The World Bank and the Brazilian National Health System in the beginning of the 21st century

O Banco Mundial e o Sistema Único de Saúde brasileiro no início do século XXI

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Abstract

This essay has the aim of updating discussions on the political perspective and the role played by the World Bank in the development of public health policies in Brazil, seeking to identify continuities and changes in the way this institution acts and suggest hypotheses about action strategies in this new century. To do this, we analyzed a 2007 and a 2013 document published by that institution, and gather data on projects funded by the World Bank from 2000 to 2015 in Brazil, with emphasis on the healthcare industry. We concluded that the traditional mechanisms of action have not changed from those used in the 1980s and 1990s, as well as the guiding principles; what we observed is that the World Bank's actions have shifted from the national level to the state and municipal level. We indicate the need for specific studies of the agreements between the Bank and subnational governments, since the Brazilian federative model and the national health system itself allow implementing decentralized management mechanisms that can alter the setting of the Unified Health System.

Keywords: Inter-American Development Bank; Health Care Reform; Brazilian National Health System; Right to Health.

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Resumo

Este ensaio tem o objetivo de atualizar as discussões sobre a perspectiva política e o papel desempenhado pelo Banco Mundial na elaboração de políticas públicas de saúde no Brasil, procurando identificar continuidades e mudanças no modo de agir dessa instituição e sugerir hipóteses sobre as estratégias de ação neste início de século. Para isso, analisam-se dois documentos, um de 2007 e outro de 2013, publicados por essa instituição, e levantam-se dados sobre projetos financiados pelo Banco no período de 2000 a 2015 no Brasil, com destaque para o setor de saúde. Conclui-se que os mecanismos tradicionais de intervenção não se alteraram em relação aos utilizados nas décadas de 1980 e 1990, tampouco mudaram os princípios orientadores: o que se observa é um deslocamento das ações do Banco da esfera nacional para as esferas estadual e municipal. Aponta-se a necessidade de estudos específicos dos contratos firmados entre o Banco e os governos subnacionais, uma vez que o modelo federativo brasileiro e o próprio sistema nacional de saúde permitem implementar mecanismos de gestão descentralizados que podem alterar a configuração do Sistema Único de Saúde.

Palavras-chave: Banco Interamericano de Reconstrução e Desenvolvimento; Reforma dos Serviços de Saúde; Sistema Único de Saúde; Direito à Saúde.

Introduction

Since the Brazilian National Health System (SUS) was created, in 1988, the World Bank has shown interest in the Brazilian healthcare industry, especially regarding the responsibilities of the State and public administration. This interest is evidenced by the number of publications and loan agreements established with different areas of public administration aimed at interfering in the dynamics of this industry (Rizzotto, 2012).

Three aspects deserve to be considered in the analysis of the World Bank's relationship with Brazilian healthcare field: guarantee of the universal right to health, how to manage this public policy, and the potential of this sector for the accumulation of capital. These are intrinsically correlated aspects, showing the dynamics of intervention by the Bank, as well as its intentions.

The universal right to health is not part of the liberal economic ideals and is also not mentioned in the philosophical principles of the World Bank. Liberal economic thought considers health care a commodity that should be offered by the market, which supposedly would better organize its production, distribution and consumption. State intervention should occur only to regulate the supply and ensure "essential minimums", organizing a reduced public apparatus to develop traditional public healthcare actions, controlling epidemics and risks that tend to disrupt the market. The notion of essential minimums comes from the Theory of Justice by John Rawls, a current of liberal economic thought that assigns to (minimal) State the promotion of social justice through policies aimed at reducing inequalities and establishing some social equity (Rizzotto; Bortoloto, 2011). The World Bank (WB) updates liberal economic ideals by incorporating concepts from the progressive field as the notion of equity, modifying them semantically and reducing to the possible economic liberalism historical projects of the health movement, as the case of universal coverage vs. universal system, which we will discuss shortly ahead.

Laurel (2014) analyzes how health care is converted into a capital accumulation strategy, through

private health insurance supply, private management of public funds, and the full incorporation of science into capital in the medical-hospital-pharmaceutical complex, while examining the struggle of progressive governments in Latin America for the inclusion of health in the public sphere and as a universal right, considering the existing contradictions between accumulation and legitimation of the social order.

We can say health care has turned into a realm of political and ideological struggle. In this respect, the Brazilian health movement has accumulated losses in the legislative branch, in the dispute over public funds and in the very implementation of the organizational guidelines of the system (Mendes, 2014). Some examples are the "*Saúde + 10*" (health + 10) movement, which fought for 10% of Gross Current Revenue from federal resources for health - but apparently only percentages of the Net Current Revenue will be approved (PEC 01/2015) -; the approval of foreign capital inflows in the health care field (Law 13097/2015); and the incentive for the expansion of the group health plan consumption (PEC 451/2014). However, despite the difficulties and attacks, "SUS' vocation to be a citizen's right and a duty of the State is still alive" (Marques; Mendes, 2014, p. 290). The reason is, to some extent, the right to health has been incorporated into Brazilian society and subjectively the health movement remains alive and active in defense of SUS.

The fact that Brazil has constitutionally guaranteed complete health care for all as a State responsibility was strongly criticized by the World Bank at the start of the SUS implementation (World Bank, 1991, 1995). The central issue has never been whether Brazil could bear the costs of the system, but the opposition between liberal economic thought and the implementation of universal public health systems. For liberalism, jettisoning the market in any sector of social life, as the Brazilian health movement intended when the SUS was created, is unacceptable. In 1990, the World Bank defended the revision of the constitutional premise that assigns a complementary role to the private sector in the system and suggested that Brazil made reforms that favored a greater participation of the private sector in the provision of health services (Rizzotto, 2012). For the World Bank, the public sector should be responsible for regulation, promotion and health education, in addition to funding; whereas services should be provided by any organization able to perform them more efficiently, since the private sector is more creative and efficient, besides offering better quality services and being "proven superior to public services" (World Bank, 1991, p. 119). These arguments are justified by the liberal program of government reinvention and State re-engineering, which incorporates rules from the organizational culture of private companies into public institutions (Osborne; Gaebler, 1994; Almeida, 1999).

In the late 1990s Brazil, the intervention of the World Bank in the healthcare industry took place systematically at the time the federal government adopted the neoliberal project, based on the guidelines of the Washington Consensus. Currently, although less visible, the World Bank still offers "recommendations" to reform our health care system, guided by the same pro-market assumptions (Rizzotto, 2012, 2014).

Decentralization, one of the SUS guidelines, was initially supported by the World Bank, which associated it to the notion of privatization, the decentralized operation of the market and the shift of power from the central level to subnational authorities, which would result in greater managerial autonomy and in the possibility of *accountability* for the managers in these levels. Arretche (1997) discusses decentralization as a myth of the State reforms from this period, a supposed mechanism for democratization and efficiency of public policies.

However, as the process of decentralization has resulted in a municipalization of the system and jettisoning of the federated states from SUS management, the World Bank began having reservations on this aspect of Brazilian reform for an alleged mistake. It claimed decentralization was excessive, with little privatization of the provision of care and a tendency towards universalization of access, which supposedly was a huge overload, far beyond the financial capacity of the country (Rizzotto, 2012).

This work has the aim of updating discussions on the political perspective and the role played by the World Bank in the development of public health policies in Brazil, seeking to identify continuities and changes in the way this institution acts and suggest hypotheses about action strategies in this new century.

To do this, first we analyze two documents from the World Bank on Brazilian health care: one from 2007, titled *Governança no Sistema Único de Saúde (SUS) Brasileiro: fortalecendo a qualidade dos investimentos públicos e da gestão de recursos* [Governance in Brazil's Unified Health System (SUS): Raising The Quality of Public Spending and Resource Management], and another from 2013, titled *20 anos de construção do sistema de saúde no Brasil: uma análise do Sistema Único de Saúde* [Twenty Years of Health System Reform in Brazil: An Assessment of the Sistema Único de Saúde]. Next, we present data on the projects cofunded by the World Bank, from 2000 to 2015, that show possible changes in its strategies to intervene in the dynamics of the Brazilian healthcare industry.

The World Bank's assessment of the Brazilian Unified Health System in this new century

One of the World Bank's forms to act is producing and disseminating documents that reflect its vision on sectors of interest, with "recommendations" generally aimed to redirect the sector to better suit the liberal market logic. In the early 1990s, the institution stated that its studies had the objectives of "contributing to deepen the knowledge about this national industry" and "making suggestions to face the challenges of the Brazilian health system over the coming decades" (World Bank, 1991, p. 120). After more than twenty years, the objectives remain almost the same, since the ones of the 2007 document are to research and describe how public resources are allocated; evaluate how the resources transferred to the states and municipalities are used; collect evidence of delays and slippages in budget execution; and "offer a set of *policy recommendations* to improve efficiency in resource management and the quality of care in the SUS" (World Bank, 2007, p. 2, emphasis added). The 2013 document seeks "to provide an *objective assessment* of the performance of the system and the challenges ahead" and "*offers recommendations* [...] based on the diagnosis presented and the experiences of other countries in addressing similar reforms" (Gragnolati; Lindelow; Couttolenc, 2013, p. 21-22, emphasis added).

Invariably, the World Bank's interest revolves around State administration, financing and relationship with the market. The 2007 document focuses on "governance", a way to administrate the State arising from theories of business management and State management, which emerged in the last decades of the 20th century with the crises of the welfare state and the growing social malaise resulting from the end of the Keynesian pact. For Graña (2005), different approaches/interpretations followed the resumption of the governance concept, in the 1980s and 1990s, nearly always suggesting it is horizontal decision-making resulting from collective negotiations involving different (supposedly homogeneous) social actors, the adoption of mechanisms that do not require the authority and sanction of the State, and the end of the boundaries between public and private. According to this author, the discourse of good governance legitimized the World Bank's intervention in economic and social policies of the countries that had taken loans and favored the implementation of neoliberal reforms of States during this period, with refusal of income redistribution, privatization of public services and return of the cult of the market.

In the 2007 document, the World Bank adopts the term governance or accountability as a mechanism that "captures the responsibilities of actors and the consequences they face based on performance" (World Bank, 2007, p. 1). With that, the institution providing health services, the managers and workers could be held accountable for their behavior in the management, planning, monitoring, and administration of financial resources, meaning that "poor performance is

sanctioned and good performance rewarded to promote quality and impact" (World Bank, 2007, p. 1). For the Bank, the absence of accountability, i.e., punishment of managers and professionals with poor performance, would lead to an unjust system that would compromise the quality and impact of health actions. The idea of local, decentralized governance transfers the responsibility for health care provided to the population to the realm of micropolitics, leaving intact any criticism to macropolitics, in which the allocation of public resources is defined, not least because the World Bank does not see the problem as lack of resources, but mismanagement.

Using a sample of six states, 17 municipalities, 49 hospitals and 40 primary health care units, the World Bank (2007) says it made a "comprehensive" diagnosis of the Brazilian health industry and presents a series of recommendations. Generally speaking, the diagnosis is negative on all aspects: the planning model adopted is too complex and centralized; the participation of the structures of social control is insufficient, ineffective, and potentially counterproductive; budgets are significantly modified during budgetary execution; management of supplies and medicines is a source of resource mismanagement and waste; management of equipment and installations is inefficient both in acquisition as in maintenance; staff management is hindered and distorted by inflexible legislation, management practices, lack of management and complete lack of manager *accountability*; and management of production and quality is in its infancy; i.e., the management of the Brazilian health system is a failure.

Given this diagnosis, it recommends: (1) synchronizing and coordinating the processes of planning, budgeting, execution, and information as well as guiding them to the performance; (2) consolidating resource transfers in broader categories and linking any increase in funding to performance improvement, rewarding good performance and penalizing the inadequate; (3) developing and introducing organizational arrangements that provide autonomy and authority for decision-making and resource management; (4) strengthening and professionalizing the managerial capacity; and (5) applying mechanisms to strengthen accountability such as management contracts that induce administrators to focus on specific objectives and measurable results (World Bank, 2007); i.e. for the Bank, the solution of this industry's problems would be in microspace and in the adoption of technical procedures, and never in macropolitical decisions.

The 2013 document (Gragnolati; Lindelow; Couttolenc, 2013) features a diagnosis about the history of the SUS, a theme widely discussed by Brazilian researchers as Campos (2007), Paim et al. (2011), Santos, Santos and Borges (2013). Thus, this work will stress what the World Bank considers the challenges to achieve the goals defined in the 1988 Federal Constitution. Its "recommendations", in our understanding, go against the SUS, for they distort principles and propose measures that favor the interests of capital and not the construction of a universal public system. This is no novelty, for since the SUS creation the Bank has repeatedly shown to be against constitutional principles, as demonstrated in a Ministry of Health Technical Opinion (Brasil, 1994), in studies on the World Bank (Almeida, 2002; Rizzotto, 2012; Lima, 2014), and by Carvalho (2013), who states:

> It is paradoxical that these critical points are still, in fact, critical, to a large extent due to the opposition that the World Bank has always posed to the SUS [...] I must warn young readers that, since the late 1980s, the World Bank has always been detrimental to Brazilian health (p. 1).

While it recognizes some advances, such as expansion of the primary care network, increase in access, decentralization of service provision, and reduction in regional disparities, the 2013 document focuses on financing and management of the system. It deliberately left out human resources and pharmaceuticals, since these areas "featured less prominently in the original SUS vision for reform and [...] have less impact on the final outcomes of interest in the assessment" (Gragnolati; Lindelow; Couttolenc, 2013, p. 18). The topics considered central are unfolded in critical analyses about the right to health, gover-

nance, efficiency, and public/private relationship in the provision of health services in Brazil.

Right to health

According to the World Bank, the right to health in Brazil was operationalized by two principles: the legal guarantee that everyone has the right to be treated free of charge in the SUS and the expansion of the public network of health care units and services. However, for the World Bank, "neither of these two principles is a necessary condition to ensure the right to health care, since health services need not be free or provided within a public system to be accessible" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48). It argues that "In several countries where the right to health care is considered to be guaranteed and universal, health services are not free (they are subsidized) and are not necessarily provided by a public system" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48). And it adds that, since a list of covered services was never defined, "(and therefore implicitly covering all services needed by a sick person), the SUS is more generous, at least on paper, than the systems in most developed and rich countries, which have regulated and defined a list of covered services and the conditions or circumstances under which they are covered" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48).

For the World Bank, countries like the United Kingdom and Canada "limit or prioritize the coverage of certain expensive procedures to cases in which the patient is most likely to benefit from them (along a cost-effectiveness principle)" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48). It analyses that an "open-ended benefits package is unlikely to be enforceable in a sustained manner" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48), which would have raised two legal conflicts in Brazil: patients obtaining medicines and procedures by legal injunctions and private insurers refusing to reimburse SUS for the costs of services provided. The absence of a clear list of covered goods and services would have enabled providers to expand the supply and use of expensive new technologies, resulting in a source of inefficiencies and unnecessary costs, "as Brazil has been quick to adopt new technologies and allocates them in an inefficient way" (Gragnolati; Lindelow; Couttolenc, 2013, p. 48).

This critique to the universal right and full access to health reiterates the World Bank's opinion that Brazil dared too much to create the SUS, and points to solutions that restrict access and reduce the right. The defense of using cost-effectiveness as the parameter to allocate resources and of a limited supply of health services is combined with the idea of "universal coverage", a concept adopted by international bodies like the World Health Organization (WHO), the Pan American Health Organization (PAHO) and the World Bank itself, according to news by the operations coordinator of the Human Development Department at the World Bank in Brazil: "In the area of health, there is a global movement to expand access to health care and achieve universal coverage. *The World Bank is fully aligned with this movement"* (Lindelow, 2013, p. 1, emphasis added).

Universal coverage is a United Nations (UN) proposal, expressed in its Post-2015 Development Agenda, that follows the Millennium Development Goals (MDGs) and refers to ensuring a limited set of services that can be offered by the market and purchased by States. This proposal is absolutely distinct from universal systems as SUS, in which services are public and access is equal, comprehensive and free for everyone. The idea of universal coverage has been heavily criticized and denounced by regional integration organizations, intellectual communities, social movements, organizations of the Brazilian and Latin American health reform, and progressive governments (Cebes, 2014; Moreno; Nascimento, 2014; Lima, 2014).

On the right to health, the analysis of the Bank (Gragnolati; Lindelow; Couttolenc, 2013, p. 58) is that the principle of universality, the cornerstone of the SUS, "is far from being fulfilled" (Gragnolati; Lindelow; Couttolenc, 2013, p. 58), and that "more recent evidence suggests that reliance on the SUS increased over the last decade [...], but these differences may be due at least in part to how the questions were asked" (Gragnolati; Lindelow; Couttolenc, 2013, p. 58). In this case, research methodological problems are supposedly "blurring" reality, as "other evidence suggests that individuals 'pick and choose' service providers, depending on the type of service and their circumstances" (Gragnolati; Lindelow; Couttolenc, 2013, p. 58). It concludes that "even if most Brazilians use the SUS at some point, the apparent decline in the share of those who use the

system as their regular source of care is significant" (Gragnolati; Lindelow; Couttolenc, 2013, p. 58).

The supplemental private sector in Brazil has actually grown a lot over the last decades. This, however, does not mean that even users of private plans do not use the SUS, especially when they need high complexity care, which is rarely covered by the plans, since the ones with better coverage are almost impossible to be purchased and/or maintained by workers, who are excluded from their company's health care plans when they retire and invariably return to the public system.

Governance

In this perspective that tends to think decision-making (always a political process) as an act of management, neutralizing the influence of political dynamics and referring it to the quality of organizational and technical means (decentralization, management, and evaluation), the notion of governance is central, because it "induces and reproduces best practices, to ensure managers the decision-making most adequate to SUS management and constitutional principles" (Gragnolati; Lindelow; Couttolenc, 2013, p. 4). Governance, in the Bank's view, would also be related to: (1) the establishment of the right to health and its consequences; (2) the institutions for coordination and financing at all levels of government; (3) the participation and influence of society; (4) the relationship between purchasers and providers of health services; i.e.,

> governance is [...] concerned with the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments of different levels, nongovernmental organizations, private firms, and other entities with the responsibility to finance, monitor, deliver, and use health services (Gragnolati; Lindelow; Couttolenc, 2013, p. 4).

This apparently more democratic notion of governance, takes away from governments and the State itself the power and the duty to define and ensure social policies, and disregards antagonistic interests in a class society and the power of pressure that each group exerts over State agents and over the use of public funds. It is based on the principle that the State is fundamentally the conductor of negotiation processes and regulator of the supply of public services such as health, without necessarily being responsible for this supply and even by its full funding.

According to the World Bank, governance is a crucial issue in the SUS at all government levels, due to low local capacity to manage decentralized responsibilities, to lack of innovation in organizational and management models that correct current distortions, adopting methods of payment that offer incentives for providers to improve their performance, increasing effectiveness in the use of available resources and improving SUS performance "in the context of a feasible and sustainable financing system" (Gragnolati; Lindelow; Couttolenc, 2013, p. 12). For the Bank, in the case of public providers,

> payment reform would have to go hand-in-hand with measures to strengthen the financial and managerial autonomy of hospitals if payment-related incentives are to have an impact on performance (Gragnolati; Lindelow; Couttolenc, 2013, p. 12).

The introduction in the public space of managerial administration, typical of capitalist companies, effected by management contracts, administrative and financial autonomy, based on meeting pre-defined goals and rewarding achievements, is no news in the World Bank's recommendations. This notion was widely disseminated and enforced in reforms of peripheral States amid structural adjustment agreements, e.g., the reform of the State apparatus carried out during the Fernando Henrique Cardoso administration in the 1990s (Pimenta, 1998; Rizzotto, 2012).

The 2013 document also resumes the defense of the privatization of the industry, highlighting that "São Paulo has pioneered the contracting of hospital services from nonprofit organizations" (p. 5) for the management of health facilities, and that "Rio de Janeiro is using a similar approach for primary care, and many other states and municipalities are following suit" (p. 108). It points out that other parts of Brazil have witnessed an increase in experiences

with public-private partnerships, both in building as in management of public facilities. According to that document, "innovations in organizational models, provider payment, and contracting are limited, but gaining momentum" through Nonprofit Organizations (OS), Public-Private Partnerships (PPP) and Public Foundations (PF) (Gragnolati; Lindelow; Couttolenc, 2013, p. 5,10). Although these management modes are not exclusive of subnational bodies, they are adopted more quickly in them, given their smaller media visibility and resistance from workers.

Efficiency

Efficiency and funding are two sides of the same coin, because efficiency is understood as the ratio of inputs to outputs, i.e., expenditures to results. For the WB, an efficient health system would be one that produces more with the same expenditure. It recognizes the difficulty in determining system efficiency in a macro level; therefore, efficiency assessments tend to focus on specific links in the chain, as **allocative efficiency** (proper distribution of resources to programs or interventions) and **technical efficiency** (greater volume of services by inputs available) (Gragnolati; Lindelow; Couttolenc, 2013).

According to the WB, creating the SUS was expected to improve health system efficiency by integration and coordination measures, focus on primary health care, payment reform and strengthening of governance and accountability. However, these reforms would have been only partially implemented, with small gains, even with the expansion of primary care. The WB analyzes that countries like Brazil have achieved better results in health with comparable or lower spending levels. The main factors contributing to the inefficiency of our system would be the absence of a clear list of goods and services covered, the small scale of operations, high use of human resources, low installed capacity utilization, in addition to the management model and payment mechanisms (Gragnolati; Lindelow; Couttolenc, 2013). In other words, we would remain inefficient because we failed to fully follow the "recommendations" given in the 1990s: we did not legally limit access and maintained the right to health; we could not organize the system on a decentralized basis; we failed to punish bad managers exemplarily; we did not create basic health care teams with workers of little educational attainment only; we did not introduce mechanisms of managerial administration as reward/punishment; and we did not implement cofinancing. For the Bank, despite constant pressure from health care for more public funding, the central issue is whether this would be really necessary, since "the report has stated *unequivocally*" (Gragnolati; Lindelow; Couttolenc, 2013, p. 110, emphasis added) that the lack of resources and materials is not the deterrent factor for an improvement in access and quality. And while the debate about underfunding was prior to the creation of the SUS, "there is no *clear* and *scientific* way to determine whether this is the case" (Gragnolati; Lindelow; Couttolenc, 2013, p. 110, emphasis added).

For the WB, the Brazilian health system could produce more services and better health outcomes with the same level of resources if it were more efficient, reduced waste, did not misuse funds, and made a better prioritization when allocating government funds, offering more cost-efficient services. It concludes by saying that "There are no simple solutions for dealing with these issues, but there is a wealth of international experience on which to draw" (Gragnolati; Lindelow; Couttolenc, 2013, p. 13). However, it admits that "government spending on health as a share of GDP [...] is significantly lower than the level of spending in most Organisation for Economic Co-operation and Development (OECD) countries and some middle-income peers" (Gragnolati; Lindelow; Couttolenc, 2013, p. 13-14), but, before increasing the SUS funding, a priority of the health movement, we should straighten everything out and explore the possibilities of management offered as "recommendations" for this national industry.

Public-private relationship

In the documents analyzed, differently from the fear of the early 1990s, when the possibility of implementing a public system in which the private sector would have a complementary role to the SUS seemed real, the WB seems to be calm before numbers widely

favorable to the private sector, particularly within the hospital and supplementary health care spheres. Data on increasing private insurance and plans, on the hegemony of private outpatient services, and on the predominance of private hospital beds seem to have reassured the institution. According to the WB, the role of the private sector was heavily debated just before the new Brazilian Constitution was established, and in the end the complementary role of this sector was defined. "Policy clearly favored expansion of the public sector over contracting with private providers" (Gragnolati; Lindelow; Couttolenc, 2013, p. 34), and "the importance of the private ('supplemental') health system was expected to decline steadily" (Gragnolati; Lindelow; Couttolenc, 2013). However, after more than two decades, "this did not happen" (Gragnolati; Lindelow; Couttolenc, 2013, p. 4). Correctly concludes that access and quality problems are contributing to the continued demand for private health plans, which "is undermining the goals of universality and equity" (Gragnolati; Lindelow; Couttolenc, 2013, p. 4, 122).

Although acknowledging that there is a regulatory framework provided by SUS, the WB says that "coordination between the two sectors remains very weak, and inconsistencies between SUS basic legislation, which confers a marginal role on the private sector, and the existence of a strong dynamic private sector need to be reconciled", and that it is "essential" to solve the lack of integration and clear definition of roles between the SUS and the private sector (Gragnolati; Lindelow; Couttolenc, 2013, p. 108).

In that regard, we must recognize that post-SUS Brazilian governments have been generous to the private sector and negligent toward the SUS, facilitating the expansion of the former and inducing the population to purchase low-coverage health plans (Bahia, 2001, 2009). The private sector has advanced beyond supplemental health care. *Serviços Auxiliares de Diagnóstico e Terapia* (SADT - Ancillary Diagnostic or Therapeutic Services), especially those of high technology incorporation, are mostly in the private sector, which in some cases offers more than 90% of the services (Menicucci, 2007; Santos; Uga; Porto, 2008; Santos; Santos; Borges, 2013).

Old and new World Bank intervention strategies in the national health industry

It is well-known that, since the 1980s external debt crisis, the WB started to finance not only specific projects, but prioritized the broader Structural Adjustment Projects and Sector Projects, of greater effects both in the redirecting of the economic development pattern as in sectoral reforms, which immediately gave greater visibility to and politicized WB's interventions (Melo; Costa, 1994; Pereira, 2014).

It is by this funding mechanism - sector projects – and its conditions that the Bank will assume a particular power of intervention in the definition of policies and national health systems in most peripheral countries. And it will not be an imposition from the outside in, but a confluence of interests of governments, entrepreneurs, and researchers in those countries who share the same ideological perspective.

In the case of Brazil, with the intense process of decentralization that began with the Federal Constitution, which transferred the decision-making power on the definition and implementation of policies to municipalities, the WB has also updated its action strategies, shifting the focus from the federal government to the states. This is evident in a recent manifestation of the World Bank's representative in Brazil: "The World Bank has supported Brazil's development for many years and now finances projects in nearly every Brazilian state" (Lindelow, 2013, p. 1).

In the last 15 years (2000-2015), the World Bank partially financed 211 projects in Brazil, considering all contracts, regardless of type, require compensation from the providing institution. Among the projects, 103 (48.81%) were contracts with a federated state or the Federal District, 66 (31.27%) with the Federal Government, 24 (11.37%) with private foundations, and 17 (8.05%) with municipalities. As shown in table 1, 23 of the 26 Brazilian states and the Federal District have signed loan agreements with the World Bank from 2000 to 2015; Rondônia, Roraima, and Sergipe

were the only exceptions. Rio de Janeiro and São Paulo were the ones who obtained the larger volume of resources and Bahia the largest amount of projects approved. Although they had only five and four projects approved, Minas Gerais and Rio Grande do Sul had a great volume of resources (Table 1) (World Bank, 2015).

Table 1 – Number and total value of the projects financed by the World Bank, according to federated states and the Federal District. 2000-2015

State/Federal District	No. of projects	Total value in million US$
Rio de Janeiro	12	2,838.60
São Paulo	13	2,794.99
Minas Gerais	05	2,092.00
Rio Grande do Sul	04	1,865.00
Bahia	14	1,766.40
Pernambuco	10	1,633.50
Ceará	10	1,289.75
Acre	03	520.00
Rio Grande do Norte	04	440.90
Piauí	02	372.50
Tocantins	02	360.00
Paraná	02	358.00
Espírito Santo	04	336.50
Mato Grosso do Sul	01	300.00
Sergipe	04	261.88
Amazonas	02	240.25
Alagoas	01	195.45
Federal District	02	187.64
Santa Catarina	02	152.80
Goiás	02	71.00
Pará	01	60.00
Maranhão	01	30.00
Paraíba	01	20.90
Amapá	01	4.80

Source: World Bank (2015)

Just as an example, the government of the state of Paraná, as part of the signed loan agreement with the WB, created the Fundação Estatal de Atenção em Saúde (FUNEAS-Paraná), transferring the management of the State Department of Health to a private State Foundation. The argument is that the purpose is to "establish a new model of health care management" with the possibility of "generating resources from non-State sources" (Paraná, 2014, p. 1). In practice, the Foundation enables flexibilization of labor relations, introduces management contracts, management by performance goals, the professional governance system and, ultimately, the unaccountability of the State towards population health.

Among the 32 projects approved by the Bank for the Brazilian health care industry from 2000 to 2015 (table 2), only nine (28.2%) are from the Federal Government; the vast majority (71.87%) are from subnational bodies, mostly federated states. As noted, the WB has privileged SUS managers who have decision-making power and autonomy to enter the mechanisms advocated by the WB in the system, initially regarding work management, but possibly expanding to the very notion of right to health. That is why we need studies that examine these state and municipal efforts more deeply, seeking to identify to what extent they are contributing to disfigure the SUS in its core, i.e., the possibility of being a universal public system for all Brazilians.

The WB's choice of agreements with state governments may be due to the fact that reforms at this level of public management are less diluted than at municipal level, consequently more effective, and can be implemented with less resistance than at the national level.

Final remarks

The crises of accumulation have made capital expand into all areas of social life, transforming them into spheres of capital appreciation. Health care represents a public field with huge investment potential, since it articulates several productive processes, forming the health industrial complex. The World Bank, as an instance of this new cycle of financial capitalism, reaffirms the centrality of the market as a more efficient organizing and managing mechanism of public policies, including those related to health.

The SUS is an experiment that, in the WB's view, should not expand to other countries in Latin America or even the world, since it constitutionally ensures the universal right to health. What should serve as a model are countries with

Table 2 – Health care projects financed by the World Bank, control number, and value, according to contracting body. 2000-2015

Contracting body	Project name	Control number	Value in million US$
Brasil MF	Hd Prgm. Sector Reform Loan	P080746	505.05
Brasil MS	QUALISUS-REDE Brazil Health Network Formation and Quality Improvement Project	P088716	235.00
Brazil MEC	Federal University Hospitals Modernization Project	P120391	150.00
Brasil MS	AIDS and STD Control Project (03)	P080400	100.00
Brasil MS	VIGISUS APL 2 – Disease Surveillance & Control	P083013	100.00
Brasil MS	Second Family Health Extension Adaptable Lending	P095626	83.45
Brasil MS	Family Health Extension Program	P057665	68.00
Brasil MS	AIDS-SUS (National AIDS Program – National Health Service)	P113540	67.00
Brazil MEC/MS/MAS	Brazil: Human Development Technical Assistance Loan (TAL)	P082523	8.00
Federal District	Federal District Multisector Management	P107843	130.00
Acre	Acre Social and Economic Inclusion and Sustainable Development Project – PROACRE	P107843	120.00
Acre	Additional Finance to Acre Social and Economic Inclusion and Sustainable Development Project	P130593	150.00
Amazonas	Alto Solimoes Basic Services and Sustainable Development Project in Support of the Zona Franca Verde Program	P083997	24.25
Bahia	Integrated Health and Water Management Project (SWAP)	P095171	60.00
Bahia	Bahia Inclusion and Economic Development DPL	P126351	700.00
Bahia	Bahia Health System Reform Project	P054119	30.00
Bahia	BR Bahia DPL	P147984	400.00
Ceará	Ceara Multi-sector Social Inclusion Development	P082142	149.75
Ceará	BR Ceará Inclusive Growth (SWAp II)	P106765	240.00
Maranhão	BR Maranhao Integrated Program: Rural Poverty Reduction Project	P080830	30.00
Minas Gerais	Minas Gerais Partnership II SWAP	P101324	976.00
Minas Gerais	Minas Gerais Partnership II SWAP AF	P119215	461.00
Paraná	SWAp for Parana Multi-sector Development Project	P126343	350.00
Pernambuco	Pernambuco Equity and Inclusive Growth DPL	P132768	550.00
Rio de Janeiro	Brazil – Rio de Janeiro Renovating and Strengthening Public Management	P132768	18.67
Rio de Janeiro	Rio State Fiscal Sustainability, Human Development and Competitiveness DPL	P117244	485.00
Rio de Janeiro	Rio State Development Policy Loan III	P126465	300.00
Rio de Janeiro	Strengthening Public Management and Integrated Territorial Development	P126465	48.00
Rio de Janeiro (municipality)	Rio de Janeiro Municipality Fiscal Consolidation for Efficiency and Growth DPL	P111665	1,045.00
Rio de Janeiro (municipality)	Rio de Janeiro Strengthening Public Sector Management Technical Assistance Project	P127245	16.20
Rio Grande do Norte	Rio Grande do Norte: Regional Development and Governance	P126452	360.00
Sergipe	Development Policies for the State of Sergipe	P126452	150.00

Source: World Bank (2015)

limited universal coverage, that give market in charge of supplying health services; governments that adopt business management mechanisms to punish managers and workers; States that adopt new public management as a form of management structures and public affairs, a micro-organizational approach that turns planning into a purely technical action.

The critical view on the Brazilian health system, associated with state reforms put into practice using loan agreements and with denial of the right to health, can feature a new liberal offensive against the SUS and against any intention of establishing universal public health systems. The goal of reforming Brazilian health from its organization in federated states appears to be the WB's immediate perspective. Its "help" is aimed at contributing to restore power to this level of government, which supposedly has more conditions to implement accountability and punishment mechanisms in public management, and the transfer of responsibilities to the market.

But financing projects and the conditions they come with are not the only ways the WB can contribute to disfigure the SUS. The liberal-private ideology, defended by that institution, constitutes the world view of part of Brazilian society, many managers, workers, analysts, and researchers involved with the Brazilian health policy, who never supported the SUS as a universal public system.

In our opinion, it is urgent that the movement in defense of the SUS and of the right to health both criticize projects aimed at ending the right to health and the organizational structure potentially able to implement this right, and work to create a common project for the defense of the constitutional values that gave rise to the SUS, in addition to measures necessary to correct distortions that have accumulated over these two and a half decades. We refer to the defense of funding compatible with the needs of health care; the strong fight against privatization by advancing a democratic reform of the State that ends patrimonialism and consolidates the mechanisms of social control of workers and society on the Executive power; the establishment of a staff policy common to the entire system; and, centrally, the advancement of quality social policies on health, education, mobility and urban life, and public safety.

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