which should be a permanent policy in relation to the availability of funds. The number of people receiving these medicaments in 2002 was 87[30].

Another measure was the creation of Strategic Actions Funds – *FAEC* (by its initials in Spanish) – with resources centered in the Ministry of Health[31]. This fund was created to guarantee the purchase of special medicines and tend to the specific health needs or the supply of some services that were not guaranteed by the decentralization of resources. In the case of special medicines, the states receive federal resources based on the number of registered patients, the cost of the medicine and the prescribed amount. On the other hand, the possibility of complementing the transfer of funds was created for states and municipalities with complete management when these offered these complex services to citizens of other states and municipalities and whose values were not included in the automatic transference and in the Integrated and Agreed Program –IAP[32]. [33] This happens based in the technological disparity in the supply of health services among states and regions, which induces the transit of patients to the place where services are offered, without the necessary resource coverage, compromising resources in the receiving state. In addition, the FAEC allows the supply of some services with repressed demand and insufficient supply, such as was the case of a number of cataracts surgeries, varicose veins, prostate, etc.

One can not forget to mention the six initiatives adopted to ameliorate hospital management in the country: i) specialization courses for hospital administration directed toward bigger hospitals; ii) management training from a distance for small and medium hospitals; iii) from a distance management courses of equipment maintenance; iv) courses from a distance for health waste management; v) creation of programs to develop

[29] The procedures table establishes the values paid by the public sector to the private sector for the services provided. The adverse selection remains, although there has been a correction of prices, even if it was because of that selection. This problem can only be substantially reduced, if the resources were sufficient enough to correct the values in a wide variety of procedures.

[30] The introduction of new medicines demands clinical protocols made with the participation of specialists of the specific area. Among the medicines that are in the list are those needed for the treatment of AIDS, High Blood Pressure, Diabetes, Transplants, Hepatitis, Osteoporosis, Multiple Sclerosis, Alzheimer's Disease, Hemodyalisis and others

[31] FAEC was created by the Ministerial Protocol Unit GM/MS n. 531 of 04/30/99

[32] The IAP is a planning instrument in each state and municipal jurisdiction, by means of which the demand and supply of health actions and services are foreseen based in the installed capacity. The document, product of debates among municipalities and states, established the necessary values needed to perform the actions.

Collaboration Centers for the Quality of Management and Hospital Assistance; vi) development of a program for hospital accreditation and the creation of Hospital Accreditation Manual. All of these initiatives were made in the Project *REFORSUS*[33].

The **Active policy of destination of resources** was a fundamental strategy of the Ministry of Health, because it contrasted with the tendency of the public sector of setting the expenses' structure based on programs and pre-existing actions, only adjusting the values based in certain price indexes. This means attempting to obtain the maximum number of results with the existing resources. Being coherent with the previous strategies, the Ministry continued some principles and sought some goals:

- A budgetary and financial execution was made giving priority to the automatic resource review of undefined dates, eliminating delays as in 1997
- Priority was given to the resources destined to the actions related to basic assistance, especially to the Family Health Program (as seen in Table 4).
- There was a resource guarantee to attend the decentralization principle.
- They tried to reduce the difference among regions and states because of the *per capita* distribution of federal resources, crucial element in the search for a more equal objective.
- There was strong concentration of investments in civil works and equipment in the standard and high complexity, offering these in the poorer regions and technologically updating the ambulatory and hospital system of all the regions, improving the foundation of the basic assistance.

The majority of these issues were already treated previously and they were all related to the Ministry expense in basic assistance and in the standard and high complexity. It only lacks in treating the investment's cases. There were three problems to be resolved; i) broaden the resources to invest in basic assistance based in pre-established priorities; ii) increase the supply of services and update the ambulatory and hospital network that had stayed a long time without investments; iii) guarantee the rearguard of standard and high complexity, necessary because of the increase in basic assistance, as well as because of disease changes caused by the urbanization process and because of the population's aging. Since the 80s crisis, the states were left without the ability to invest and the only alternative was that the Union would provide the necessary resources. The volume of the National Treasury resources was extended gradually with this objective and there was an investment project in the 1996-2002 period named *Reforsus*, with financial help from IBD y BIRD[34].

Table 6 shows the values that were invested in 1995-2002 in real values. Not taking into account the investment in basic disinfection, there was an average investment in the infrastructure of the SHS of R$ 777.6 millions per year, which represented an average of

[33] The data about the content of the course can be found in SANTOS, Reforsus, 2002 and other information can be found in BRASIL, Ministry of Health, 2002b.

[34] Loan of US$ 650 millions, in which only the infrastructure investments reached almost 1,000 hospitals in the country, 198 blood centers and 27 laboratories of public health, increasing to close to 10 thousand new beds in the network and if it works properly, allowing the performance of 60 thousand new hospitalizations/month and 25 thousand new surgeries/month (SANTOS, Reforsus, 2002)

4.2% of the available resources for the Ministry to execute the actions of affordability and costs, seen in the ACP[35]. As it can be seen in the 1999-2002 period, at the same time in which the majority of the Ministry actions occur, the volume of investments in the SHS infrastructure (4 billion) reaches almost twice of what it was during the last 4-year period (R$ 2.2 billions).

In addition to basic assistance, which requires less resources due to its low technological complexity, a big part of the investments' value was to conclude, reform, enlarge, and adequate existing health establishments, in addition to provide adequate equipment. All of the third level federal university hospitals received the investments in high complexity equipments, as well as the main state hospitals. The majority of investments were for maternities, chirurgical centers, intensive care units (ICUs) for adults and children, oncology (diagnosis and treatment), neurology, cardiology, and emergency. Specific investment plans were created for emergency and oncology, because these are precarious services and because of the evidence of having several deaths caused by accidents and also due to the growth of degenerative chronic diseases, result of the population's aging. There were also investments in public laboratories that produce generic medicines, items of a specific plan[36].

[35] It is not the Ministry of Health's tradition to invest in basic disinfection. Its actions are restricted to simple disinfecting systems and sanitary enhancements in small localities and rural areas. The same way, in 12/14/2000, by means of Constitutional Amendment n. 31, the Fund for the Eradication of Poverty was created and as an exception, the Ministry of Health started to receive resources for basic disinfection beginning in 2001.

[36] BRASIL. Ministry of Health, 2002d.

Table 6
Ministry of Health Investment
(1995/2002)

R$ millions in 2001 price

Description	Period		Total 1995/2002
	1995/1998	1999/2002	
1- SHS Infrastructure	2,201.8	4,019.2	6,221.0
1.1 - REFORSUS Project (BIRD/IBD)	308.8	991.1	1,299.9
1.2 - New Hospital Equipment Project	-	212.6	212.6
1.3 - Direct treaties with States/Mun,/Entities	312.5	493.5	806.0
1.4 - Parliamentary Amendments Status/Mun./Ent.	403,7	1,110.0	1,513.7
1.5 - Northeast Projects I and II (BIRD)	169.2	-	169.2
1.6 - Blood and derivatives	41.9	136.8	178.7
1.7 - Battling Cancer	87.4	100.5	187.9
1.8 - Battling Aids	9.9	52.7	62.6
1.9 - Sanitary Watch	26.3	69.8	96.1
1.10- Immunizations and Vaccines	134.3	100.8	235.1
1.11- Endemic Control	256.5	405.8	662.3
1.12- Native's Health	-	40.0	40.0
1.13- Others	451.3	305.6	756.9
2 – Basic Disinfection	753.8	2,635.2	3,389.0
2.1 - Direct treaties with Status/ Municipalities	484.8	594.1	1,078.9
2.2 - Parliamentary Amendments	269.0	551.1	820.1
2.3 - *Alvorada* Project (Battling Poverty Fund)	-	1,490.0	1,490.0
GENERAL TOTAL	2,955.6	6,654.4	9,610.0

Deflator: IGP-DI/FGV
Source: Subsecretaria de Planeamiento y presupuesto, Ministerio de Salud

Financing and regulation reached three areas of the health sector: the resources, the medicines, and the private health plans. In financing, there was an attempt to maintain stability by means of the Constitutional Amendment n. 29 already treated. In the regulation, it is evident a concern with the costs, with the system's quality, and population protection, which tends to benefit both the population depending on the public system, as well as that which is supplied by private health plans and liberal medicine. On one hand, there were attempts to slow down the medicine's prices, by means of the implementation of a policy to facilitate the introduction of generics[37], with a subsequent fixation and control of prices for

[37] Even if there was a government order regarding generic medicines (Order n. 793 of 04/04/93), objective conditions for its application and for the development of a policy in this area were not created. Only with the creation of the National Health Surveillance Agency –*ANVISA* (Law n. 9.782 of 01/26/99) it was possible to implement a generic medicine policy (Law n. 9.787 de 10/02/99). Simultaneously, an inversion plan for the modernization of official laboratories was created (public state laboratories that produce some generic medicines) which, besides serving the public health sector demand, serve as reference price comparison for the generics.

the majority of the medicines[38]. On the other hand, in the institutional side, the regulation was implemented by means of the creation of two regulating agencies: The National Health Surveillance Agency – *ANVISA* (by its initials in Spanish) - and the National Supplementary Health Agency- *ANS* (by its initials in Spanish)[39].

The first Agency, among other functions, has the job of deciding the introduction of new medicines in the market, evaluating the tests for generic medicine approval, even examining readjustments requested by the corporations and defining the index of these. The second one must accompany and ensure compliance in the contracts of health plans operators and its clients, establish contract registers, evaluate and decide the readjustments of those contracts, in addition of demanding, according to the legislation that created it, an compensation to the public sector for private health plans, the occasional assistance of its affiliates for the public sector, as long as the adopted procedures are foreseen in the contracts.

4. Tools

To reach the defined objectives and strategies, tools foreseen in the legislation and SHS regulations were used, or other alternatives were created. Since the topics were previously presented, this is just a summary:

The primary tools used in basic health assistance were:

- The definition of a *per capita* minimum.
- The elaboration of automatic resource transfer mechanisms for municipalities based on the *per capita.*
- The creation of additional incentives to the *per capita* as long as the municipalities assumed other types of programs or actions defined by the Ministry (basic pharmaceutical assistance, health and epidemiological surveillance, and facing of nutritional deficiencies/ nutrition funds).
- The definition of a value to transfer from health family teams to the municipalities and subsequently the creation of a progressive incentive function of the population's coverage level in each municipality.

The tools for medium and high complexity were:

- The readjustments differentiated from the procedures' prices as an incentive for services identified as population's interest by the Ministry.
- Gradual introduction of new especial medications to be distributed to the population free of cost according with the availability of the Ministry's resources.
- Creation of the Strategic Actions Fund.
- Investments to increase and modernize the physical and technological infrastructure of the system with Treasury resources and international financing.

[38] By means of the Provisional Measure n. 2063, of 12/18/00, the medicine prices were fixated, establishing a formula for its readjustments and a Medicine Chamber for the analysis of the readjustment solicitations, among other objectives.

[39] The legislation which created the National Health Surveillance Agency was already cited in note n. 38. The National Supplementary Health Agency was created by Law n. 9.9961 of 01/28/00.

The rest of the tools used; those of a more general nature were:

- Approval of the Constitutional Amendment n. 29 which secured stability in the financing for the public health system.
- Approval of a legislation to develop a generic medicine policy, and to control the price of medicines.
- Creation of Regulating Agencies of Health Surveillance and of Supplementary Health.

It is important to underline that part of the used tools did not require institutional changes, since the existing legislation on the matter already anticipated these or left room for its conception and usage. As it was pointed out at the beginning of this analysis, the health system is managed by norms and regulations created by the Ministry of Health, with the participation of the majority of municipal and state shareholders. During the analyzed period, only the generic medicine issue, medicine price control, health plan regulation, and definition of the minimum resource limits in all the government spheres, required legal and constitutional changes approved by the National Congress.

5. Results

Because this entire process is very recent, there is a lack of sufficient scientific work to analyze the policy's impact. The existing results are of quantitative nature and are expressed in the service supply. On the other hand, the impact could only be verified by access and usage indicators and by testing the quality of the population's health care. In this case, in addition of not having sufficient and adequate data, other variables concur in its explanation. This way, some of the currently available data will be presented, from which the impact on the population's health can be deducted.

Since there are no specific indicators, the hypothesis of this work are: i) the resource expansion for basic health assistance and an increase in the number of family health teams; these are indicators that suggest an increase in access and an improvement in the population's health; ii) a more equal distribution of federal health resources, improving the relative situation of the poorest regions of the country, this is an indicator of the disparity reduction in the supply of health services and as a consequence there must have been an increase in this population's access; iii) since there is a lack of quality evaluations of the rest of the health policy actions, it is assumed that the impact can be reflected in a drop in mortality rate, even if it is known that this is indicator reflects much more than the specific action in the health sector.

Tables 7 and 8 present the results of the incentive policy for the implementation of the family health program in the country. The first one shows the significant increase in the number of equipment, which in 1994 added up to 328 serving 1.1 million Brazilians (0.7% of the population), and by the end of 2002 increased up to 16,847 equipments serving 58.1 millions of people (33.7%) The second one, displays the distribution of these equipments throughout the country and the degree of population coverage, noting that the northwest region, the less affluent, is the one that had a larger coverage (48.1% assisted people).

Table 7
Family Health Program: Number of Equipments, Assisted Population and Population Coverage
(1994/2002)

YEAR	NUMBER OF EQUIPMENTS	ASSISTED POPULATION (Millions of inhabitants)	PERCENTAGE OF COUNTRY COVERAGE
1994	328	1.1	0.7
1995	724	2.5	1.6
1996	847	2.9	1.8
1997	1,623	5.6	3.5
1998	3,083	10.6	6.5
1999	4,254	14.7	8.7
2000	8,604	29.7	17.5
2001	13,168	45.4	26.3
2002	16,,847	58.1	33.7

Source: BRASIL, Ministerio de Salud, 2003

Table 8
Family Health Program: Number of Equipments, Assisted Population and Regional Distribution
(Diciembre/2002)

REGION	RESIDENT POPULATION		FHP EQUIPMENTS		ASSISTED POPULATION	
	Millions of Inhabitants	% with relation to the rest of the country	Quantity	% Region	Millions of Inhabitants	% of Population Coverage
North	13.2	7.7	1,193	7.1	4.1	31.0
Northwest	48.3	28.0	6,741	40.0	23.3	48.1
Midwest	11.9	6.9	1,420	8.4	4.9	41.2
Southeast	73.5	42.6	5,053	30.0	17.4	23.7
South	25.4	14.8	2,440	14.5	8.4	33.1
TOTAL	172.4	100.0	16,847	100.0	58.1	33.7

Source: BRASIL, Ministerio de Salud 2003

Tables 9 and 10 exhibit part of the result of the readjustments policies differentiated from the procedures price as an incentive for the supply of some medium and high complexity services, associated with an investment policy for buildings and equipment. In table 9, the increase in the production of certain services can be appreciated for the 1995-2001 period.

Since the majority of these procedures depend of an authorization to performed, the growth can only be explained by the existence of a repressed demand that started to be attended. Additionally, its growth rate was superior to that of the population growth rate for the period, 8.4% according to *IBGE*.[40] Table 10 shows these numbers in a regional distribution. In the majority of the procedures a larger increase in supply can be observed in the North, Northwest and Midwest regions, historically regions with a reduced installed capacity and with an inferior service supply, which demonstrates that the regional disparity of supply was reduced and that the access of the poorer, previously unattended population increased, since these are the country's poorer regions.

Table 9
Quantity of some Selected Procedures
(1995/2001)

Procedures	YEAR		2001/1995 (%)
	1995	2001	
Mammography	589,729	1,475,224	150.1
Oncology Surgeries	43,310	86,386	99.4
Magnetic Ultrasound	43,873(*)	87,004	98.3
Hemodyalisis Sessions	3,375,573	6.585,913	95.1
Chemotherapy Sessions	497,034	945,299	90.2
Transplants	4,134	7,229	74.9
Neurosurgeries	90,953	151,555	66.6
Cardiac Surgeries	51,345	78,141	52.2
Tomography	573,018	817,656	42.7

(*) 1999 Data
Source: www.datasus.gov.br

[40] www.ibge.gov.br

Table 10
Increase in the Number of Procedures per Region
(1995/2001)

Procedures	Variation % per Region				
	North	Northwest	Midwest	Southeast	South
Mammography	196.4	176.9	246.7	139.9	115.6
Oncology Surgeries	115.2	68.6	85.2	104.5	128.0
Magnetic Ultrasound (*)	925.9	447.7	486.2	64.5	(8.2)
Hemodyalisis Sessions	283.0	105.4	126.9	89.5	82.2
Chemotherapy Sessions	174.4	89.7	95.6	89.5	85.1
Transplants	726.9	117.3	107.7	79.5	35.7
Neurosurgeries	78.5	69.3	79.3	48.9	106.5
Cardiac Surgeries	228.3	65.7	56.3	36.2	78.3
Tomography	143.1	76.6	101.8	27.6	40.4

(*) Comparison 2001/1999
Source: www. Datasus.gov.br

Table 11 presents a synthesis of the results of the disparity reduction policy in federal resource distribution for health management (sum of basic assistance and medium and high complexity resources). It is noticeable a significant reduction in the *per capita* values of the regions between 1994 and 2001. The difference between the smaller (R$ 29.66) and the greater *per capita* (R$ 52.89), which was 78.3% in 1994, changed to 24.3% in 2001. The *per capita* values of the north and northwest regions, which represented 64.75% and 80.48% of the 1994 national average, went to represent 84.44% and 96.3% in 2001. On the other hand, the difference between the higher *per capita* values and the average *per capita*, which was 15.46% (in favor of the southeast region) in 1994, changed to 4.96% (in favor of the south region) in 2001. The explanation for the north region to continue having a lower *per capita* than that of the other regions can be found in its poor capacity to expand the installations and offer some high complexity services, primarily because of the lack of adequate human resources, a factor related to the lower attraction that this region exerts on health professionals.

With these results, in addition to the ones previously noted, it is possible to conclude regarding the increase in the equality of health in Brazil. In addition to an increase in the service supply, both in basic assistance as well as in medium and high complexity, the larger relative increases are concentrated in the country's poorer regions. This only became possible because the increase in the average *per capita* value of 78.4% was superior to the period's inflation of 45.6%. It can be added to this that the raise in the *per capita* value was larger in the less affluent regions, reducing the difference in the federal resource availability for health amongst the country's regions. It has to do with an improved horizontal equality, the first step leading towards an increased in vertical equality[41].

[41] According to Starfield, adopting the distinction formulated by West (apud PORTO, 2002, p.129), equity in health services "means that there are no differences between health services for the same necessities (horizontal) and more services will be offered wherever health necessities are bigger (*vertical equity*)" (apud

Table 11
Regional Distribution of the Per Capita Values, Including Basic Assistance, Medium and High Complexity
(1994/2001)

Region	1994		2001		***Per capita variation*** **2001/1995 (%)**
	Per capita	*Per capita* region/ country average (%)	*Per capita*	*Per capita* region/ country average (%)	
Midwest	45,19	98,65	81,26	99,41	79,8
Northwest	36,87	80,48	78,71	96,30	113,5
North	29,66	64,75	69,02	84,44	132,7
Southeast	52,89	115,46	84,68	103,60	60,1
South	50,42	110,06	85,79	104,96	70,1
BRAZIL	45,81	100,00	81,74	100,0	78,4

Source: BRASIL, Ministerio de Salud, 2002 a

According with the previously cleared issues, in the absence of other direct impact indicators, it was chosen the usage of a synthesis indicator, represented by the infant mortality rate. In favor of this indicator, there are references that this is associated not only to the population's general living conditions, but also to the access possibilities and the quality of the health services offered (CAMPOS et al., 2000). Table 12 presents the rates of Brazil and its regions in the years 1994 and 2002. It is noticeable a drop in the country's rate from 32.2% between 1994 and 2002, with a larger reduction in the northwest region (35.1%) the poorest of the country. Even though these rates are high compared to those of countries with similar level of *per capita* rent, it is important to observe its evolution in the following years, when the effects of the adopted health policy must have increased its results, while there is a temporary discrepancy between the resources, the organization of services, and the impact on the population's health.

MACINKO e STARFIELD, p.3). In other words, equity means securing the access and usage of health services, according with the population's needs.

Table 12
Infant Mortality Rate in Brazil
(1994/2002)

Region	1994	2002	Variation %
Norte	37.7	27.7	(-) 26.5
Northwest	63.8	41.4	(-) 35.1
Midwest	26.7	20.4	(-) 23.9
Southeast	27.5	20.2	(-) 26.5
South	23.5	17.9	(-) 23.8
Brazil	41.0	27.8	(-) 32.2

Source: 1994 (www.saude.gov.br); 2002 (BRASIL, IBGE, 2004)

6. Challenges

It does not seem hard to point out that one of challenges to be faced by the health sector would be to increase the actions regarding basic assistance, including an increase in the number of family health equipment, especially in the bigger centers and metropolitan regions, where the difficulties have been greater and where the environments are more complex[42]. This obviously demands more resources, but these are relatively low, as demonstrated by the raise in the number of installed equipments (Table 7) versus the increase of the destined values (Table 4). Due to an accelerated growth in the number of equipments throughout the country, it is also necessary to perform an evaluation of the achieved results and a correction of the occasional problems, especially in the quality of assistance and in the permanent training and qualification of the equipment professionals.

The second challenge is in the service and investments areas to guarantee the necessary rearguard for basic assistance actions. On one hand, it is shown the necessity of evaluation of the pharmaceutical assistance policy and its occasional corrections, because the access to essential medicine is a primary element for cost reduction. On the other hand, there is a necessity to better organize the system to allow the population access to the remaining complexity levels of the system at the appropriate time, as long as these are indicated by basic assistance. Therefore it has to do with accelerating the implementation of the ONHA, norm which allows, by means of each State's RNPs and MPIs, to select the priority of the services that must be established and the investments that need to be performed.

The advancement on decentralization is a challenge that occurs, among others, because of a *per capitation* of the medium complexity, after the reorganization of the system anticipated by ONHA. This is an immediate possibility that does not depend on the investments that might be performed in the proper services, because with the resources that might be transferred, the managers would of course have the possibility of constructing those alternatives which would be more convenient in order to count with the required services. In high complexity, *per capitation* objective should also be sought. The primary problem is the costing, because with the currently available resources for health, it is inevitable a

[42] In 2002, the Ministry of Health signed a financing contract with *BIRD* to develop a project with this objective, called *PROESF*. The IBD is also interested in continuing its support to family health related projects in Brazil

supply division. In any way, there is a tool, the PPI with its respective assistance parameters, which lends the elements to keep moving in that certain direction.

In medium and high complexity, the procedure table values should also be permanently revised, not only to preserve the service supply and give incentives to that of the repressed ones, but also to pursue a better quality in these. In the special medications area, as long as there are no developments in the medicine policy (industrial policy) and in a more universal pharmaceutical assistance policy, the necessity of creating incentives for the supply of generic medicines will continue, as well as the need to enhance the high cost differentiated medicines list for a distribution to the population free of cost.

There is a long way ahead in the human resources and management areas. There is a clear necessity of a permanent technical training plan, in addition of the need of qualification in the management field. The Brazilian health system only has 16 years of existence and presents great management difficulties the way it is organized today, because of an almost total predominance of health professionals lacking administration knowledge in charge of its management. On the other hand, even though there was an improvement in the data network and now many health data can be accessed, there is still a need for great investment in this area and it is necessary integration health data bases and management tools for the planning, organization, control, and evaluation of the actions.

Finally, there is the problem of financing. Although the temporary stabilization obtained was a great conquer, the expenses with relation to the GNP are still much more inferior to what is spent in countries with health systems that work relatively well. Therefore, there exists a necessity to change health expenses in proportion to the country's product. This challenge is related to the partial removal of the country's macroeconomic restrictions, where the fiscal component is an obstacle for the advancement in the social policies field in general and particularly regarding health.

II-EDUCATION

1. Institutional and Resources Panel

1.1. *Education system structure in Brazil*

The current structure of the standard Brazilian educational system includes basic education –consisting of childhood education (pre-kindergartens up until the age of three and kindergartens until the age of six), "primary" education (eight years of study, starting at the age of seven), "mid" education (three years of study, of general or technical formation) – and "higher" education.

In all levels the students are attended by federal, state, or municipal educational networks. According to the current legislation, the counties must attend with priority childhood and primary education. It is the States and the Federal District's duty to supervise education especially during the last four years of primary education and during mid education. Higher public education is responsibility of the Federal Government and of each State. It is a Federal Government's task the organization of the higher educational system, aside of

redistributing and supplying, giving technical and financial assistance to other spheres of the government.

Primary or "fundamental" education, with a minimum duration of eight years, is free and mandatory in public schools, and it is the Public Sector's task to ensure it is given to everybody including those who did not have access to it at appropriate ages. In mid education, the current legislation foresees progressive universality.

It is also part of proper formal education, that differentiated to those who have especial needs and the education of youngsters and adults that did not have access to primary and mid education at the appropriate age or lose continuity in their studies. Professional education, integrated to diverse forms of education, to the job formation, to science and technology, has the objective of developing aptitudes for productive life. Technical level education is given independently from regular mid education. Regardless of this, it is a requisite to obtain a technical diploma.

Higher education is conformed by graduation and post-graduation programs. Graduation covers different professional areas, open to those candidates that concluded mid education and that were classified in selective processes. Post-graduation consists of Master, PHD, and specialization programs. The legislation also foresees the possibility of sequential courses at graduation level, with a shorter duration, to attend specific market demands. These courses have been offered basically by the private sector while the public sector option has been extension and specialization courses for graduates.

1.2. *Primary Education*

Prior to the 1998 Constitution, education was financed by 13% of federal taxes and 25% of state and municipal taxes. Although the legislation explicitly established as a priority the destination of these resources for primary education, they were free to be applied at any educational level, from childhood education until post-graduation[43]. This freedom provoked a disorganized expansion of the country's education, promoting an increase in higher education, which consumed more than 50% of the Ministry of Education's resources (53% in 2003), and that scattered across the municipal and state's networks negatively affecting the lower educational levels. Besides the virtually complete absence of the public sector in kinder garden education, primary education (1st to 8th grade) reached up to a little over 80% of the kids between 7 and 14 years old and access to mid education was restricted[44].

With the 1998 Constitution, the 25% binding of the municipal and state taxes remained, increasing to 18% the binding of Union taxes, and it was confirmed the complementary contribution of the education salary for primary education. In addition, the values destined for education were increased, raising the Income Tax (IT) and the Industrialized Products

[43] Law n. 7.348 from de 7/24/85, known as Calmon Law.
[44] To have an idea of the distortion, one must note that while the liquid scholarity rate of primary education went from 80,1% to 83,8% between 1980 and 1991, this same rate for secondary education went from 14,3% to 17,6 during the same period:
(http://www.inep.gov.br/imprensa/estatisticas/indicadores/atend_escol.htm

Tax (IPT) percentage for the States Participation Fund (21,5%) and for the Municipal Participation Fund (22,5%), out of which 25% should have been destined to the sustainability and development of education. It was still maintained the autonomy in the destination of the resources between the educational levels, same with the growth in primary education registrations, which increased in 27,4% between 1987 and 1994, causing the schooling rate to reach up to 87,5%[45].

The resources reserve anticipated in the Constitution, even though it has advanced when compared to the previous situation, maintained some imbalances and inequities that are explained here:

- The definition of the education expenses remained open, which favored the usage of the resources for diverse ends which were interpreted as relative or related to education.
- There were no adequate taxing mechanisms for resource usage, and due to the fragility of the previously mentioned definitions, all the accounts in general were approved by the Account Courthouses of each state (legally responsible of this action), which were more concerned with the official confirmation of the percentages foresaw by the law and less concerned with its contents.
- Since there was not a clear division between the states and the municipalities' responsibilities regarding primary education, a few imbalances surfaced, being the most important one, the differences in resources and therefore, in the quality of the education and the salary of school teachers within one state, given the unequal distribution of the resources between the governments of different states and municipalities.
- In 1994, while 96,1% of the kids between the ages of 7 and 14 years old in the most affluent region of the country (southeast) were attended with primary education, in the northwest region (the poorest region) the percentage decreased to 87,3%[46].

1.3. *Financing Education*

Faced with this scenario, Negri[47] was appointed to study the possibility of proposing alternatives that agreed with the available resources, in order to change this situation. A portion of the following comments and tables were taken from his work, which constitutes the base of the diagnosis and proposal that will become implemented with the creation of the Fund for the Maintenance and Development of Primary Education and Valorization of the School Board- *FUNDEF*. This fund will determine the sub-commission of 60% of

[45] 1994 data can be found in the Basic Education Statistical Synopsis 1991-1995 (www.inep.gov.br) and those corresponding to 1987, in:
http://www.inep.gov.br/imprensa/estatisticas/indicadores/atend_escol.htm
[46] SEMEGHINI, 2002
[47] Barjas Negri was the executive secretary of the National Fund for the Development of Education (NFDE) at the time. It is important to point out that, even though part of the data presented by Negri are estimates and do not correspond exactly to the values verified subsequently, this information is a good approximation and it formed the base of the diagnosis and proposal for the constitutional amendment that resulted in the creation of *FUNDEF*.

education values to be applied in primary education. This work allows the comprehension of the origin and construction of this proposal.

In table 13 the estimate data of the tax collect for the year 1995 is presented, according to Negri. It is feasible to verify the following: i) the federal government collected $42.3 billions, and its two main taxes, IT and IPT, accounted for 84.4% of the total collected; ii) the state governments and the Federal District collected $50.9 billions, its main tax, the MSCT representing 92.7% of the collected total; iii) the municipal governments collected $7.3 billions and its main taxes, the ANST and the TUPT, represented 87.5% of the total collected.

Table 13
Tax Collected in Brazil, by Government Sphere
(1995)

Government Sphere /Tax Type	Collected (Billions of $)	Percentage. no total	Percentage. In each sphere
FEDERAL	**42.277**	**44.8**	**100.0**
Income Tax – IT	26.455	25.0	56.0
Industrialized Products Tax – IPT	13.408	12.7	28.4
Others	7.414	7.1	15.6
STATE	**50.943**	**48.3**	**100.0**
Merchandise and Services Circulation Tax – MSCT	47.200	44.7	92.7
Motor Vehicle Property Tax – MVPT	2.454	2.3	4.8
Others	1.289	1.2	2.5
MUNICIPAL	**7.316**	**6.9**	**100.0**
Any Nature Service Tax – ANST	4.500	4.3	61.5
Territorial and Urban Property Tax – TUPT	1.900	1.8	26.0
Others	.916	.8	12.5
TOTAL	**105.536**	**100.0**	**-**

Source: NEGRI, 1997.

Since in Brazil there is a constitutionally defined transfer and division system, the final result between what is collected and what is available in each government sphere, is highly altered, especially those related to federal and municipal values, as shown in Table 14. It is noticeable that, after this process, the federal government, which collected 44.8% of the taxes in 1995, would keep 28.5%; the states, which collected 48.3%, kept 44.2%; and the municipalities, responsible for only 6.9% of the collection, kept 27.3% of the total resources.

Table 14
Collected and Available Taxes, by Government Sphere
(1995)

Government Sphere	Collected		Available	
	R$ billions	%	R$ billions	%
Federal	47.277	44.8	30.131	28.5
State	50.943	48.3	46.638	44.2
Municipal	7.316	6.9	28.767	27.3
Total	105.536	100.0	105.536	100.0

Source: NEGRI, 1997

Table 15 presents the values that should be destined for education for the different government spheres according to the binding predicted in the 1998 Constitution. The total was $24.3 billions (3.84% of the GNP), which if added to the 2.4 billions tied to the education-salary, reaches up to $26.7 billions (4.22% of the GNP).[48]

Table 15
Existing Taxes to Sustain and Develop Public Education in Brazil, by Government Sphere
(1995)

Government Sphere	Constitutional Binding	R$ billions	%
Federal	18%	5.423	22.3
State	25%	11.659	48.1
Municipal	25%	7.192	29.6
Total	23%	24.274	100.0

Source: NEGRI, 1997

The R$ 26.7 billions would be financing approximately 38 million persons registered throughout all the levels of public education, distributed as shown in Table 16. As can be noticed 52.8%, more than half of higher education, was concentrated at the federal sphere, even though there was a high participation (33.4% of the state governments and a lesser participation (13.8%) of the municipal governments. Childhood education (kindergarten) was concentrated in the municipal area (73.8%) and primary education was divided between the state governments (64.0%) and municipal (35.9%).

[48] The education-salary, which must be applied in primary education, represents 2.5% of the salary budget of the corporations and, according with Proposed Law n. 1.422 of 10/23/75, the collected resources are distributed in a 2/3 proportion for the state governments, according to the participation of each federal union in its total collection, and 1/3 for the federal government

Table 16
Estimate of Initial Registration in the Public Network, by Education Level and Government Sphere
(1995)

Education Level	Number of Registered Students						Total Students	Students/ Level above total (%)
	Federal		State		Municipal			
	Number	Sph/Lev (%)	Number	Sph/Lev (%)	Number	Sph/Lev (%)		
Preschool	6,589	0.1	1,186,085	26.1	3,358,789	73.8	4,551,463	12.0
Primary	41,429	0.1	18,327,363	64.0	10,260,801	35.9	28,629,593	75.3
Secondary	114,558	2.8	3,740,533	90.6	273,946	6.6	4,129,037	10.9
Higher	369,196	52.8	233,427	33.4	96,642	13.8	699,265	1.8
Total	531,772	1.4	23,487,408	61.8	13,990,178	36.8	38,009,358	100.0

Source: NEGRI, 1997

Negri observed that there was an alteration between the available resources for primary education in the state and municipal spheres and the respective registered students, as it is shown in Table 17 for the different regions of the country. The first disparity occurred between regions: the most affluent ones, southeast and south had available 50.4% and 15.6% of the resources to attend 40.1% and 13.7% respectively of the primary education students. The Northwest region (the poorest one) and the North region, had access to 20.2% and 7.3% of the resources to attend 29.8% and 9.3% of the students respectively. Both in absolute and relative terms, the Northwest region was the one most affected. Another imbalance occurred between the state and municipal governments in each region of the country. The most evident case occurred in the Northwest, where the states managed 66% of the resources and 46% of the students, while the municipalities managed 34% of the resources and 54% of the students.

Table 17
Distribution of the Resources and Registrations in Primary Public Education, by Region and Government Sphere
(1995)

Region	Total		States		Municipalities	
	% Resources	% Students	% Resources	% Students	% Resources	% Students
North	7.3	9.3	74	67	26	33
Northwest	20.2	29.8	66	46	34	54
Midwest	6.5	7.1	72	71	28	29
Southeast	50.4	40.1	70	74	30	26
South	15.6	13.7	66	60	33	40
Total	100.0	100.0	69	63	31	37

Source: NEGRI, 1997

What the author lacks showing in this document, even though it points out some of the alterations in given states, is an important third disparity between the resources and

registrations of the schools of state and municipal governments for each state, poor or rich, with different values per student, depending of the school registration, whether this is a state or a municipal one. Table 18 was created to solve for the lack of information on this important element in Negri's diagnosis; it presents the differences based on 1997 registrations and on the constituent values of *FUNDEF* which would be later created.

The alterations presented here are the result of an increase or decrease in the number municipalities with primary education system, valid in different states of the federation. While in the São Paulo state (SP) there were fewer municipalities (18.8%), in Alagoas state (AL) it reached up to 73.2%. The larger alterations occurred in the states of the Northwest region, as it is shown in the table's alteration index. In Acre state (AC), in the North region, something similar happened, and in the Southeast region, in the Rio de Janeiro state (RJ), the situation was the worst among all the states with the exception of Acre state. Another alteration that took place, but is not presented in this work because of the amount of data required, was the disparity in the power to collect and its respective expense capacity amongst the more than 5,500 Brazilian municipalities: those who were economically richer had a higher value per student than the poor ones.

It was based on this diagnosis and data that *FUNDEF* was created. The fund did not seek the reduction of regional disparity, because this would fall outside of its possibilities, since part of the *resource per student* alteration in primary education depended of each federal union's capacity to collect. But, as the federal government's possibility to complement state resources was predicted, the possibility to obtain a minor advance in this direction was open, even if this was not sufficient to greatly reduce the disparity resulting from the country's economic and social structure.

Table 18
Expenses per student by Region, States and Municipalities of Brazil (1998)

FU/Region	State Government			Municipal Government			Alteration Index
	Contrib. to FUNDEF	Registration 1997	Value per Student (a)	Contrib. to FUNDEF	Registrations 1997	Value per Student (b)	(a)/(b)
AC	65.3	86,527	755	12.8	42,123	304	2.48
AM	166.2	340,400	488	64.9	203,155	319	1.53
AP	64.7	91,477	707	10.1	16,891	598	1.18
PA	217.8	816,692	267	105.8	577,333	183	1.45
RO	79.9	182,080	439	26.8	92,923	288	1.52
RR	48.5	59,806	811	7.7	2,569	2,997	0.27
TO	89.3	212,083	421	34.4	111,044	310	1.36
NO	**731.7**	**1,789,065**	**409**	**262.5**	**1,045,998**	**251**	**1.63**
AL	117.9	142,065	830	58.9	388,251	152	5.46
BA	471.7	1,347,163	350	270.4	1,475,557	183	1.91
CE	272.8	535,209	510	147.1	964,301	152	3.35
MA	165.8	430,731	385	91.3	907,721	100	3.85
PB	139.2	327,043	426	80.1	364,271	220	1.94
PE	305.5	723,561	422	158.2	787,901	201	2.10
PI	105.3	240,717	437	57.4	361,486	159	2.75
RN	124.5	283,249	439	63.9	260,882	245	1.79
SE	107.9	203,740	530	38.8	168,146	231	2.29
NE	**1.810.6**	**4,233,478**	**428**	**966.1**	**5,678,516**	**170**	**2.52**
GO	221.0	673,072	328	126.3	330,183	382	0.86
MS	92.1	224,596	410	51.7	168,408	307	1.33
MT	138.9	311,742	446	69.0	181,852	379	1.18
CO(*)	**452.0**	**1,209,410**	**374**	**247.0**	**680,443**	**363**	**1.03**
ES	166.8	372,466	448	80.2	161,499	497	0.90
MG	758.8	2,556,432	297	470.3	912,407	515	0.58
RJ	765.9	607,111	1,261	303.8	1,121,890	271	4.65
SP	2,635.5	4,634,560	569	1,119.0	1,075,850	1,040	0.55
SD	**4,327.0**	**8,170,569**	**530**	**1,973.3**	**3,271,646**	**603**	**0.88**
PR	434.5	870,440	499	256.4	780,997	328	1.52
RS	579.6	934,365	620	306.4	644,045	476	1.30
SC	269.3	553,911	486	154.4	334,883	461	1.05
SU	**1.283.4**	**2,358,716**	**544**	**717.2**	**1,759,925**	**407**	**1.34**

(*) With the exception of the Federal District, which does not include municipalities
Source: BRASIL, Ministry of Education, FUNDEF, and Schools Census (www.inep.gov.br)

2. Objectives

The main objectives sought by the primary education policy were: increasing the kids' access to primary education, to improve the quality of it, and to reduce the interstate disparities.

3. Strategies

The primary strategy to achieve these objectives was: **decentralizing the resources and actions amongst the state instances** (state and municipal governments), redistributing the total values anticipated by *FUNDEF* – which resulted in one value per student (*per capita)* registered for each state – based on the verified registrations in the schools; meaning that, in each state of the federation, both the state and the municipal governments would start to have access to a same value per registered student. In case the state *per capita* was inferior to the nationally defined minimum, the federal government would complement the values until reaching this minimum. This complementation was the only disparity reducing element amongst the states and regions of the country, because the fund did not foresee resource transfers from one state to another, something that would not be politically viable.

With this procedure it was expected to: i) create an incentive for the municipalities to increase their registrations, locating more kids in school, since this increased the resource transfer to the municipality, ii) to improve the quality of education and the remuneration of teachers, especially in those regions that fall below the state average, iii) to increase the independence of mayors from state governments regarding school construction and investments in the education network, allowing them to choose the desired education network, and the investments considered necessary; iv) to avoid using education resources for other means, a common practice in a large portion of the municipalities, which would increase the effective resources for education as a whole.

Another strategy was to **develop more primary education support programs** to reinforce the positioning of the new financing policy. With this mean several projects, programs, and activities were created and developed, some of these with financing programs that will not be explored in this work, but are worth mentioning: National Program of Minimum Rent linked to education (*Beca Escuela*); National Program of Didactic Book; Curricular Parameters and Guidelines; National Program of School Health; National Program of School Transportation; *Fundescuela*; Learning Acceleration Program, Direct Money for Schools; Decentralization of School Lunch; School Development Plan; School Improvement Projects and School Building Enhancement; Data System for School Administration; School Census; Evaluation System of Basic Education; Formation Program of Alphabetizing Professors; Formation Programs for Active Professors; and TV School[49]

[49] All this information is available on the Ministry of Education site (www.mec.gov.br) and some of its results can be seen in BRASIL, Ministry of Education, 2002a.

4. Instruments

The main modification done was obtained through the approval of Constitutional Amendment n. 14 in 1996, which created the Maintenance and Development Fund for Fundamental Education and Valuation of the School Board (*FUNDEF)*.[50] According to this amendment, a minimum of the resources out of 60% available for education in states and municipalities defined in the Constitution were bonded to attend primary education (out of the 25% anticipated, a minimum of 15% would have to be destined to this objective), the same way at least a minimum of these resources (60%) should be destined for the remuneration of active teachers.[51]

FUNDEF was constituted from 15% of the following taxes and transfers: Merchandise and Services Circulation Tax (MSCT); Municipalities Participation Fund (MPF) and Exportation Funds. The remaining of the resources that was not a part of the fund, but the 15% was destined for primary education, came from other taxes collected in states and municipalities, 25% of these constitutionally bonded; in addition to 100% from the state education-salary installments, the Union complementation from Treasury resources, and the federal installment for education-salary. Negri's estimate for these values, for the year 1995, is presented in Table 19.

According to the author's preliminary calculations, from the total of state and municipalities' taxes related to education (R$ 18.8 billions, Table 15), between R$ 5.6 and R$ 7.0 billions were being destined for primary education, which represented an expense between R$ 200 and R$ 250/year per student. With the *FUNDEF* proposal, 60% of these taxes would increase the amount in 1995 to R$ 11.3 billions, which guaranteed an expense of $395/year per student. If we add to these resources the R$ 1.6 billions representing 100% of the state installment for education-salary, the total would be R$ 12.9 billions and the cost per student would reach up to R$ 450/year[52]. If on top of this are added R$ 0.8 billions from the federal installment and R$ 0.5 billions from the National Treasury resources (to complement the minimum *per capita* values), the total value would amount up to R$ 14.2 billions and to R$ 495/year per student. It can be noticed that this value reached up to twice the larger expense estimated by the author, before the introduction of *FUNDEF* (R$ 250/year), which was a reason to expect important changes in education financing.[53]

[50] Constitutional Ammendment n. 14 of 09/12/96

[51] Among other reasons, this minimum was compatible with the national legislation that establishes an expense limit for public employees of the Executive Power by means of the guidelines from different government spheres, according to the Complementary Law n. 82 of 03/27/95, incorporated afterwards, by the Complementary Law n. 96 of 05/31/96 and for the Fiscal Responsibility Law, already mentioned.

[52] The state installment of the education-salary is not part of the new fund, but should be destined in its entirety for primary education (see note n. 49).

[53] A value of R$ 7.5 billions was exceeding (40% of the total), or a value per student of R$ 848/year, to be destined for other education levels, supported by the States and Municipalities.

Table 19
Available Resources for Primary Education According to *FUNDEF*
1995

Resource Source	R$ billions	Participation%
1. Fund Resources	9.650	67.9
State Taxes	6.645	
Municipal Taxes	3.005	
2. Additional Resources	1.660	11.7
State Taxes	0.350	
Municipal Taxes	1.310	
3. Education-Salary	2.376	16.8
State Installment	1.584	
Federal Installment	0.792	
4. Federal Treasury Resources	0.517	3.6
Total	14.203	100.0

Source: NEGRI, 1997

As mentioned previously, the constitutional amendment also foresaw a national minimum value of R$ 300 per student, which was defined by law n. 9.424/96, for the year 1997, which at the time represented approximately US$ 300[54]. However, the implementation of *FUNDEF* only became mandatory starting in 1998, but it actually became effective in 1999[55]. During the first five years (1997 to 2001) since the constitutional amendment was approved, the values should be differentiated in function of the students costs, defined by the serial stage (grades) and by the nature of the education that was being given: from 1º to 4º, from 5º to 8º, from especial education establishments, and from rural schools.

Since the studies were not conclusive according to the Ministry of Education, the Federal Government only set this difference in 2002. On the other hand, there was only an update of the minimum value per student, even though the legislation referred to the value per student according to the prevision for the final Fund guideline and the total registration from the previous year expanded into the estimated total of new registrations[56]. Table 20 presents the evolution of the minimum value estimates, proving that there was only a correction in the inflation levels.[57]

[54] Law n. 9.424/96 regulated Constitutional amendment n. 14. There is no technical document that justifies the value of R$ 300.00. According to Negri (02/15/04 interview), the technicians that took part in this decision and the Ministry of Education itself, acknowledged that US$ 300/*capita* were equivalent to the expenses of other countries having a reasonable primary education system.

[55] Only Pará State implemented it in 1998.

[56] There is a legal discussion taking place in the country today, regarding the understanding of the legislation. If the update would be performed by the national average value and not by the monetary correction of it, this would cause a larger reduction of the regional disparities in primary education. However, this would limit the amount of resources for other education levels, including childhood, mid, and higher, where there are still challenges to be faced.

[57] [58] The data was extracted from the document of a work group formed by the Ministry of Education, which also analyses the obstacles upon the minimum value (BRASIL, Ministry of Education, 2003). The document from another work group from the Ministry of Education (*GRUPO DE TRABAJO, 2001)* discusses other aspects and obstacles in the application of the *FUNDEF* legislation.

Table 20
Evolution of the Minimum Value of *FUNDEF*
(1997/2002)

Year	Minimum set value				Inflation index *IPCA/IBGE*
	1° to 4º grade	5° to 8º grade and Special Education	1 º to 8º grade	Annual Growth (%)	
1997	-	-	300.00	-	-
1998	-	-	315.00	5.0	1.65
1999	-	-	315.00	0.0	8.94
2000	333.00	349.65	-	7.9(*)	5.97
2001	363.00	381.15	-	9.0	7.67
2002	418.00	438.90	-	15.1	12.5
Cumulative not periods				42.1	42.1

(*) Considering an average value of R$ 339.92, as a result of the number of students in each grade.
Source: BRASIL, Ministry of Education, 2003.

After establishing the minimum percentages required for primary education, there was an attempt to fix a serious defect in the current legislation, which was to define education expenses that up until that point were subject to different interpretations and were object of deviations for other ends. For this mean the opportunity to dispatch was taken advantage of and also the approval of the Guidelines and Bases for Education Law, developed after a long process of debate with the society[58]. In addition to make explicit in this law those that were considered maintenance and development expenses, there was care taken to create a list of those expenses that should not be considered related to education, many of these were historically used by states and municipalities for inappropriate means, which only aggravated the situation.[59]

Another important instrument was the creation of a measurable fund within the same scope of the law that regulated *FUNDEF*, – the *FUNDEF* fund – in which the resources contemplated by the legislation and the constitutional transfers are deposited, and also in which all the education related expenses are registered. The creation of this account was crucial to avoid the registration of resources in a single safe where they could be used for other means, which was very common in the public sector. The existence and flow of this account simultaneously takes care of the social control actions performed by the Social Control and Accompaniment Consensus of *FUNDEF* which exists in each government sphere as mandatory by the legislation which created it, in addition to facilitating the taxation of the Board of Accounts and the Public Ministry, the latter as an incentive to achieve this.

To support the collection of policies destined to the universality of primary education, it can be left behind without mentioning the National Program of Minimum Rent linked to

[58] Law n. 9.394 from 12/20/96, which establishes the principles and the organization of the national education system.
[59] Particularly read articles 70 and 71 of this law.

education (*beca escuela*), created in early 2001. *Beca escuela* guaranteed families the payments per child, between 6 and 15 years of age registered in a public school and with an attendance frequency equal or superior to 85%, starting with the point on where the *per capita* rent would fall below the annually defined value by the Executive Power Act[60]. The initial value of this benefit was set as R$ 15.00 per registered child.

5. Results

The most evident and immediate result since the implementation of *FUNDEF*, was the re-distribution of the resources amongst the state governments and its respective municipalities, reducing the interstate disparities and the alterations in the value per student amid the municipalities of each state. As a consequence, there was also a redistribution of the registrations amongst the schools that were state and municipal governments' responsibilities. The numbers are presented in Table 21. This Table allows a few remarks:

- As a matter of fact, there was an incentive for the municipalities to assume a larger participation in the primary education registrations, as it can be appreciated between 1997 and 2001 where the participation in the state's registrations fell from 59.3% to 48.3%, and that of the municipalities increased from 40.7% to 51.7%.
- As it can be noticed in the 1998 column, the immediate effect of the increase in the value per student in the municipalities was very important in the northwest region (88.9%) and in the north region (46.1%), while in the rest of the regions, for instance in Paraná State from the south region there was an important variation (27.4%), while the Rio de Janeiro State in the southwest region, showed a very high variation (129.3%).
- In those states with fewer municipalities, there was an inverse effect: the municipalities transferred resources to the state governments, as shown in the negative variations in the value increase/student column for Roraima (RR), Goiás (GO), Espírito Santo (ES), Minas Gerais (MG) and São Paulo (SP).
- The real variation in the value/student between 1998 and 2001 in the municipalities, as can be appreciated in the last column of the table, sought to capture the new policy's subsequent effects, confirming the initial increases, with ascendant or descendent variations and one or another more eloquent one, that in average caused an increase in the municipalities' earnings from 22.9% in 1998 to 31.5% in 2001.
- It can be noticed that the more affluent states of the federation (in order: southeast, south, and Midwest) which had lost resources in 1998, by 2001 already presented earning as in the case of Goiás (GO) and Espírito Santo (ES), or had reduced their losses as in the case of Minas Gerais (MG) and São Paulo (SP).

[60] Law n. 10.219 of 04/11/01

Table 21
Variations in the Values per Student in Municipalities
(1998/2001)

FU Region	1997		1998			2001			Real Variation in value/student with *FUNDEF* 2001/1998 (%) (c/a) (**)
	Registrations (%)		Value/Student In Municipalities (R$)		Increase in value/student (%) (b/a)	Registrations (%)		Value/Student with *Fundef* (R$) (c)	
	Stat.	Mun.	Without Fundef (a)	With Fundef (b)		Est.	Mun.		
AC	67.3	32.7	304	607	99.7	64.8	35.2	812	118.3
AM	62.6	37.4	319	425	33.2	53.0	47.0	506	29.7
AP	84.4	15.6	595	690	16.0	80.5	19.5	895	22.9
PA	58.6	41.4	184	315	71.2	29.4	70.6	372	65.3
RO	66.2	33.8	289	388	34.3	56.0	44.0	550	55.6
RR	95.9	4.1	2,986	901	(69.8)	91.8	8.2	1,050	(71.3)
TO	65.6	34.4	309	383	23.9	61.6	38.4	605	60.0
NO	**63.1**	**36.9**	**251**	**366**	**46.1**	**45.1**	**54.9**	**447**	**45.6**
AL	26.8	73.2	151	336	122.5	27.8	72.2	372	101.4
BA	47.7	52.3	183	315	72.1	35.9	64.1	372	103.3
CE	35.7	64.3	152	315	107.2	26.3	73.7	372	100.0
MA	32.2	67.8	101	315	211.9	26.7	73.3	372	201.1
PB	47.3	52.7	220	325	47.7	40.3	59.7	372	38.2
PE	47.9	52.1	201	315	56.7	41.1	58.9	396	61.0
PI	40.0	60.0	159	315	98.1	35.5	64.5	372	91.2
RN	52.1	47.9	245	346	41.2	47.0	53.0	569	89.8
SE	54.8	45.2	231	395	71.0	47.7	52.3	541	134.2
NE	**42.7**	**57.3**	**170**	**321**	**88.9**	**34.7**	**65.3**	**388**	**128.2**
GO	67.1	32.9	382	346	(9.4)	60.4	39.6	473	1.20
MS	57.1	42.9	306	366	19.6	52.7	47.3	565	50.9
MT	63.2	36.8	379	421	11.1	53.7	46.3	606	30.7
CO(*)	**69.4**	**30.6**	**370**	**371**	**0.3**	**56.9**	**43.1**	**534**	**18.0**
ES	69.8	30.2	496	463	(6.7)	56.1	43.9	764	25.9
MG	73.7	26.3	515	354	(31.3)	56.0	44.0	525	(16.7)
RJ	35.1	64.9	270	619	129.3	33.3	66.7	784	137.4
SP	81.2	18.8	1,039	657	(36.8)	70.8	29.2	934	(16.5)
SD	**71.4**	**28.6**	**602**	**550**	**(8.7)**	**59.1**	**40.9**	**751**	**2.0**
PR	52.7	47.3	328	418	27.4	50.2	49.8	615	53.3
SC	62.3	37.7	460	477	3.7	55.9	44.1	1,093	94.2
RS	59.2	40.8	475	561	18.1	58.0	42.0	667	14.8
SU	**57.3**	**42.7**	**407**	**482**	**18.4**	**54.2**	**45.8**	**700**	**40.6**
BR	59.3	40.7	335	411	22.9	48.3	51.7	539	31.5

(*) Excluding the Federal District which does not include municipalities
(**) Deflator: *IPCA/IBGE*
Source: BRASIL, Ministry of Education, *FUNDEF*

Another result of education policies aimed for the universality of primary education, including the elements of *FUNDEF* and of the scholarship grant school, was an increase in the primary education registrations and the respective increase of the schooling monetary rate.[61] In fact, the number of registrations went from 30,565,641 in 1997, to 32,089,803 in 2001, even though since then these have been decreasing (31.9 millions in 2002 to 31.1 millions in 2003) as a result of a decrease in the vegetative growth rate of the Brazilian population. An increase in the schooling rate is presented in Table 22. As can be observed, in 1994 the rate was 87.5% and increased to 95.3% in 1998 and to 96.5% in 2001. The correlation existing between *FUNDEF* and the increase in schooling, between 1994 and 1998, is clearly evident: the registrations in primary public education went from 30,565,641 in 1997 to 32,409,215 in 1998, a 6% growth in just one year, which represented almost 2 million new registrations, a phenomena that is justified by the fact that *FUNDEF* begin paying in 1999 for the number of registrations listed in the 1998 Census.

Table 22
Monetary Schooling Rate of Primary Education

Region	Year				
	1991	1994	1998	1999	2001
North	75.8	81.5	90.4	93.2	95.3
Northeast	72.0	77.3	90.0	92.8	95.2
Mid West	90.6	92.0	93.9	95.6	97.1
Southeast	91.3	94.4	97.4	97.6	97.4
South	92.1	93.8	96.2	96.6	97.0
Brazil	**83.8**	**87.5**	**95.3**	**95.4**	**96.5**

Source: www.inep.gov.br

Due to the fact that the increase of the schooling rate was higher in the poorer regions of the country (northwest and north), there was a significant social inclusion, since it reached the children of the poorest families. As a matter of fact, more recent data from *IBGE* for the year 2002 (Table 23), indicate a significant increase in the monetary schooling rate of the population's poorest 20%, which went from 75% in 1992 to 94.8% in 2002, in addition to the same process reaching up for the next 40% of the poor sector of the population.

[61] The liquid schooling rate is the relationship between the total number of registrations for students that are age compatible with the grade they are in and the total population in that same range.

Table 23
Schooling Rate between 7 and 14 years of age, by fifths of monthly family performance per capita (%)

Fifth of the family rent *per capita*	AÑO	
	1992	2002
First	75	94.8
Second	83	96.1
Third	87	96.7
Fourth	93	97.8
Fifth	97	99.2

Source: 1992 (BRASIL, Ministerio da Educación, 2002a); 2002 (BRASIL, IBGE, 2004)

Another effect of social inclusion was the monetary schooling rate of primary education depending on the people's race. Table 24 shows the change occurred between 1992 and 1999. It can be perceived a significant increase in the rate of blacks and mulattos a corollary to the inclusion already demonstrated with the level of rent. Recent data from *IBGE* leads toward a greater advance in 2002: the whites already reached a schooling rate of 97.7% and the sum of blacks and mulattos 96.2% (BRASIL, IBGE, 2004).

Table 24
Schooling rate, according to race

Color	Schooling Rate(%)	
	1992	1999
White	91	97
Oriental	98	99
Mulatto	82	95
Black	79	93
Indian	77	87

Source: BRASIL, Ministerio de Educación, 2002[a]

Although it is not possible to evaluate the consequences of *FUNDEF* on the quality of the education in a direct manner, by using indirect indicators represented by the teacher's qualification and by their remuneration, especially during the short period since the policy's implementation, it can be concluded there was an advance toward this direction. Table 25 presents the result of a research team, hired by the Ministry of Education, where variations in the number of primary education teachers are estimated, by level of qualification, between December 1997 and June 2002. In this it can be observed a substantial decrease of 46.0% in the number of teachers without middle qualifications, and an increase in the other levels of qualification; those with a superior level increased by 12.3%, more than the 10.6% of the middle level. In other words, along with the rapid expansion of primary education, the qualification of the teachers also augmented.

Table 25
Qualification Level of Primary Education Teachers in Brazil

Qualification Level	Administration Sphere	Month/Year		Variation (%)
		Dec./1997	June/2000	
Primary Education	Municipal	74,422	39,530	(46.9)
	State	8,861	5,475	(38.2)
	Total	83,283	45,005	(46.0)
Standard Mid Level completed	Municipal	325,749	430,860	32.3
	State	307,043	268,989	(12.4)
	Total	632,792	699,849	10.6
Superior with Full License	Municipal	150,337	189,672	26.2
	State	302,129	318,616	5.5
	Total	452,466	508,288	12.3
Total Teachers	Municipal	607,592	753,423	24.0
	State	709,008	690,410	(2.6)
	Total	1,316,600	1,443,833	9.7

Source: BRASIL, Ministry of Education, 2002a

Table 26 shows the results of another research, regarding the teachers' remuneration, between December of 1997 and June of 2000, for the functional categories which represent approximately 85% of the primary education teachers. The data shows that for standard level teachers, normal mode, the real average increase in Brazil was 9.3% while for the superior level teachers with full license, the raise represented 13.1%. It is significant the raise for the teachers in the poorer regions of the country (north and northwest), especially for those in the standard level, normal mode, which received real raises of 36.6% and 23.5% respectively. It is important to mention that 60% of the primary education teachers in those two regions have this level of qualification.

Table 26
Estimate of the Average Salary of Primary Education Teachers with a workload of 40 hours/week, by qualification level

Value in December/1997 *reales* (*)

Region	Qualification Level					
	Standard Level Normal Mode		Var %	Higher Level Full Licence		Var %
	Dec./1997	Jun/2000		Dec./1997	Jun/2000	
North	425	525	23.5	778	867	11.4
Northeast	344	470	36.6	560	679	21.2
Midwest	552	597	8.1	880	1,015	15.3
Southeast	867	890	2.6	1,165	1,375	18.0
South	634	712	12.3	855	916	7.1
Brazil	**578**	**632**	**9.3**	**1,005**	**1,137**	**13.1**

(*) Deflator: INPC/IBGE
Source: BRASIL, Ministerio de Educación, 2002 a

Finally, it is important to chronicle the effects of *FUNDEF* on social control. As mentioned before, to receive the resources of the Fund it was required the creation of the Accompaniment and Social Control Councils of the *FUNDEF*. This requirement caused an increase in the creation of these, as shown in Table 27. Here, it can be noted that that the number of councils installed in 1998 reached 80.6% of the municipalities, and in June of 2000 it reached up to 98%. Since then, many sues have been made regarding the deviation of resources; these have been rigorously pushed by the Public Ministry. However, there is still lacking the implementation of tools which guarantee the control, follow up, and taxation of resources by the counselors, given the vast amount of documents used in the account transfers of *FUNDEF*.

Table 27
Municipalities with Accompaniment and Social Control Council of *FUNDEF* (1998/2000)

Region	Municipalities with established councils (%)	
	1998	Junio/2000
BRAZIL	80.6	98.0
North	61.3	99.0
Northwest	86.8	99.0
Southeast	74.3	93.0
South	79.8	99.0
Midwest	80.7	99.0

Source: SEMEGHINI, 2002

An inquiry is made if the registration numbers did not increase the education expenses of the states and municipalities, and in a positive case, of how the additional expense would be supported. As a matter of fact, the expense increased: considering the value per student starting with *FUNDEF*'s 1998 bindings (R$397.98), and considering the increase in the number of registrations in this year compared to 1997, in the order of 1.843.574, it is possible to have a good estimate regarding the need of additional resources in 1999, around R$ 746 millions. The fact that the system had financially supported this necessity has its reasons. The first one is that the states –the ones who lost more resources in that process- had a reduction of 833,189 in its 1998 registrations, diminishing their losses. The second one is that the municipalities knew how many resources they were receiving, and this way they could organize the system better, according to a lower cost structure than that of the states[62]. The third reason is that the states increased the collection of the most significant weight for themselves, the MSCT, by approximately R$ 14 billions between 1998 and 1999, which represented for *FUNDEF* alone a resource increase in the order of R$ 2.1 billions, much more than the R$ 746 additional required millions. The fourth is that between 2001 and 2003, the primary education registrations begun to drop (because of the previously exposed reasons), thus the monetary increase in registrations fell from 2 millions

[62] Generally, the states have a solid administrative structure, product of many long years of administration, supervision, and regulation of the education in its spheres, in addition to a salary structure built around a legislation that guaranteed many rights to public employees, including progressive advantages and full retiring plans. There was also a reasonable amount of freedom in the usage of education resources contained in the previous registration, which increased the costs of the state system.

to 500 thousand, which represented an additional cost of only R$ 199 millions (in 1998 values). Finally, the creation of the *FUNDEF* account, which divided the resources for primary education from other government expenses, in addition to the legal definition of education expenses, it was promoted a reduction in the deviation of resources for other means.

6. Challenges

In the specific field of primary education, the already mentioned primary challenge is the reduction of regional disparities. This cannot be achieved without increasing the Federal Treasury resources destined for the Ministry of Education budget. On the other hand, resources must become available to cover the inevitable growth of secondary education, as noted earlier[63]. It is truth that the primary education registrations have been decreasing in function of the population growth rate, allowing opening spaces, both in the physical infrastructure and in human resources for an eventual re-management. However, maintaining the sub-binding of primary education resources, it is still required an improvement of its quality to face the challenges and there is no other alternative than expanding the secondary education resources.

In a low economic growth environment with severe fiscal restrictions, there will probably be a dispute about resources in the budget scale between the childhood, secondary, and higher education. The latter is been demanding advances for a long time, the fundamental ones being the mindset in the necessity of additional resources, the necessary raise in the number of vacates for teachers (the minimum to substitute the retired), to improve the salaries and the pressure that society exerts for an increase in the number of public vacates, because there has been taking place and important growth of those finishing secondary education. According to this, new alternatives must be created. It is clear that the task will be less demanding in an economic growth environment and with some fiscal relief.

FINAL CONSIDERATIONS

The main difference between the federal government actions in the health and education areas is that in the former, the federal sphere accounts for 53.1% of the resources, while in the latter, it accounts for only a small portion (22.3%) in relation to the total. The other difference is that the federal resources for health serve to attend all the complexity levels of the system, while the education ones are basically tied to the higher education level.

This context helps in explaining the possibility of promoting more active policies to reduce the regional disparities on health, by mean of innovations in the policy, in the destination criteria of the resources and in the creation of incentives in a determined direction. In the case of education, as long as the resources are not directed towards other education levels, besides the higher level, this possibility does not exist.

[63] In the five year period from 1997 to 2002, registration in public secondary education grew 47.7% reaching 8.7 million, while the increase during the same period for primary education was only 4.4% reaching 30.5 million registrations. Relationship between secondary/primary educations was 18.5% in 1997 and went to 28.5% in 2002.

The fund created for education initially affected the majority of the states, but strongly benefited the municipalities. A political alliance was made with the latter, with the exception of the São Paulo and Minas Gerais states, which were more affected at first but eventually were able to recover the benefits through time[64].

The result was a better interstate balance, complemented with a policy which guaranteed a minimum *per capita* for the states as a mean to protect the economically weakest and those with an inferior collection power. In health it was decided not to take away resources from the states, this way taking advantage of the gaps created by the increase in nominal and real resources for a more equal destination among the regions.

Therefore, it is more evident the increased equality policy in health than in education. However, in the case of the latter, the fact of making universal the access to primary education, of decentralizing in the municipalities the decision about the required and desired education network, of reducing the salary disparities –even if only partially- and improving the teacher's qualifications, were unequivocal steps in a more equal direction. These were the objectives, and it cannot be obtained from the policy more than that which was proposed. However, if the objective of the policy in the education area was reducing the regional disparities, as was achieved in health, it would be required to have more Treasury resources in the Federal sphere, and from this point on the criteria to promote a broader equality would be created. If desired, this could be reflected in the instruments and strategies adopted in the health sector, as it was noted already in this work.

Triumphs should not be left without recognition, but there is still a long way to go. In health, the disparity between regions is still left for examination, a thing that was partially fixed for education, and there is a need to advance in the direction of vertical equality. In education, in addition to facing the regional imbalances, which were partially conquered in health, there must be a continuation in dealing with the issues related with education quality, teacher salaries, and also the collection of the resources required for advancing in childhood education, as part of the certain growth of secondary education and higher education instances.

The experiences presented and analyzed here, show that there is a space to develop more inclusive and equal social policies, the same regarding the severe macroeconomic restrictions being faced. As it was seen in health, these are spaces filled with an improved definition of priorities and an improved efficiency in resource usage (basic assistance), an increased rationality (readjustments differentiated from procedure charts, medicine policy and regulating agencies), a sense of complementation in decisions (investments) and stability in financing (constitutional amendment). In education, the space was filled by a clear priority definition, for which all efforts were coordinated, from a change in the legislation (constitutional amendment, Guidelines and Bases Law, scholarship funded school) and all the projects, programs, activities, and actions projected on giving support and complying with the defined objectives.

[64] The losses in São Paulo and Minas Gerais municipalities, that were in each case 36.8% y 31.3% during FUNDEF first year, dropped to 16.5% and 16.7% in 2001 (see Table 21).

As noted, the challenges must be faced from both sectors; and there are many issues to deal with. Apparently, the limit of the possibilities within the existing frame of fiscal restrictions was reached. This means that new profits will only be possible if there was emancipation from the macroeconomic ties of the country, which has made fiscal policy the primary anchor of the economic policy of the country. Without going into the jurisdiction of this policy option, the fact that the whole social policy complex is depending on it is undeniable. Similarly, if some degree of freedom was granted from the economic policy, this would be an important contribution for a larger triumph in the social area, in addition to the unequivocal consequences that an increase in economic growth could allow, from the recuperation of the employment and rent level, lessening the pressure on the demand of social services of public nature.

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