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Brazilian healthcare in the context of austerity: private sector dominant, government sector failing

Nilson do Rosário Costa [1]

Abstract *This paper presents the arguments in favor of government intervention in financing and regulation of health in Brazil. It describes the organizational arrangement of the Brazilian health system, for the purpose of reflection on the austerity agenda proposed for the country. Based on the literature in health economics, it discusses the hypothesis that the health sector in Brazil functions under the dominance of the private sector. The categories employed for analysis are those of the national health spending figures. An international comparison of indicators of health expenses shows that Brazilian public spending is a low proportion of total spending on Brazilian health. Expenditure on individuals' health by out-of-pocket payments is high, and this works against equitability. The private health services sector plays a crucial role in provision, and financing. Contrary to the belief put forward by the austerity agenda, public expenditure cannot be constrained because the government has failed in adequate provision of services to the poor. This paper argues that, since the Constitution did not veto activity by the private sector segment of the market, those interests that have the greatest capacity to vocalize have been successful in imposing their preferences in the configuration of the sector.*

Key words *Austerity, Health insurance, Out-of-pocket payments, Health plans, Public expenditure*

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Introduction

Vocalization of concepts of fiscal adjustment and control of public expenditure has grown to an extraordinary degree in the political-crisis context that has affected Brazilian democracy this year[1]. The formulators of the austerity agenda have argued for the financing of a basic health package, bringing back into consideration an agenda from the 1990s of unrestricted focus on government intervention in the social area.

Lisboa[2], for example, argues for austerity in the following terms: "I would separate whatever is basic education, whatever is basic health care, whatever is transfer of income to the poorest 10%. These funds should be preserved. They can even grow by more than inflation – not by a lot, but by a little. But all the rest need to be reviewed".

Defense of containment of expenditures on the scale imagined by this author causes enormous discomfort, because it is a consensus among analysts of public policies that in contemporary society the social compact is unfeasible without active governmental participation in financing and coordination of the provision of public goods. Further, due to the singular nature of the health sector, the scope and scale of regulatory intervention by the government should go much further than the provision of basic care.

One can have recourse to Arrow[3] to show that, in contrast to the demand for common goods, such as health and clothing or other private assets, the demand for health services is unpredictable. Indeed, since illness is so very unpredictable, individual demand for medical services, with the exception of their preventive aspects, tends to largely reflect the uncertainties inherent in the functioning of unregulated markets. Also, demand for healthcare may be directly associated with the risk of loss of capacity to work, and indeed in extreme cases loss of life itself, and is not something that can be postponed[3].

The supply of healthcare also has significant differences in relation to traditional products, in two aspects: the first is the high dependence of the patient on professional intervention, especially medical care. Arrow believes that it is necessary to highlight that medical activity, which is supposedly oriented by the concern with the well-being of the patient and of the collective, can be influenced by the quest for income, with important effects on the effectiveness of the treatment. Secondly, the access to diagnostic and input services (laboratory tests, imaging, consumption of medication) is determined by a professional decision, in such a way that the patient does not have control over important components of the treatment process[3].

Healthcare is, thus, a good which differs substantially from other essential services. In most situations, there is a low probability that an individual will have a serious or chronic illness during the course of their life. But if they do, it is highly unlikely that they will be in a position to finance the treatment with their own funds or those of family members[4].

The cost of contemporary medicine (diagnoses, treatments, surgery and hospitalization) is in no way financeable from the pocket of the majority of individuals. Studies in the 1990s already showed that in countries of average income such as Brazil, between 20% and 30% of families had to take a loan or sell assets to pay medical expenses[5]. A family's decision to go into debt for health treatment produces a catastrophic pattern in the family's spending[6].

Thus, it is not possible to individually plan the future consumption of healthcare that is of high cost, due to the devastating consequences for families and individuals[7]. This is why, as Hsiao[5] has warned, it is extremely worrying that targets for public spending and fiscal burden formulated by political leaders and economists do not explain and make clear the regressive effects on availability of services and inputs and, in the last analysis, on the financial and health conditions of the population.

The existence of a market in health services that is not regulated, or is incompletely regulated by the government, favors: (i) development of the private insurance sector; and (2) transfer of the burden of financing of expenses on health to out-of-pocket expenditure by families.

The problems associated with deregulation of healthcare are thus in no way trivial. Private healthcare plan companies and insurance companies are oriented to achieving profitability. For this reason, the cost of the insurance premium has to be greater than the actual cost of possible healthcare that the insured person might come to need. However, the health plans and the insurance companies do not know the risks for each individual and calculate the value of the premium based on an average risk[7].

Individuals who buy a private health insurance tend to know more about their health conditions and, when they perceive that their risk is lower than the average of people who are insured, they opt not to participate in the insurance.

Ciência & Saúde Coletiva, 22(4):1065-1074, 2017

When the insured people with lower risk stop participating, it increases the average risk of the group that continues to be interested and, consequently, the final premium price. This situation repeats itself indefinitely for those who remain, because the risks will never be the same for all[7].

As a way of getting around the effects of this process, companies and health plans create insurances that evaluate the risk of each individual based on personal and family history. The direct result of the strategy of risk selection is increased in the value of the premium for the groups of highest risk (chronic sufferers, the elderly) who, normally, do not have the ability to pay the cost of insurance and will remain without cover[7], demanding government care.

The out-of-pocket expenditure mode of paying for healthcare is associated with the liberal scheme of organization of financing – the starting point of every experience of developing a provision for healthcare in any country. The liberal provision rests, on the supply side, on ample autonomy of health professionals and of companies, who hold the monopoly of competence in provision of the services. On the demand side, the liberal model is sustained by the format of acquisition of health services by individuals or families through out-of-pocket expenditure. Expenditure by out-of-pocket expenditure results in the catastrophic expenditure patterns referred to above, and leads to the impoverishment of families[6].

Faced with the limitations of market-based options, the democratic societies adopted public financing for health services as a way of avoiding the bankruptcy of individuals and families in response to the risk of serious, chronic or incapacitating illness. Esping-Andersen[8] identifies, in this experience, the process of de-mercantilization, indicating that countries choose the construction of 'regimes' of social protection against families' dependence on the dynamics of the market in areas that are considered to be critical.

The construction of public welfare systems after the Second World War, and the crises and reforms of the 1990s, produced a vast comparative bibliography on the national health systems in the context of the protection regimes[9]. The literature identifies two ideal types of government financing regime. The first is based on the idea of universal right, in which societies delegate to the instances of government the decision to allocate the majority of the funds in the sector. The second is associated with the scheme of public health insurance[10].

In the first model, governmental intervention in the financing is the variable that determines the level of de-mercantilization in the field of health. The dominance of government expenses, financed by taxes and contributions, indicates the adoption of institutional market coordination mechanisms, reducing the options of individuals, professionals and companies for achieving improved conditions of access[11].

The countries with regimes of instituted social protection finance the health services using the coordination of the government[11]. Paradoxically, this is the model adopted in the central economies where the access to health services is not limited to a basic basket of health services, and restricted to preventive interventions of low complexity.

The second social protection regime based on health insurance also has wide-ranging governmental intervention, and is adopted in the rich continental countries of Europe. This arrangement is based on the corporate compact[12], where workers and government employees are protected by the national government from liberal practices in healthcare through the institutions of social security/insurance. The source of funds is the financial contribution by employers, employees and governments to parastatal entities that manage social security.

When social security was put in place in the medium-income countries, the access to healthcare took place in a highly stratified form due to the informality of the labor market. In these countries, employees with formal employment have the exclusivity in the use of the health services provided by the social security, which is not the case in the central economies with corporate systems. The population of the informal sector of the medium-income countries accesses healthcare through out-of-pocket expenditure or through basic and focal health programs. The example of Mexico is a paradigm in this regard[13].

In Brazil, two and a half decades have gone by since a universal health access system was approved by the federal constitution in 1988[14]. Over the course of the democratic transition of the 1980s, the members of the Constitutional Assembly accepted the model based on the predominance of public financing and direct provision by healthcare by the government[15].

The chapter of the 1988 Federal Constitution dealing with health, and the enabling laws and Ministerial Orders, aim to achieve integration of the actions taken by public health and individual medical assistance in a single system with univer-

sal and equitable access – the Single Health System (*Sistema Único de Saúde, or SUS*)[16].

The 1988 Constitution innovated in that it created the Social Security Budget to finance the activities of social security, social assistance and health[17]. In the light of these changes, Draibe[18] suggests that the 1988 Constitution made a break with the social protection system built over the course of the Republican regime, due to the emphasis given to the dimension of 'security' in social policies as a whole. The social security dimension, he said, was defined by the condition of financing through taxes and contributions and through the criterion of universal access to the benefits.

Contemporary studies on the development of the Brazilian health system describe it, however, as a system that is fragmented and under the predominance of the private sector[19,20]. The present format of the Brazilian health sector does not correspond to the configurations delineated by the 1988 Constitution, due to the limitation of government activity and the role of the private sector in the financing and provision of services.

The 1988 Constitution did not constrain the action of the market in the health sector with the intensity necessary for institutionalization of a universal access model for health services. On the contrary, it ratified the composition between the government and the market, developed in the country since the 1970s, by declaring that 'private initiative is free to operate in healthcare'. The members of the constitutional assembly did not at the time have sufficient information to identify the structural dynamic of the market in healthcare in Brazil, and attributed to the private sector only functions that were 'complementary' to public intervention in the provision of services[17].

What happened in the organization of healthcare in Brazil as a result of the institutional limitations defined by the 1988 Constitution? Did governmental regulation of healthcare become so significant that it merits being restrained in the form proposed by the austerity agenda?

Design of the study

The principal theoretical argumentation in this paper is that the regime of governmental financing conditions the social reach of the provision of healthcare. The notion of 'regime' aims to refer to the principles, laws, regulations, rules and procedures that constrain the expectations and choices of the social actors[21]. It is thus considered that the magnitude of governmental expenses is an adequate indication of the condition of de-mercantilization of a national health system.

Based on the secondary information of the Health Ministry's DATASUS and of the Federal Comptroller's Office, this paper exemplifies the profile of Brazilian public and private expenses with data from temporal and transversal series.

The paper uses the classification categories of the WHO, which describe national health accounts. The descriptors of the WHO expenses comprise the funds that enter the health system for acquisition of goods and services financed by taxes, social security contributions, companies, civil society organizations, families or international agencies[22]. The central categories of the national accounts of the WHO are: government expenditure – including public health insurance; and private expenditure on private health insurance and out-of-pocket expenditure.

The source for the analysis of Brazil and other economies, in terms of normative comparison, is the site http://who.int/nha/database. The health system of the central economies is taken as a normative reference to describe the Brazilian experience of de-mercantilization of health care[10].

The information produced by the Brazilian Geography and Statistics Institute (Instituto Brasileiro de Geografia e Estatística, or IBGE) through the Medical Healthcare Survey (AMS), the Family Budget Survey (POF), and the National Households Sample Survey (PNAD – Health Supplement) enable us to describe the effects of the dynamics of the private sector market on the Brazilian health system. The data are analyzed by descriptive statistics.

Segmentation and focalization in healthcare

In a manner that was not anticipated by the members of the Constituent Assembly, since the late 1980s the private sector has assumed a more wide-ranging configuration than that of simply provider[23,24]. The segment of health insurance and the private healthcare plans has strengthened and established itself, favored by a low degree of regulation, tax incentives, absence of entry barriers, and exit barriers, for companies, and by the wide liberty for differentiation of contracts and provision of services[25,26].

The passing of Law 9656/1998 and the creation of the National Supplementary Health Agency (ANS) in 2000 modified the regulatory regime by setting new rules for protection of consumers, new conditions for entry and exit,

Ciência & Saúde Coletiva, 22(4):1065-1074, 2017

and limitation of segmentation in coverage[27]. Even so, the regulatory regime restricted to the health insurance industry and private health plans made it possible for companies to become stronger economically, instituting private healthcare consumption by employees with formal employment and by government workers.

It is possible to consider, then, that a new corporate standard/pattern was inaugurated in the area of healthcare in Brazil during the 1990s[28]. The segment succeeded in determining that the population occupied in the formal employment market was its preferred clientele, promoting collective plans financed by companies, to the determent of individual plans, and adopting selection of risk. The National Supplementary Health Agency has ratified companies' strategy of selection of clientele.

In the ambit of provision of health services, the hospitals, diagnostic support services and specialized outpatient providers are used exclusively by the private clientele (individuals who have health insurance or with out-of-pocket expenditure capacity)[20]. Only in small towns do private health services have, even if only residually, a pattern of combined use by both the clientele of the SUS, clients of health plans and those who purchase medical services by out-of-pocket expenditure .

In the majority of the medium-sized and large cities, the dominant trend is distinction between (a) the services linked to health insurance or acquired by out-of-pocket expenditure, and (b) the government services of the SUS, due to the contractual rules of coverage prevented by the private market as a differential of quality of provision of service.

The institutionalization of the health reform was not sufficient to impose governmental coordination on the totality of Brazilian spending on healthcare. As Table 1 shows, since the 1990s government and private expenses have been stable. One thing that especially calls the attention is the fact that private expenditure has continued to be the larger proportion in the 1990s and 2000s, with out-of-pocket expenditure dominant. The exuberant scale of out-of-pocket expenditure on health in Brazil reflects the ambiguity of the country's decisions in the sector, which is demonstrated below.

The unchanging relative percentages of government and private expenditure in the 1990s and 2000s is due essentially to funds being input by the municipal governments[29]. The participation of specifically municipal expenditure on healthcare underwent a significant expansion within government expenses as a whole: in 1995 the municipal percentage was 12.3%; and in 2012, it had risen to 18% of total public expenditures – while the expenditures of the state governments remained stable at around 25% of total Brazilian public expenditures on health. At the same time, there was a reduction in the proportion of the total coming from the federal government between 1995 and 2012, from 61.7% to 57%[30]. The dynamic face of the Brazilian public sector has been the development of primary care by the municipal governments[31]. Financing has ceased to be led, as a priority, by the federal Executive in recent years[30].

The activity of the Brazilian government in financing of health has, even so, federal characteristics that are not completely irrelevant: (1) incorporation of the interests that originated territorially into the decisions of the central government; (2) the high quantity, and highly heterogeneous nature, of agents focalizing regional and local ideas and interests; (3) government jurisdictions that share responsibility for formation and implementation of health policy; (4) fiscal transfer arrangements; and (5) vertical and horizontal arrangements for informal cooperation between the levels of government[32]. This federal component in arrangements has a direct impact on the development and diffusion of health policy, on the scale and generosity of programs, and on the

Table 1. Brazil - % distribution on governmental and private health expenditure – 1995 and 2008.

Indicator	1995	2008
Government expenditure, %	43	42
Private expenditure by out-of-pocket expenditure, %	39	39
Private expenditure on health insurance, %	18	19
Total	100	100

Source: World Health Organization National Health Account database (see http://apps.who.int/nha/database for the most recent update).

redistributive scope of the central government's allocation of funds. The pattern of governmental development based on the municipality indicates, in this aspect, the focalization on provision of a simplified portfolio of public services mainly directed to infancy and women's health. The SUS has been especially successful with this scope of services[33].

Falleti[34] argues as follows:

Brazil had some of the best-designed, most encompassing, innovative, and pro-poor social policies in Latin America. It is indeed very likely that universal health coverage and a decentralized structure that is funded with guaranteed federal transfers and that promotes users' participation in health councils are largely responsible for the improvement of Brazil's health outcomes. The evolution of health care reforms in Brazil shows that it is possible to break away, in a gradual and incremental manner, from the historical institutional preconditions that preclude universalization of health. They also appear to indicate that such institutional evolution leads to significantly better public health outcomes.

Studies on the impact of decentralization have, indeed, shown the positive results of healthcare activity through infant health figures over the 1990s and 2000s[35,36].

It is necessary, however, to call attention to the fact that the Brazilian central government allocates only a small portion of its financial allocation as an incentive to municipalities to develop primary care. In 2013, only 18% of the federal funds were allocated to primary care – especially for financing of the Family Health Strategy (Table 2). This is a fact that does not receive the appropriate critical treatment in the literature on health policies in Brazil, especially in literature on the field of collective health.

The stagnation of the process of decentralization in the present decade resulted in a further 37% of federal health funding being executed in 2013 directly by the Health Ministry through the National Health Foundation, and the remaining 45% also allocated to purchasing by the central, state and municipal governments of hospitalizations, services, and high-cost medication.

If the decentralization for primary care had recognized redistributive effects at local levels[37], there are two considerable limitations attached to the funding distributed centrally by the Health Ministry or in which the payment decision is shared, federally:

1) The National Health Foundation allocates a considerable portion of the funding to federal hospitals in the city of Rio de Janeiro, which are functionally of little use to the SUS due to their organizational insulation. Paradoxically, decades after the implementation of the health reform, almost nothing is known about the allocation efficiency, technique, quality and equity guidelines of these hospitals.

2) The payment of specialized private and public hospitalizations and services by the Health Ministry, state governments and municipal governments has for decades been made in an inertial, and obscure, manner by a confusing web of procedures which does not favor development of any strategic guideline for guaranteeing future access and transparency in the use of the funds allocated by the Health Ministry to healthcare.

Another factor that stands out is that, even when the federal Executive places on the agenda the proposal for regionalization through Public Health Action Contracts (Contratos Organizativos da Ação Pública da Saúde, or COAPs), no new idea of governance of the use of the strategic funds is placed on the table for public consultation and decision by society[38].

Due to this deficit of governance, in these later years of the present decade the principal strategy for provision of health services of all the

Table 2. Health ministry expenses in 2003 (R$ million, nominal).

Category of expense	Amount	%
Direct execution (National Health Foundation and other activities)	30.929	37
Execution by states and municipalities (especially remuneration of hospitalizations and specialized outpatient services)	46.823	45
Execution by municipalities (basic care, Family Health Strategy and other activities)	15.144	18
Total	82896	100

Source: Federal Comptroller's Office[39].

Ciência & Saúde Coletiva, 22(4):1065-1074, 2017

instances of government in the country has been the Family Health Strategy – which focused, primarily, on poor families, in all regions. In 2009, 54% of people with income of up to two times the minimum wage were registered in the Family Health Strategy, while only 16% of those with income above five times the minimum wage were registered[39].

At the same time, in most of the large cities – with population of over 100,000 – there has been a high deficit in the supply of specialized services and diagnoses and in free distribution of medication. Also, there has been development of public hospitals and specialized services in only a few of the states of the federation[40]. It is the habitual practice of state governments to take decisions which result in erratic and discontinuous supply of public emergency services, dissociated from any articulated structure of follow-up of patients and support in access to medications[41].

Thus, the government's policy for focus indirectly encourages development of private expenditure either out-of-pocket of through health insurance, in all the country's income strata[40]. Since the 1980s tax incentives have existed for families to acquire health insurance through direct purchase or through the intermediation of private or government employers[26].

It is also necessary to remember that, in spite of the formal responsibility of implementing and development of the SUS, the federal, state and municipal governments are also active purchasers of health insurance for government workers. In 2010 a significant proportion of all people insured by private health systems – 22.5% – was financed by the three levels of the government of the federation[39].

In 2011, 79.5% of those insured after the creation of the ANS had a collective or corporate plan[42]. As shown by Table 3, proportions of individuals and families with private health insurance in Brazil are directly associated with family income. In 2008, the percentage of individuals with a health plan was 82.5% in the income range above five times the minimum wage – while at the other end of the scale, it was only 4.4% for families with income of up to one half of the minimum wage.

The significant differentiation by income group in access to the health insurance market supports a pessimistic prognosis for public policy for universalization of Brazilian healthcare, formalized in the SUS – namely that implementation of the universality of access to the SUS, without rapid expansion of the supply of public services, would lead to the population in the formal market, or those with labor union negotiation capacity, leaving the public health system[16].

Indeed, the focusing and centralization of governmental financing in the federal government – which produces scarcity of hospital beds and specialized services – explains why the Brazilian population chooses, as preference, to leave the SUS whenever a person achieves a change in position in the income structure. The social mobility made possible by the country's economic growth in the years 2003-2011, for example, caused a substantial increase in the number of insured families, comprising the new workers in the formal labor market who had changed income level[43]. This change is understandable because, on the one hand, the private insurance sector has a larger supply of specialized services and tests than the public sector (Table 4); and on the other, because the availability of use of the service network of the insurance companies and private health plans reduces exposure to the rationing found in the public sector.

Consultations in medical specialties, medical tests and surgeries are the main interventions that are the subject of rationing by the SUS, which imposes long waiting times on users. As an example Table 5 shows the very high delay in the SUS for provision of various types of specialized medical consultation, tests or surgeries in October 2012 in São Paulo, the country's richest municipality. On that date, 660,000 people were on the waiting list for these procedures.

Table 3. Per capita monthly family income and proportion of private health insurance coverage – Brazil, 2003.

Monthly family income (in multiples of the minimum wage)	% of resident population with private health insurance
No income, or up to 1/2 of minimum wage	4,4%
1/2 to 1 x minimum wage	16,1%
1 to 2 x minimum wage	33,7%
2 to 3 x minimum wage	54,8%
3 to 5 x minimum wage	68,8%
5 x minimum wage and over	82,5%

Source: PNAD by IBGE. 2010.

Table 4. Availability of support and diagnostic establishments in the SUS and the health insurance sector – Brazil 2009.

	Frequency	Population covered	Establishments per 10,000 population
SUS	63.401	161.804.365	3,40
Health insurance	30.669	29.676.265	10,33

Source: IBGE/AMS, 2010.

Table 5. Waiting time for specialized consultations, tests and surgery in the SUS public system in the municipality of São Paulo - October 2012.

Descriptor	Waiting time in days
Orthopedic and general trauma consultation	35
Ophthalmology consultation	74
Dermatology consultation	152
Ear, nose and throat consultation	110
Vaginal ultrasound	183
Endoscopy of upper digestive tract	288
Whole abdomen ultrasound	83
Surgery on digestive system, connected organs and abdominal wall	510
Surgery on circulatory system	103
Osteomuscular surgery	451

Source: 'Folha de São Paulo' newspaper, 18 January 2013.

Final considerations

Paim et al.[19] are completely right when they say that the health sector in Brazil has become dominantly private. The argument that the SUS was the result of a process of democratic mobilization is acceptable. However, the various mechanisms of participation created by the health reform did not prevent consolidation of an institutional arrangement led by the private sector[20]. Many authors already accept the uncomfortable idea that the Brazilian health sector is iniquitous and regressive in terms of families' expenses, due to the dominant role played by out-of-pocket expenditure[44].

Overcoming the deficit of equity in the provision of health service is still a challenge for the country. The proposal of the 1988 Constitution was an efficient solution by the political elites for the social debt in health during the redemocratization of the 1980s. It was considered that the universalizing reform for the sector would produce a systemic solution for the question of financing, access and provision of collective and individual healthcare.

The significant growth in strength of the private-sector interests in the new democracy, however, was an event that the reformers did not anticipate[15]. The growing focalization of provision by the SUS in the strata of lowest income in the country indicates that public action, today, carries out merely distributive functions which abdicate from the project for a wide-ranging and systemic reform of the sector. The distributive intervention of the federal government does not seek even to put in place new regulatory functions, as is seen in the health systems of the central economies, but development of public policies that are focused on and selective for the poor[45].

The Brazilian health sector is, thus, very singular when compared to emerging countries, due to its significant participation of private healthcare insurance and the scale of out-of-pocket expenditure in its configuration[20]. Unfortunately, the development of the SUS is not the distinctive trait of the Brazilian experience in health, as Brazilian intellectual output would have us believe. There is no doubt that the combination of focalization of primary healthcare on the poorest strata, with the practice of risk selection by the health insurance companies and health plans, imposes the burden of out-of-pocket expenditure as the solution for those who need healthcare at all levels of complexity. The evidence of the waiting list proves that the population is not being served in the area of health, in spite of the institutional orientation for universal and free services in Brazil. With such a large scale of systemic deregulation, we submit that the governmental failings in provision of healthcare will not be overcome only with the silver bullet of austerity, as the thinking of Brazilian liberal economists supposes.

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