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Brazil
Governance in Brazil's Unified Health System (SUS)
Raising the Quality of Public Spending and Resource Management

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ABBREVIATIONS AND ACRONYMS

ABRAMGE	Brazilian Association of Group Medicine
ANS	National Agency for Supplementary Health
ANVISA	National Agency for Health Surveillance
CLT	Consolidation of Labor Laws
CQH	Hospital Quality Control Program
DST	Sexually Transmitted Diseases
EC	Constitutional Amendment
FAEC	Fund for Strategic Actions and Compensation
FIDEPS	Incentive Scheme for Development of Teaching and University Research
FNS	National Health Fund
FUNASA	National Health Foundation
GPAB	Primary Care 'Full Management' System
GDP	Gross Domestic Product
GPAB-A	Enhanced Primary Care 'Full Management' System
GPSM	'Full Management' of Municipal System
IBGE	Brazilian Institute for Geography and Statistics
LDO	Budget Guidelines Law
LFR	Law of Fiscal Responsibility
LOA	Annual Budget Law
MAC	Medium and High Complexity
MS	Ministry of Health
NOB	Basic Operational Norms
MOH	Ministry of Health
NOAS	Operational Health Regulation
OSS	Social Health Organization
PAB	Federal Grants for Primary Healthcare Program
PABA	Primary Health Care Funding Cap –Enhanced
PACS	Community Health Agent Program
PCCN	Program to Combat Nutritional Deficiencies
PAHO	Pan-American Health Organization
PCH	Hanseniasis Control Program
PCT	Tuberculosis Control Program
PETS	Public Expenditure Tracking Survey
PNAD	National Households Sampling Survey
PPA	Pluriannual Plan
PPI	Negotiated Programming Exercise (SUS/States/Municipalities)
PSF	Family Health Program
QDD	Expenditure Charts in Annual Budget
SADT	Auxiliary Services for Diagnosis and Therapy
SES	State Health Secretariats
SIA/SUS	SUS Outpatient Information System
SIAFI	Integrated System for Financial Tracking (Financial Administration Information System)
SIAFEM	Financial Administration Information System for States and Municipalities
SIGEO	Budget Management Information System
SIH/AIH	Hospital Information System and Authorization for Hospital Admissions
SIOPS	Public Health Budgets Information System
SMS	Municipal Health Secretariats
SUS	National (Unified) Health System
TCE	State Audit Tribunal
TCU	Federal Court of Accounts
TFECD	Epidemiology and Disease Control Financial Ceiling
UTI	Intensive Care Unit
WHO	

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Gerard La Forgia (Task Manager, LCSHH), Bernard Couttolenc (Interhealth, Ltda) and Yasuhiko Matsuda (LCSPM) prepared this report. Requested by the Ministry of Health, this study applied the *Public Expenditure Tracking Survey* (PETS) methodology, adapted to the circumstances of Brazil's Unified Health System (SUS). This report is the result of collaboration between the World Bank's Latin American and Caribbean Human Development Network (HD) and Poverty Reduction and Economic Management Unit (PREM).

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EXECUTIVE SUMMARY

Introduction

Brazil has made significant progress in human development over the last decade, thanks to a series of policy innovations, and equity of access has increased considerably. In health, consolidation of government health financing, the organization of the sector into a country-wide system (Unified Health System, or SUS) and the greater emphasis on primary care have been critical for these improvements.

Significant challenges relating to inefficiencies and low quality of services remain, however. Given high public debt and tax burden, system affordability and sustainability may be increasingly threatened, while equity gains obtained in recent years may be difficult to sustain. Financial authorities are increasingly concerned about rising health care costs, which already represent about 11 percent of public expenditures. At current levels of health system inefficiency, by 2025 total health spending may increase from 8 to 12 percent of GDP while household spending on health as a share of income can rise from 5 to 11 percent. Increasing the efficiency and effectiveness in the use of health resources to contain rising costs is perhaps the greatest challenge facing the Brazilian health system.

Many of the challenges facing the health sector are linked to governance failures – the lack of *incentives* and *accountabilities* that ensure that services are affordable and of acceptable quality, both essential to raising health status. Public spending constitutes a powerful instrument to influence performance in publicly-funded providers. The structure and management of funding flows to these providers strongly influences the incentives they face. In health, governance also refers to the means by which a provider organization (such as a hospital), its managers and staff are held accountable for their behaviors (such as resource management, planning, service monitoring, financial management, etc.) to deliver services with quality and efficiency. Accountability is a key concept that captures the responsibilities of actors and the consequences they face based on performance. That means that poor performance is sanctioned and good performance rewarded to promote quality and impact. Where there is no accountability those that excel and those that under-perform are treated equally; a system that is unfair, and compromises quality and impact. In short, governance impacts the quality of public spending, the effectiveness of resource management, and ultimately, the efficiency and quality of service delivery.

This report assesses resource allocation and management, planning and budgeting functions, and budget execution at different levels of government for public expenditures on health services. The emphasis is on understanding the incentives generated for service providers, and the overall soundness of the accountabilities established in the public health services expenditure system.[1] The analysis seeks to identify weaknesses of accountabilities for service provision that stem from the structure and process of intergovernmental and provider funding flows and related managerial practices.

The paper draws on and enhances an accepted governance tool, public expenditure tracking, in both tracking funding and analyzing the governance and corresponding managerial challenges that

[1] The degree of managerial autonomy (for public providers), and the effectiveness of the regulatory framework are also critical elements of the governance regime for healthcare providers, and these are discussed in another World Bank study: "In Search of Excellence: Improving Hospital Performance in Brazil." (2007, forthcoming).

impede effective public sector financing. The tracking instrument was applied to a sample of states, municipalities and healthcare facilities in the country in 2004.

The Unified Health System

The publicly financed Unified Health System (SUS) nominally covers the entire Brazilian population with a complete range of services free of charge. However, it effectively is the only health service for over half of the population (IBGE, PNAD, 1998), but is the main provider of care for the poor.

Brazil's federal structure and the decentralized nature of the SUS make the financial flows difficult to track and monitor, which in turn makes accountabilities diffuse and difficult. Despite continuous upgrading, existing information systems do not permit accurate identification of how resources are allocated within the context of SUS, nor how expenditures are executed and services provided at the health unit level. Information is lacking regarding how much SUS as a whole (including the federal, state and municipal governments) spends on hospital and primary care. The levels of efficiency in health service provision are not systematically documented.

This study assesses how the processes of allocation, transfer and utilization of resources are conducted at the different levels of the system. The study provides valuable information regarding the reality of the executing units of the system and how these relate to the central levels. It also seeks to identify problems related to financial flows, analyze how resources are used at the local level, and estimate their impact on the efficiency and quality of health services in general. In this respect, the study provides a basis for improving the entire cycle of public resource management processes (i.e., planning, budgeting, budget execution, input management, and health service production) in the health sector, which together help to bolster good governance in health care delivery.

Specifically, the study seeks to survey and describe how public expenditure is allocated for each type of health unit, program or health program; assess the extent to which the resources transferred to states and municipalities are used for the purposes for which they are intended; collect evidence of delays and slippages in budget execution by state and municipal secretariats and service provider units and how these problems affect service delivery; and offer a set of policy recommendations to improve efficiency in resource management and the quality of care in the SUS.

The survey was based on a sample of six states, 17 municipalities in those six states, and 49 hospitals and 20 outpatient units in the sampled municipalities. While the sample is not statistically representative of SUS as a whole because of its small size, an effort was made to capture a variety of situations found in the Brazilian federation so that the findings would exemplify typical conditions found in SUS.

Planning and Budgeting

The planning and budgeting process in SUS – similar to that of Brazilian government institutions in general – is well structured but overly formalized. Its complexity and bureaucratic formalism limit its usefulness as an effective management tool and as a basis for holding public entities accountable. Its main characteristics and limitations are summarized below.

- Legally mandated deadlines for the process of planning and budget preparation and delivery are usually met with few delays. However, the use of data and analysis to identify priority problems in a given locality and as a basis for planning is rare. Plans are often made on the basis of the previous year's plan or following the guidelines from the Ministry of Health.

- States and municipalities suffer from a serious lack of capacity to develop evidence-based plans to guide their health policies and interventions. Planning at the level of health facilities is non-existent. The planning process is truncated; little consistency and articulation is evident between the various documents and stages of planning. Worse, once the plan is submitted, it is usually not consulted or used to guide decision-making.

- The plans present objectives and targets, but almost never define articulated strategies and actions to meet them. In many cases, the plans constitute declarations of intentions rather than maps of how to arrive at desired outcomes.

- Participation of the various actors involved, including the expected accountability structures, such as the Health Councils, is insufficient, largely ineffective and potentially counter-productive.

- Planning and budgeting are disconnected, especially at the local level. The lack of cost parameters for services to facilitate forecasting of resources required for programs results in the widespread use of past values as the main basis for the new budget. This reduces the validity of the budget itself as well as its usefulness as a management tool.

- Strategic and financial data needed to develop plans and budgets are often centralized in the Finance or Planning Secretariat and not often made available to the Health Secretariat and or unit managers.

- Managers of most public facilities (primary, diagnostic or hospitals) have limited or no authority to plan service provision, define their budgets, reallocate resources or manage inputs. They generally do not manage human resources or control their payroll, and therefore execute only a small portion of their budgets. Smaller facilities have no internal financial information whatsoever.

Budget Execution

The weaknesses in planning and budget formulation is further evidenced by the widespread practice observed at sub-national levels of significantly modifying allocations during the budget execution phase often ignoring priorities specified in the planning process. Therefore, it is through the analysis of budget execution that real allocation priorities become evident. In addition, budget execution also affects the efficiency and quality of service provision because it determines how the secretariats and the front-line units perform key management functions such as purchasing and distributing medicines, supplies, and equipment. The most common problems are as follows:

- Significant changes between the initial budgetary allocation and the amount actually available limit the benefits of planning and financial forecasting. The frequent delays observed in the release of budgeted funds results in their suboptimal use by managers. For example, some of the "frozen" funds can be released only at the end of the year, leaving little time for purchases. The unpredictability and delay in funding release is also applicable to federal transfers. Frequently, the "committed" expenditure is usually less than the "real" allocation due to delays in releasing funds, the slowness of the tendering process, and to the sluggish pace of financial processes in general. Payment delays raise costs and result in relatively low levels of spending.

- Municipalities have little capacity for robust budgetary execution due to a lack of qualified personnel and limited autonomy and decision-making authority of line secretariats and health facilities.

- Most of the states and many municipalities do not comply with the constitutionally-mandated minimum percentage of their funding to be spent on health, even though some spend considerably more. Federal transfers do not compensate for this inequality in spending.

- At the level of the state and municipal secretariats, the system for budget monitoring, control and reporting is well structured, but focuses on compliance with legal standards and financial control, with little concern for assessing results. At the facility level, monitoring and oversight is rare.

- A multitude of parallel reporting exists associated with programs having restricted funding and/or specific payment mechanisms. This consumes considerable resources and time, thus increasing administrative costs in the secretariats and the operational units.

- Availability of disaggregated data on budget execution is limited. This hampers tracking actual application of budgeted resources, including federal transfers, and evaluating the efficiency and effectiveness of resource use.

Management of Supplies and Medicines

In the health sector, management of supplies (e.g., from acquisition to use) consumes a substantial portion of financial resources (about 20 percent of the total) and can be a major cause for inefficiency and loss. The current norms governing the process of government purchases are effective in limiting (but not eliminating) the likelihood of misappropriation of resources, but at the same time, their strictness and lack of flexibility create significant distortions.

- The complexity and rigidity of the rules controlling the process of tendering, and the time lines stipulated, require a degree of fine-tuned planning which is rarely found in practice. Long drawn-out buying processes and extended terms of payment encourage suppliers to build additional cost into the prices they quote, and make it impossible for hospitals to take advantage of the best opportunities, frequently ending up causing a delay in supply. Delays in buying, stemming from the sluggishness of the process, are also very frequent in the service units, resulting in lower quality, interrupted patient care, and a large number of costly emergency purchases.

- The inadequate control of stock combined with the existence of multiple stocks within service units and inefficient methods of dispensing drugs to inpatients, contributes to considerable waste, loss and misappropriation, possibly as high as 10 percent of the total.

- Poor planning, excessive centralization of purchasing decisions, and an overly rigid legal framework tend to result in a mismatch between the supplies required and those actually made available.

Management of Equipment and Installations

Acquisition and maintenance of equipment and physical plant is among the most costly elements of any health system. Inefficiency in this area can therefore be a significant source of cost escalation. In recent years, the Ministry of Health (MOH) and state and municipal health secretariats have

attempted to achieve more rational planning of equipment purchases and distribution. Nevertheless, the findings reported herein demonstrate that most units still encounter serious difficulties in maintaining installations and equipment, with significantly negative consequences for the quality and efficiency of treatment; but to date facilities have not been held accountable for the management of equipment and installations.

- The acquisition of equipment is overly dependent on the availability of irregular federal investment funds. This impedes systematic needs assessment and capital investment planning. In many states and municipalities, there are no predefined and transparent criteria for distributing equipment that periodically becomes available.
- Due to a lack of a consistent program and sufficient funding for preventive maintenance, the frequency with which equipment breaks down results in service interruptions. In addition, to the obvious quality implications, this situation results in higher costs because poorly-maintained equipment has to be replaced sooner.
- Physical installations are often in a state of disrepair, which again undermines the quality of services and their continuity. It also contributes to increased expenditure when major remodeling has to be undertaken or new installations built.

Management of Personnel

The rigid legislation governing human resources in the health sector makes management of human resources difficult and burdensome. However, the problems identified in personnel management in the health secretariats and units – principally those of the public sector – are not solely due to limitations and distortions imposed by legislation. Many problems are related to management practices that result in inefficient use of resources, and in some cases, an absence of management. More fundamentally they are grounded in a complete absence of manager accountability.

The main problems are as follows:

- Inefficient staff mix (by category and level) as well as poor staff allocation practices. Often there exists an excess of poorly qualified personnel combined with a shortage of qualified personnel. This is principally the case in smaller service units as well as for managerial positions system wide.

- Absence of an effective system for incentives and performance evaluation, and of opportunities for professional advancement. When incentives exist, they often become generalized and incorporated into fixed remuneration.

- Low level of remuneration for qualified personnel which results in well-qualified staff seeking positions elsewhere. High rotation of personnel compromises continuity of care.

Management of Production and Quality

Service and quality management is in its infancy. Few health secretariats or units regularly collect data on productivity, efficiency, or quality. In some cases, the classic indicators of productivity (average hospital-stay, turnover of beds, occupation rate) and quality (mortality, hospital infections) are monitored, but rarely used for decision-making, which contributes to the inability to hold providers accountable for their performance.

The data gathered through this survey show, for example, that doctors work fewer hours than the number of hours contracted, while still producing the same number of consultations. This situation

is typical of public facilities where "real" working hours are negotiated between doctors and managers, and have little relation to "contracted" hours. The reduced time spent with patients may also compromise quality of care. In addition, 40 percent of the cancellations of scheduled surgeries reported in the survey are attributed to internal management problems and inefficient use of resources, such as the absence of medical or support staff, lack of materials, the failure to sterilize the equipment, etc.

The survey inquired about the principal problems affecting the service offered and its quality. The principal problems as identified by state, municipal and facility managers include: shortage of medical drugs, lack of personnel, limited installed capacity to deal with demand in outpatient units, and lack of medical supplies. These are all related to shortcomings in resource management practices detailed in this study. Hospitals managers also report poorly qualified personnel and low quality hygiene practices (e.g., raising the risk of hospital-acquired infections) while outpatient managers citied the lack of or unavailability of diagnostic and therapeutic equipment.

Main Challenges and Recommendations

The analysis of the quantitative and qualitative results shows the existence of various problems, which impact negatively on the quality and effectiveness of health services provided by the SUS, as well as on the cost of these services. These are grouped into four categories below, with recommendations for how to improve them.

Fragmentation of the planning and budgeting process

Synchronize and align the processes of planning, budgeting, execution, and information, and orient them toward performance. Planning should be the basis for defining performance targets. Plans should contain a limited set of easily measurable performance goals. Measurement of activity costs would be an important complement. As such, the MOH should support the installation of cost accounting systems at the facility level, particularly in hospitals.

Consolidate the transfer of funding resource-by-resource and link growth in financing to growth in performance, thereby rewarding good performance and penalizing low performance. The existing transfers can be streamlined based on broad functional/programmatic categories that are already well-accepted in the sector (e.g., Primary Care, Hospital Treatment of Medium and High Complexity, etc.).[2] The states and municipalities could then allocate the funds received through these block transfers to specific programs, based on their own plan and budget. The formula for determining the distribution of the transfers should be guided by explicit policy criteria such as (i) attenuation of inter-regional/jurisdictional inequality in health outcomes and access to services, or (ii) performance enhancement at the unit level (i.e., greater efficiency and better quality, as measured by specific, results-oriented indicators).

Inflexibility and complexity in budget execution

Develop and introduce organizational arrangements that give the management units increasing levels of the freedom of action and authority to make decision on the management of resources. The pace of granting such autonomy must be calibrated with each unit's demonstrated capacity, however, and the capacity of the central agency (e.g., health secretariat) to monitor and control its performance. On a pilot basis, some of the large hospitals (e.g., referral units), and possibly regional health districts, can be granted full autonomy to manage its finance and human and material resources. It would be best to start with hospitals that already are official budgetary units

[2] In early 2006 the MOH approved a regulation mandating the consolidation of transfers into six block grants.

and therefore have some experience with autonomous input management. For smaller units with more limited administrative capacity, specific aspects of decision-making authorities could be delegated. Some could become budgetary units, whereas others may need to be given less autonomy. For each case, a preparatory study should be conducted to determine the exact level of decision-making each of the authorities is to be delegated.

Lack of managerial autonomy, incentives and capacity

Strengthen and professionalize management capacity. The Ministry could promote adoption of modern management techniques by the secretariats and health units. Such techniques would include management of decentralized personnel; management of purchases and stocks that facilitates estimation of needs, programming of purchases and better control of stocks; management of equipment and installations that enables monitoring of the state of the equipment and its permanent maintenance; evaluation of activity costs and efficiency; evaluation of results in terms of coverage and performance indicators on effectiveness and quality of services. It would be necessary to revamp human resource policies (e.g., better structuring of health care and management careers, systematic training policy) to make careers in the public health sector more attractive.

Apply mechanisms to strengthen accountability, such as management contracts that make the administrators focus on specific goals and measurable results. This instrument could serve as a basic mechanism for planning, monitoring, and evaluation. Greater autonomy granted to specific facilities should be balanced with clear performance expectations (targets) and ex-post accountability. In using management contracts as a tool of accountability, a mechanistic application of "reward and punishment" should be avoided. Instead, the performance targets should be used as references around which the secretariat and the unit can develop on-going reviews, dialogue, and appropriate corrective measures to enhance the unit's performance.

Inadequate management information

Establish strong monitoring systems that aim to improve organizational performance. These systems should supply useful and clear information for internal management, including data on program/unit performance that permit comparisons with targets as well as among the units themselves.

1. INTRODUCTION

Brazil has made significant progress in human development over the last decade, reflecting gains in health status, education attainment and social assistance. Thanks to a series of policy innovations in each of these sectors, equity of access has increased considerably. In health, consolidation of public financing, organization of the sector into a country-wide system (Unified Health System, or SUS), and the greater emphasis on primary care and control of infectious diseases have been critical for these improvements.

Significant challenges remain, however. Social services continue to suffer from inefficiencies and poor quality. Given high public debt and tax burden, which in turn may constrain future public spending, a case can be made that without improvements in the efficiency and quality of social service delivery, system affordability and sustainability would be increasingly threatened, while equity gains obtained in recent years may be difficult to sustain. Financial authorities are increasingly concerned with the growing costs of health care, which represent approximately 11 percent of public expenditures. A recent study estimates that at current levels of health system inefficiency, by 2025 total health spending as a percent GDP will increase from 8 to 12 percent while household spending on health as a percent of income will rise from 5 to 11 percent.[3] Increasing the efficiency and effectiveness in the use of health resources to contain rising costs is perhaps the greatest challenge facing the Brazilian health system.

Many of the challenges facing the health sector are linked to governance failures – the lack of *incentives* and *accountabilities* that ensure that services are affordable and of acceptable quality, both essential to raising health status. Public spending constitutes a powerful instrument to influence performance in publicly-funded providers. The structure and management of funding flows to these providers strongly influences the incentives they face. In health, governance also refers to the means by which a provider organization (such as a hospital), its managers and staff are held accountable for their behaviors (such as resource management, planning, service monitoring, financial management, etc.) to deliver services with quality and efficiency. Accountability is a key concept that captures the responsibilities of actors and the consequences they face based on performance. That means that poor performance is sanctioned and good performance rewarded to promote quality and impact. Where there is no accountability those that excel and those that under-perform are treated equally; a system that is unfair, and compromises quality and impact. In short, governance impacts the quality of public spending, the effectiveness of resource management, and ultimately, the efficiency and quality of service delivery.

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[3] Marcos Bosi Ferraz (2006). "Brasil 2005: Desafios do Sistema Saúde," *Economia da Saúde On-line,* Centro Paulista de Saúde, http://www.economiasaude.com.br/new/destaques?id_destaque=8.

[4] The degree of managerial autonomy (for public providers), and the effectiveness of the regulatory framework are also critical elements of the governance regime for healthcare providers, and these are discussed in another World Bank study: "In Search of Excellence: Improving Hospital Performance in Brazil (2007, forthcoming).

The paper draws on and enhances an accepted governance tool, public expenditure tracking, in both tracking funding and analyzing the governance and corresponding managerial challenges that impede effective public sector financing. The tracking survey instrument (PETS) was applied to a sample of states, municipalities and healthcare facilities in the country in 2004.[5]

The survey was necessary because of the complex financing structure of SUS that makes tracking of fund flows difficult and the inadequacy of the existing information systems, which, despite continuous upgrading, do not permit accurate identification of how resources are allocated within SUS, nor how the expenditures are executed and services provided at the health unit level.[6] Similarly, information is lacking regarding how much SUS as a whole (including the federal, state and municipal governments) spends on hospital and primary care. The levels of efficiency or inefficiency regarding health service provision are neither known nor documented.[7] The PETS methodology enables systematic collection of relevant information at the secretariat (state and municipal) and facility levels to gain insights into institutional and managerial causes of inefficiencies, and their effects on the quality of health services.

Specifically, the study seeks to survey and describe how public expenditure is allocated for each type of health unit, program or health action; assess the extent to which the resources transferred to the states and municipalities are used for the purposes for which they are intended; collect evidence of delays and slippages in budget execution by state and municipal secretariats and service provider units and how these problems affect service delivery; and offer a set of policy recommendations to improve efficiency in resource management and the quality of care in the SUS.

The report is divided into 5 chapters. This first chapter presents background information on SUS, its structure, financing arrangements, and planning and budgeting systems. The following four chapters report on the survey findings. Chapter 2 reports on planning and budgeting in SUS. Chapter 3 centers on materials management and Chapter 4 focuses on human resource management. Chapter 5 presents the results of quality and production management. The final chapter presents summary conclusions and recommendations.

METHODOLOGY

This study applies a modified approach of the Public Expenditure Tracking Survey (PETS) methodology developed by the World Bank and applied in a number of countries. The methodology is adapted to the complexities of resource allocation in Brazil's Unified Health System. In this study, PETS was applied to a sample of states (6), municipalities (17), hospitals (49) and ambulatory units (40). Six areas of analysis were included in design: (i) planning and budget formation; (ii) budget execution; (iii) material management; (iv) equipment and plant management; (v) human resource management; and (vi) production management. Data was collected through a survey instrument that was applied in situ by surveyors, complemented by interviews with key personnel and analysis of secondary data. The annex contains an in-depth discussion of the survey design, methodology and analysis.

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[5] The sample includes six states (Sao Paulo, Rio de Janeiro, Rio Grande do Sul, Ceara, Mato Grosso, and Amazonas) with a variety of socioeconomic characteristics and differentiated levels of institutional development, and 17 municipalities within these six states, and hospitals and outpatient clinics in these jurisdictions. The sample is too small to be statistically representative of SUS, but is sufficiently diverse to be illustrative of its systemic problems. See the Annex for additional details of the sampling and other methodological considerations.

[6] It is not unusual, for example, for the director of a public hospital to be unaware of his payroll costs and the total amount of resources spent in his hospital.

[7] A forthcoming World Bank report, *In Search of Excellence: Strengthening Hospital Performance in Brazil* (2007), examines efficiency of hospital services in Brazil.

CHALLENGES OF RESOURCE MANAGEMENT IN BRAZIL'S HEALTH SECTOR

Health status in Brazil has significantly improved in the last 10 years: infant mortality decreased by 47 percent in 14 years (from 47.5 per 1,000 live births in 1990 to 25.3 per 1,000 in 2004). Mortality rates from vaccine-preventable diseases in children are negligible; and diarrhea diseases are the cause of less than 7 percent of all deaths among children under 5 years of age. Brazilians are living longer and are much less likely to die from communicable diseases. While Brazil has a relatively high incidence of HIV/AIDS compared to the rest of Latin America, the number of new cases annually has now leveled off due in part to improved surveillance, effective detection measures, and aggressive prevention and education campaigns.

Despite these gains, two important challenges have come to the fore. First, non-communicable diseases (NCDs) and injuries are now the leading causes of death with cardiovascular diseases, injuries and cancer the top three causes, accounting for 62 percent of all deaths. Continuing with the status quo will add US$ 34 billion to the country's health care expenditures over the next decade, and also result in US$38 billion in lost productivity.[8] Without shifts in how care is provided and good health promoted, the additional cost of treatment combined with lost productivity (due to earlier death and disability) could consume an additional five percent of GDP over this period. Second, despite the fact that more than 97 percent of all births occur in hospitals, which should mean better care, neonatal mortality currently represents over 60 percent of infant morality.[9] Addressing neo-natal mortality requires establishment of effective care referral systems as well as quality improvement in hospitals.

Since the launching of Unified Health System (SUS) in 1988, change has been incremental but steady. The main strategy of Brazil's health reform (*Reforma Sanitaria*) has been the decentralization of service provision from the federal government to the municipalities, and to a lesser extent, to state governments. All states and most large urban municipalities have gained full management responsibility (*gestão plena*) for higher level care.[10] A second key element of the reform was the establishment of a federal financing system based on grant transfers. Accounting for over 80 percent of federal health financing, this system represents an important shift away from directly paying for (and operating) services to financing programs and health care through sub-national entities. A praiseworthy achievement of decentralization and the grant-based financial systems has been the financial buy-in from states and municipalities, which currently finance nearly 45 percent of all publicly funded health care (See Table 1.1 below). The federal government finances the difference through grants transfers.

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[8] Status quo refers to under-provision of health promotion and prevention interventions, weakness of referral systems, lack of dissemination and use of cost-effective treatments, and the absence of functional networks to facilitate the application of case management protocols across all levels of care. See *Addressing the Challenge of Non-communicable Diseases in Brazil,* World Bank, Report No. 32576, 2005.

[9] Deaths occurring during the first 28 days of life.

[10] Between 2002 and 2005 all states and 667 urban municipalities signed agreements for full management of the delivery systems under their jurisdiction. This means that these sub-national entities are responsible for all publicly-financed health spending and delivery within their jurisdictions. This entails a combination of direct management of public health programs and publicly-owned facilities as well as financing of private providers under contract with SUS.

TABLE 1.1: HEALTH EXPENDITURE, 1995 AND 2004 (IN 2004 R$ THOUSANDS)

Spending Indicator	1995	2004 *	Growth % 95-04
Federal health expenditure	35,138	35,611	1.3
States health expenditure	11,296	13,447	19.1
Municipal health expenditure	10,040	15,640	55.8
Total Public Health Expenditure	**56,474**	**64,698**	**14.5**
% of Public Expenditure	10.98	10.17	-
% of GDP	3.89	3.66	-
Private Health Expenditure	**67,312**	**81,896**	**21.7**
% of GDP	4.64	4.64	-
Household Health Expenditure	53,909	62,416	15.8
% of Household Consumption	6.20	6.40	-
Total Health Expenditure	**123,785**	**146,594**	**18.4**
% of GDP	8.52	8.30	-
% Private	54.38	55.87	-
% Public	45.62	44.13	-

* estimated.

Health spending excludes spending on pensions and retirements of public servants, debt-related spending and health care to public servants, but includes estimates for federal university hospitals.

Source: DATASUS, SIOPS, IBGE (for GDP)

The health system still faces structural and organizational challenges that may compromise its ability to achieve further gains. For its level of income and spending Brazil still exhibits comparatively low health status indicators. In 2004, total health expenditure was estimated at R$ 147 billion (US$ 50.7 billion), or about 8.3 percent of GDP. Public resources accounted for 44 percent of spending while private spending constituted the remainder (Table 1.1).[11] Real health spending has increased an average of 2 percent annually between 1995 and 2004. Over this period real annual government and private spending rose on average 1.6 and 2.4 percent respectively.[12]

Comparing spending with health indicators such as life expectancy, infant mortality, and maternal mortality, places Brazil at an average performance level among middle income countries and in Latin America.[13] Other countries spend less on a per capita basis (adjusted for purchasing power

[11] The private sector covers around 45 million people. Between the SUS and the private sector, the system includes 7,400 hospitals (65% private), with 471,000 beds, 6,000 outpatient clinics (75% public), and 11,500 diagnostic service units (94% private).

[12] Government health spending as a percent of public spending has decreased slightly during this period. However, this indicator oscillates by year depending on estimation methods and the availability of data. For example, it was estimated at 12 percent in 1997, but declined to 10 percent in 2003. As described in this report, such estimates are hampered by the poor quality of data available on health spending at the sub-national level. Between 1995 and 2004, average government health spending represented 10.8 percent of public spending.

[13] A WHO report on the performance of national health systems ranked Brazil as 125th among 191 countries and 28th in the Latin America and the Caribbean region (out of 33). In spite of methodological and data issues, the results are indicative of the low performance of the Brazilian health system when relating outcomes to expenditure (WHO, 2000).

parity)[14] and as a percent of GDP, but are able to achieve equal or superior health outcomes for their populations. However, it is important to note that other factors can influence comparisons between spending and outcomes, such as access to water and sanitation, education of girls, and the distribution of resources. (Medici, 2005; World Bank, 2003).[15] Generally, spending alone is not a good predictor of health outcomes across countries.[16] However, even controlling for these factors, some countries perform better than others at similar levels of spending and economic development (World Bank, 2003). This suggests that additional factors may modulate the effectiveness of public spending on health. Policies that direct spending to address the health needs of the poor and improve the quality of spending can contribute to better health outcomes. For example, higher levels of spending on high complexity hospital care may have little impact on overall health outcomes. The study aims to understand how resource allocation and management may contribute to overall system performance.

SUS AND ITS FINANCING ARRANGEMENT

Structure

The health reform process of the 1980s and 1990s redefined responsibilities within Brazil's public health sector. SUS was established in the 1988 constitution, and subsequent basic legislation guiding its implementation and functioning, was a culmination of this reform process. The main feature of the reform was decentralization of health service delivery to the municipal level. According to the basic SUS legislation, the responsibilities within the system are divided as follows:

- Coordination and definition of policies: this is basically the responsibility of the Ministry of Health, although the states and (to a lesser extent) municipal levels of government have a complementary role to play in adapting and prioritizing the federal policies to local circumstances.

- Regulation: this is also essentially a federal responsibility exercised by the Ministry of Health and by a number of specialized autonomous agencies such as ANVISA (the National Agency for Health Surveillance) and ANS (the National Agency for Supplementary Health).[17] The states and municipalities can also undertake a complementary regulatory role within their spheres of influence.

- Financing: this role is shared among the three levels of government (federal, state and municipal) but the decentralization process and the changes introduced in the financing arrangements of SUS over the years have led to a reduction in the importance of federal financing and increased responsibilities of the states and mainly municipalities (See Table 1.1).

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[14] Purchasing power parity is an economic method of using the long-run equilibrium exchange rate of two or more currencies to equalize the currencies' purchasing power.

[15] See: Medici, André. "Financiamento *público em saúde na América Latina e no Caribe: uma breve ánalize dos anos 1990.* Inter-American Development Bank, Technical Health Technical Note No. 3: 2005; World Bank: *World Development Report 2004: Making Services Work For the Poor.* Washington: World Bank, 2003.

[16] Médici found that public spending as a percent of total spending was not correlated with health outcome measures in Latin America. The author did not analyze the association between outcomes and total per capita spending or spending as a percent of GDP.

[17] The ANS regulates and supervises private health insurance plans since 1998.

- Service delivery: as a result of the reform, service provision is currently conducted on a more rational basis with a clearer division of responsibilities. In general, primary and secondary care is the responsibility of the municipal level and management of high-level referral facilities is that of state governments. However, a number of states operate secondary-level hospitals. The federal government hardly participates in the direct delivery of health services with the exception of certain specific areas (e.g., teaching hospitals). Many SUS-financed services are in effect delivered by private philanthropic or profit-making enterprises either under contract with SUS or through special agreements known as *convenios*.

The Basic Operational Norm 01/96 defines the levels of SUS implementation in the municipalities according to the capacity and interest of the municipal secretariats to assume the different levels of services and programmatic activities.[18] These are divided between:

- "Full management (*Gestão Plena*) of primary care", under which the municipality is responsible for all primary care activities but not for delivering higher level services; and

- "Full management of the municipal health system," under which the municipality assumes total responsibility for managing all services and health units within its geographical area.

By December 2000, 10% of all Brazilian municipalities were qualified under the full management scheme of the municipal health system and 89% in the full management of primary care system, while 44% of states were qualified under 'advanced' or 'full' management regimes. However, the operation of the entire system is made highly complex by the enormous diversity of local conditions and the different levels of technical and fiduciary capacities of the sub-national (especially municipal) governments and their facilities.

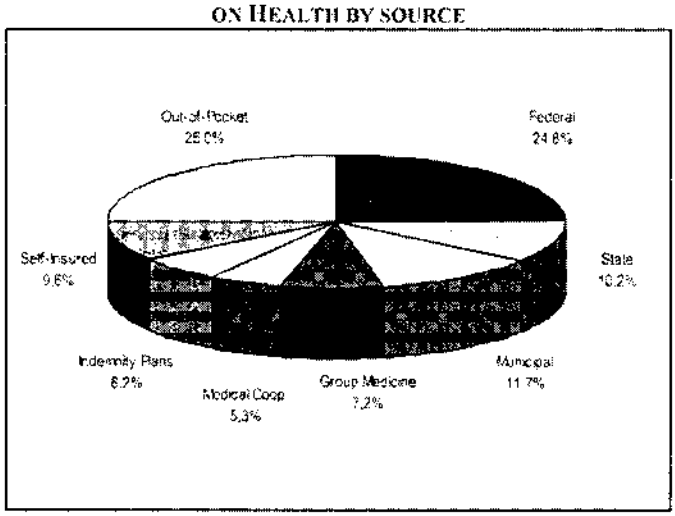
Financing

The federal government, through the Ministry of Health, is the main financier of the SUS, with federal financing accounting for around 53% of the total public expenditures on health. Public resources amount to just over 45% of the total national expenditure on health, including out-of-pocket contributions by families that account for almost half of all private spending. Figure 1.1 presents a breakdown of spending by source.

Given the decentralized structure, much of federal expenditure is transferred to state and municipal governments through a variety of transfer and payment mechanisms. In total, around two thirds of the Ministry of Health expenditure is transferred to the state and municipal health secretariats or to private health providers through more than 70 different modalities.[19]

[18] Equivalent classification defined for the states: State level 'Full' and 'Advanced' Management.
[19] A recent, 2006 policy initiative aims to collapse these transfers into six block grants.

FIGURE 1.1: COMPOSITION OF NATIONAL EXPENDITURES ON HEALTH BY SOURCE



Source: SIOPS, ABRAMGE and IBGE 2002 data.

Planning and Budgeting in SUS

The Brazilian public budget system is relatively well structured, although its rules tend to be highly formalistic and complex. While the basic structure and legislation apply to all, each sub-national government can modify the details of its own budget based on its own policies and priorities. This is a natural aspect of decentralization, but the lack of uniformity in budgeting rules and classifications among states and municipalities makes facile comparison and consolidation of health spending data difficult, if not impossible.

Planning and budgeting is performed in several stages: planning and programming of actions, budget preparation and approval, budget execution, control and ex-post reporting. Each stage has to comply with legal deadlines. The final budget proposal is the result of two complementary flows: a "bottom-up" flow, with budget proposals developed by the service units and programs under the coordination of the health secretariat, and forwarded to the higher levels of the system, and a "top-down" flow, resulting from the definition of policy priorities and budget caps that in turn depend on the revenue received by the public sector. This latter process is usually coordinated by the Finance Secretariat.

At the planning stage, three basic SUS documents are considered:

The Health Agenda: this is the first stage in the planning process. It defines the priority lines of intervention and action strategies in order to establish the programs, objectives, and targets of health policy. This agenda is submitted and approved by the Health Councils.[20]

[20] Health Councils are permanent SUS entities established by law (Law 8142 of 12/28/1990) to ensure social participation in SUS oversight and policy-making. They exist at each level of government (national, state and municipal), and include representatives from health authorities (ministry or secretariat), health services providers, health professionals and users. Their role is broad, and includes reviewing, approving and monitoring health plans, overseeing and evaluating budget execution and approving annual reports, and proposing health policies and guidelines at each level of government. The councils' decisions need to be endorsed by the executive of the corresponding level of government.

- The Health Plan: this document is prepared annually to update the sector's diagnosis, strategies, priorities, programs, objectives, targets and assessment indicators. The Health Plan must include a Targets Chart (*Quadro de Metas*) based on the Health Agenda, and form the basis for programming and budgeting. The Plan must also be submitted and approved by the Health Council.

- The PPI (Negotiated Programming Exercise) consolidates the health plans of the different levels of government (state and municipalities there in) in order to bring their objectives in line with the relevant targets.

- The Management Report is the final step in the planning process. Developed at the end of the budget year, this report assesses the performance of the activities carried out and the results achieved, and, in principle, should compare the results with the objectives and targets fixed in the Health Agenda and Health Plan.

Federal Transfers

The transfers from the Health Ministry to the states and municipalities and the direct payments to service providers represent the largest part of federal health expenditure and one third of the total amount spent by SUS. The three main categorical mechanisms for these transfers are outlined below. Tables 1.2 presents summary features of specific mechanisms for each category while Box 1.1 describes recent changes in SUS financial flows. Figure 1.2 schematically illustrates the financial flows in SUS.

- Payment for services delivered: this consists of payments to hospitals, outpatient departments, clinics and professionals for services provided to SUS based on a fixed rate schedule. Traditionally, payments were made directly to health care providers (e.g., to hospitals through the Hospital Information System and Authorization for Hospital Admissions systems [SIH/AIH] and to ambulatory facilities through the SIA/SUS system), depending on the quantity of services produced. However, direct federal payments to providers have been gradually replaced in recent years by "fund-to-fund" transfers, for the corresponding amount, to states and municipalities, which in turn pay providers. Public providers are funded through state or municipal budgets, while private providers are paid by states and municipalities based on AIH and SIA bills. [21]

- Direct fund-to-fund transfers: these consist of regular and automatic grants transferred directly from the National Health Fund (FNS) to state and municipal health funds. These transfers are earmarked for financing SUS programs and services. Nearly all transfers for financing health services (primary, medium and high care) are channeled through this system. The funds are then used by the state and municipalities to complement their own spending to cover facility and program budgets.

- Agreements (convenios): these are specific but formal agreements drawn up between public authorities and public and non-profit, private providers. They usually fund specific activities, investment programs, or service provision in the non-profit sector. The *convenio* modality was historically used between public entities, but was extended to non-profit institutions.

[21] Direct federal payments to providers through SIH and SIA decreased from 69% of MOH transfers in 1995 to 19% in 2003. These federal payments were eliminated in 2005 and merged into fund-to-fund transfers.

- Other special incentives and programs: these are resources for financing specific actions or health inputs defined by the Health Ministry (e.g., special drugs) or aimed at specific population groups (such as the Program to assist indigenous populations). Generally these funds can only be applied to the program to which they are linked.

The Health Ministry annually defines state-by-state caps on each type of transfer and/or payment based on a historic series of production and payments within technical parameters (e.g., one hospital admission per inhabitant/year) and targets set for specific programs. The amounts transferred to the state/municipal health funds usually have to be transacted in accounts that are linked specifically to the program or the item of expenditure to which they are allocated. While this system is intended to reduce the scope for divert resources from their original purpose, it involves high transaction costs for the local administrators.[22]

TABLE 1.2: SUMMARY CLASSIFICATION OF FEDERAL TRANSFER MECHANISMS

TYPE	MECHANISM	PROGRAM/ACTION	BASE FOR CALCULATION
Direct/ automatic Transfers (fund to fund)	Fixed PAB (Basic Care Threshold)	Tuberculosis Control Hypertension Control Diabetes Control Oral Health Children's Health Women's Health	Global value fixed on per capita basis
	Variable PAB	Health Surveillance Basic Medicines Program Nutritional Deficiencies Program Community Health Agents Program Family Health Program /PSF	Proportional value depending on production or coverage of each program
	Surveillance	Health Surveillance Epidemiology and Disease Control	Value proportionate to production or coverage
	Medium and High Complexity	Outpatient and hospital care/ medium and high complexity	Same as AIH and SIA
Payment for Services Delivered	AIH/SIH – Authorization for hospital admissions	Payment for hospital admissions according to tariff calculated on basis of procedure or treatment involved	Value per admission pre-fixed by tariff; includes fees, hospital services and special materials
	SIA – Outpatient Information System	Payment for treatment received,: - primary/basic (consultations, small cures) - high complexity (tomography, magnetic resonance, haemodialisis)	Value per procedure or treatment, pre-fixed by tariff
Covenants	Covenant system	Payment defined by object of covenant	Negotiated value/ case to case basis
Other incentives and special programs	Direct transfer	Special medicines Mental health drugs Public emergency Health campaigns, National Health Fund	Global value
	Direct Payment	Hospital and outpatient care for indigenous peoples.	Value per admission and procedure, pre-fixed by tariff

[22] In most cases, every earmarked fund requires a separate account, including accounting bookkeeping, and reporting procedures. Since there were until recently nearly 100 different payment mechanisms, this practice implied considerable managerial inputs.

BOX 1.1: RECENT CHANGES INTRODUCED INTO SUS FINANCIAL FLOWS

Primary care:

The operational care norm – NOAS 2001 (Directive 95 of 26 January 2001) – created the *Gestão Plena da Atenção Básica Ampliada* (Extended Full Management for Basic Care) as one of the management modalities for the municipal health systems, modifying the basic care threshold which saw its range of activities broadened. This became known as the *PAB-Ampliado* (PABA). This new threshold takes into account actions to control tuberculosis, eliminate hanseniasis, control hypertension, diabetes mellitus, women and children's health and oral health. The PABA, similar to the PAB, consists of a fixed portion of resources (*PABA Fixo*) targeted to Primary Care with a further portion targeting variable care (*PABA Variável*), related to incentives for developing specific programs carried out at this level of care. The PABA values are defined in a band ranging from R$ 10.50 to R$ 18.50 (R$ 0.50 higher than the value of the PAB).

Medium and high complexity:

In 1999, the Ministry of Health created the Fund for Strategic Actions and Compensation (*Fundo de Ações Estratégicas e Compensação,* FAEC*)*. The purpose of this Fund is to pay for highly complex procedures for patients referred by other states. The resources originate from the National Compensation Chamber (*Câmara Nacional de Compensação*). The resources earmarked to FAEC have been increased on an annual basis. By December 2001 they stood at R$1 billion. – equivalent of 10% of the resources made available in the "caps" (*tetos*) of the states and the Federal District – approx R$10.2 billion (Management Report 1998 – 2001 of the Secretariat for Health Care of the Ministry of Health). Although originally targeted to high-complexity services, in recent years FAEC funds have been applied to specific initiatives unrelated to care complexity but deemed "strategic" by the MOH. These include campaigns for diagnosing cervical cancer, eye care, tobacco control, reduction of waiting time for elective surgeries, and a hospital quality survey initiative.

Reimbursing costs arising from patients with health plans

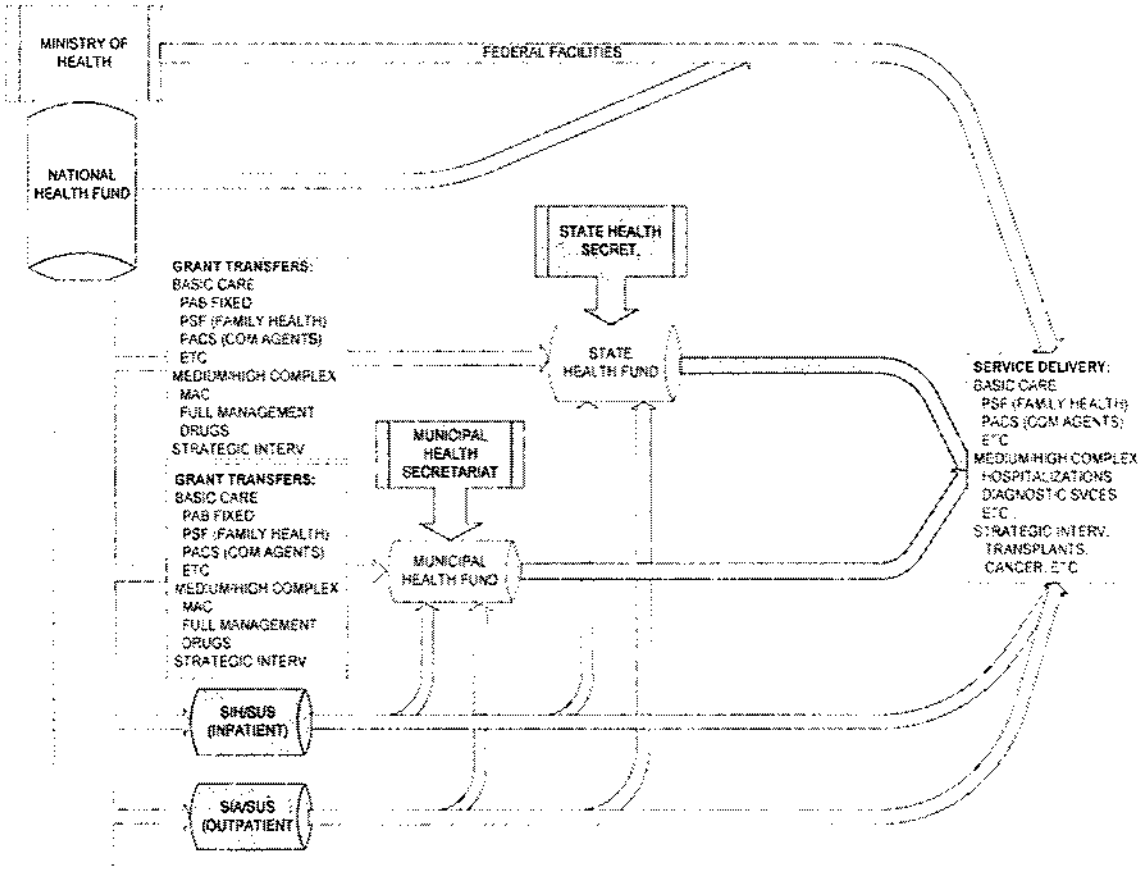
In the case patients covered by private health plans who receive care in SUS units, the value of the services rendered must be recovered by ANS in accordance with a SUS rate schedule.[23] The value is reimbursed by the health plan operators to ANS and must be credited to the Health Fund (*Fundo de Saúde*), or to the unit that has provided the service.

Consolidation of Transfers

In early 2006, the Health Ministry consolidated over 70 separate transfers into a six block grants: basic care, medium and high complexity care, health surveillance, pharmaceuticals, and management. State and municipal managers can reallocate resources to activities and interventions within each block, but not across blocks. Linked the block-based allocation, sub-national entities are to sign "health covenants" (*pactos de saúde*), specifying interventions as well as compliance with performance indicators. The "pactos" are an important step to streamline the complex grant-based financing system because they eliminate the one-size-fits-all normative rigidities of the previous system. In short, they allow states and municipalities flexibility to design and organize their delivery systems to fit the local context.

[23] Law 9.656/98, Article 32, and ANS Resolution RDC 18 of March 30, 2000.

FIGURE 1.2: FINANCIAL FLOWS IN SUS



2. PLANNING AND BUDGETING IN SUS

A key function of government planning and budgeting is to ensure that allocation and utilization of the scarce public resources are properly aligned with the government's policy priorities and that the funded activities are implemented efficiently and effectively to achieve desired results at reasonable costs. While definition of policy priorities is fundamentally a political process, the political decisions should be supported by systematic considerations of the population's needs and of the appropriate roles of the public sector, and should be disciplined by the availability of financial resources (i.e., hard budget constraint). This is what effective planning and policy analysis offer.

Once policy priorities (i.e., what social needs to be addressed) and programs (i.e., how these needs are to be satisfied) are defined, the government assigns resources through the annual budget process. Smooth integration of the planning phase and budgeting phases, including substantive consistency between the two, is a fundamental requirement of sound public policy and expenditure management. Effective integration of planning and budgeting can be compromised in a variety of ways, including the weak analytical and evidentiary basis of the plan, lack of financial considerations in the planning phase (which leads to a plan being a pure wish list), incremental budgeting where resource allocation is determined as an increment of the previous year's budget irrespective of the recognized needs and past performance, and the existence of multiple planning processes for different purposes.

A good budget should be comprehensive in its coverage and transparent in its content. For example, all revenues including non-tax revenues such as proceeds of user charges and expenditures such as grant-financed activities should be captured in the budget. The budget documents should include sufficient details to allow policy-makers and outside observers to understand the government's policy and financial intents (e.g., functional or programmatic, and economic classifications) and accountability of resource use (e.g., administrative classification). The emerging trend is to link allocation of financial resources to concrete service outputs, although this requires a fairly high level of technical sophistication, which is not always present in developing countries.

Once resources are allocated, budget management should ensure adequate control of the government's financial obligations and expenditure levels so as to prevent waste or unsustainable build-up of liabilities. A good budget system that facilitates efficient service delivery is characterized by credibility and predictability. On the one hand, a credible budget is one which limits discretionary reallocation of approved funds for other purposes during the execution phase. When lacking credibility, a budget is not able to guide activities of service delivery units in ways that are consistent with the previously defined policy priorities and operational plans, thus rendering the pre-defined policy objectives meaningless and diluting accountability of service delivery units. On the other hand, a good system maintains predictability regarding the amount and the timing of funding releases to service delivery units so that the latter could plan their operational activities and deliver the services efficiently without disruption for lack of funds.

Once the funds are spent and activities are executed, a good system leaves clear and proper records that account for the actual use of the funds, and in sophisticated systems, information of the outputs produced.

This chapter covers the process of planning, budget preparation, and budget execution among the secretariats and health units of SUS. It proceeds in four sections, examining first the current state of planning, then budget preparation, budget execution, and concluding with a summary assessment of the findings.

PLANNING

Planning is the first stage of the resource management cycle in SUS. At the planning stage, the health secretariats and units should conduct diagnosis of the main epidemiological issues facing the population, effectiveness of government interventions during previous periods, and prioritize future actions to ameliorate the existing conditions. A well-crafted plan would be based on a balanced use of top-down policy directives (emanating from the health secretariat and the Ministry of Health) and bottom-up needs assessments (conducted at the facility level).

The survey reveals that, in general, the informational and analytical bases of the existing planning tools in SUS are precarious. Planning is conducted mainly as a formal exercise to comply with the legal requirement rather than as an instrument to implement policy or as a basis for resource allocation. In a decentralized setting such as SUS, tension arises between the need to maintain a degree of consistency in policy priorities across the system (as defined by the Ministry of Health) and the purported benefits of decentralization that should be gained from letting sub-national entities define their own, locally adjusted priorities. SUS has yet to develop ways to achieve a satisfactory balance between these competing rationales of decentralized health policy management (see Box 2.1).

Planning at State and Municipal Health Secretariats

Figure 2.1 reports the survey responses regarding commonly identified problems in the health planning process. Three categorical problems are evident: (i) weak analytic bases; and (ii) fragmentation of programs and priorities; and (iii) lack of time for planning.

Weak analytical bases of sub-national health planning: All the states and most of the municipalities develop Health Agendas and Health Plans. The survey reviewed the informational bases of these planning tools, and found diverse sources being utilized by state and municipal health secretariats. At the state level, these include: a diagnostic measure developed by the secretariat (4 states), the policies defined by the Ministry of Health (3), followed by assessment of the demand and needs, compliance with the requirements of the Health Council and others (with 2 instances each). Assessing the experience of previous years appears as an important source of information in only one state (Ceará). Therefore, there is evidence of efforts to develop state health plans based on a survey of problems and the local situation, although federal policy and programmatic directives exert considerable influence.

In contrast, municipalities have not invested much in developing their own diagnoses as a basis for their health plans. Sixty percent of the municipalities in the sample reported that they simply followed the Ministry's policies and programs in developing their own plans. This is followed by the diagnosis/survey of problems conducted by the secretariat (53%), the assessment of demand and needs (35%), experience from previous years and compliance with the requirements of the Health Council (29%).[24] Planning by the municipalities is therefore strongly influenced, or even directly determined, by the policies and priorities defined by the Ministry of Health at the national level.

[24] The percentages do not add to 100% because of multiple answers.

BOX 2.1: THE TENSION IN A DECENTRALIZATION MODEL

The legislative underpinnings of SUS date to the 1988 Constitution, which instituted SUS and defined the general principles of universality and free services, along with the government's responsibility. Subsequent legislation and regulations defined how the system would operate, establishing a complex system of funding transfers and administrative requirements for states and municipalities. Throughout this process, two central themes were dealt with by the subsequent regulatory measures: specific designs of the decentralized system and the criteria and mechanisms for transferring federal funding to states and municipalities. There is an inherent tension in designing a federal transfer system in a decentralized context: on the one hand, decentralization implies granting greater autonomy to the lower levels of the system, and thereby freedom to determine resource use (which is substantiated in the principle of automatic funding transfers with no prerequisites); on the other hand, there is the need, on the part of the Ministry of Health, as overseer of the system, to promote national policies and priorities, provide incentives for their implementation, and to motivate the states and municipalities to more efficiently allocate and apply federal resources. Naturally, this tension has generated heated debates, which have yet to be adequately resolved in SUS regulations. The main points are summarized below.

Decentralization

The successive regulatory directives defined levels, stages and methods for decentralizing SUS. NOB/93 defined three levels of voluntary participation in SUS for the municipalities (Initial Management, Partial Management and Semi-complete Management) – each tied to a set of official requirements. Many municipalities (and even states) had trouble meeting these requirements and/or were only able to comply in a formal, bureaucratic sense. Operationally, many of the requirements remain partially implemented. As a result, four years later, only 2.9% of the municipalities were qualified under Semi-complete Management, 12.4% under Partial Management and 47.6% under 'Initial Management', with the rest (37%) not eligible at all. A year earlier, NOB/96 had already defined other methods for insertion in the system – Full Management of Basic Services and Full Management of the System – as a replacement for and improvement on those stipulated in NOB/93. Ten successive steps are required for a municipality to become qualified, implying 14 to 20 requirements (all procedural) with 29 justifying documents. In 2001, a new set of regulations, NOAS 01/01, altered the management methods defined by NOB/96, introducing 'Full Management of Extended Basic Services,' and proposed a new model for regionalization of High-Complexity Services, thus creating new administrative procedures and controls. In sum, what it means to be an officially certified sub-national entity in SUS has shifted resulting in considerable confusion among states and municipalities.

Transfer Mechanisms

A municipality's or state's official decentralization status in SUS was always tied to types and amounts of federal funding transfers. In the 1980's, a typical method was agreements (*convenios*) between the federal government and the sub-national governments. Since the 1990's, these have increasingly been replaced by direct and automatic transfers. Depending on differences in the municipalities' and states' conditions and capacities, and on the methods for their incorporation into the system (NOB/93/ NOB/96, N0AS/2001), there was always a coexistence of different transfer mechanisms, which made management of the system even more complex. NOB/96 heightened this complexity when it increased the number of specific transfers for certain programs and actions. Each type of funding was required to be handled using a specific account within municipal and state health funds, created for the purposed of receiving the transfers. Many of the 70 or more payment and transfer mechanisms that exist today are restricted, meaning the funding may only be used in the programs for which it is intended. If, on the one hand, these restrictions contributed to the expansion of basic services programs (such as the Family Health Program - PSF) with positive effects on the health indicators, on the other hand, they require separate and parallel systems for monitoring, control and reporting, which substantially increases the work and manpower devoted to these essentially administrative tasks and thus reduces the system's efficiency overall.

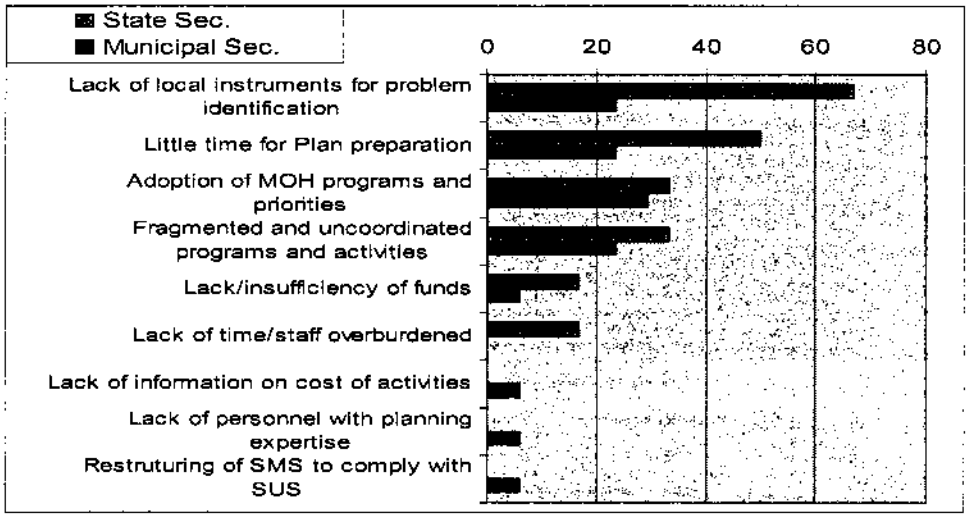
Except for a few municipalities, Health Councils have little influence on the definition of priorities and allocation of resources, which contradicts one of the basic principles of SUS.[25]

Finally, in half the states and over one-fifth of the municipalities, respondents report having little time for planning. This suggests that planning may be low-priority activity in these sub-national entities.

Fragmented prioritization: The survey also shows a wide dispersion and fragmentation of priorities. The five programs and five interventions that were defined as priorities by the states and municipalities seldom coincided, resulting in a total of 25 different programs and 19 interventions.

Two of the 25 programs were mentioned by only two states, whereas none of the 19 priority actions was mentioned by more than one state. Similarly, among the 17 municipalities in the sample, 59 programs and 60 actions were mentioned, with only seven programs and one action cited by two or three secretariats. This dispersion suggests considerable autonomy in dealing with the local situation and needs, but it also shows that nationally-defined priorities are not often respected in the sub-national planning efforts. Besides, the actions and programs defined as administrative priorities in the survey do not always figure in the Health Plan or Agenda (one state and several municipalities identified priority programs and actions "forgotten" in the plans, and in general the correspondence is not clear), which suggests autonomy is not used to draw up credible plans to guide the states' and the municipalities' health policy interventions. .

FIGURE 2.1: PROBLEMS IN THE PLANNING PROCESS MOST OFTEN CITED (% OF RESPONSES)



Note: The total exceeds 100% due to multiple responses.

Planning in Health Facilities

As expected, planning is weak at the facility level. Although a large share of the hospital units (75%) – especially larger units – in the sample develop some sort of plan, only around 30% of the outpatient clinics do so. When a plan is prepared, this is frequently late vis-à-vis the legal deadlines. Once again, the analytic bases of these plans seem limited: among those hospitals that develop a plan, 69% base it on the previous plan as the main source of information. The plans'

[25] See footnote 12 for the role of health councils.

value in guiding the facility's performance management also seems limited: 36% of the hospitals use only production or physical targets (e.g., number of consultations and admissions, coverage indicators, etc.);[26] 20% apply only financial targets; and 32% use both physical targets and financial ones (expected expenditures). Half of the hospitals surveyed perform technical and financial planning without correlating physical targets with the resources required.[27]

BUDGET PREPARATION

In the budget preparation phase, the substantive content of the sector plans is translated into an action-oriented framework with specific amounts of resources allocated to each budget category. The extent to which annual budgets are well-linked to the problem identification and policy prioritization in the planning phase determines the adequacy of the annual budget in addressing important problems in the sector (as opposed to continuing to allocate resources to low-priority areas because of inertia). Budgeting is also a domain of financial specialists. In a highly technical sector such as health, the risk exists that a budget proposal is drawn up by financial specialists without sufficient regard to the technical content that would have been developed by sector specialists in the prior planning phase. The survey results suggest that this divorce between the financial and technical budget formation processes is common at the sub-national level.

Budget Preparation in Health Secretariats

Compliance with legal calendar and requirements: Budget preparation follows a strict calendar. With only a few exceptions, the states and the municipalities in the sample usually meet these legal deadlines in preparing their budgets. In addition, SUS mandates that the budget proposal be approved by state or municipal health councils. The majority of the states and the municipalities in the sample report not having their budget proposals approved by their health councils, however.[28]

Linking planning and budgeting: All of the states reported using the Agenda and Health Plan as a basis for preparing their budget, along with previous iterations of the budget itself. In the municipal secretariats, the budget preparation process faces greater difficulties. Few municipalities use the Agenda and the Health Plan as a source of information for preparing their budget (only 5 of 17: São Paulo, Parintins, Sobral, Resende and Ivoti), and instead turn to the previous year's budget as the source of information.

A review of the documentation reveals that programs defined as priority in the plan often have no resources directed to them in the budget. This is partly due to the government's strategic posturing whereby it attempts to keep the allocation at an aggregate level and avoid the fragmentation of resources and facilitate re-allocation across programs and actions during the implementation phase. In some cases, however, the very detailed budget classification structure hinders flexibility during execution. For example, the State of São Paulo lists 41 programs, which apparently represent temporary priorities of the government as well as specific parliamentary amendments that "pulverize" resources.

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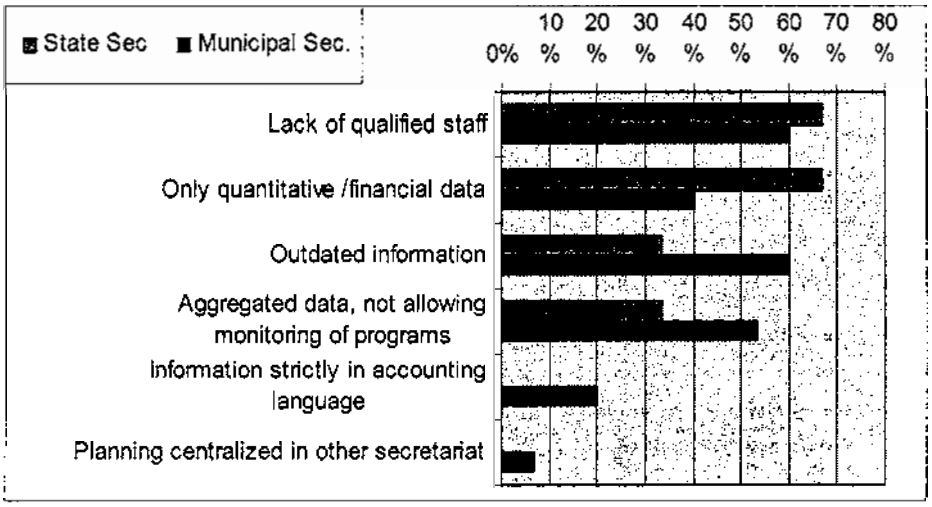
[26] but without linking them to financial execution

[27] The main problems observed in the planning process, classified by order of importance, are: financial limitations (73% of the hospitals), little autonomy in running the unit (48%), vague goals including those without quantification (30%), and excessive red-tape or bureaucracy (27%).

[28] Only the States of Rio Grande do Sul and Ceara and the Municipalities of São Paulo, Resende, Sobral, Cuiabá and Assis have had their budget proposals approved by the Health Councils. Mato Grosso had only its Multi-year Plan (PPA) approved by the Health Council, but not the budget proposal.

Figure 2.2 reports the main difficulties in budget preparation: lack of information on costs (cited by 67% of the states and 29% of the municipalities) and the absence/insufficiency of baseline financial data to guide the detailed budget preparation process, due to poor communications among the planning and budget/accounting sectors and the health secretariat (67% of the states and 35% of municipalities).

FIGURE 2.2: PROBLEMS IN BUDGET PREPARATION MOST OFTEN CITED RESPONSES (AS % OF RESPONSES)



Note: The total exceeds 100% due to multiple responses.

In order to deepen this assessment of quality of, and consistency in, the planning and budgeting process, a case study was conducted based on those secretariats that had attached their plans and budgets to their survey responses.[29] This assessment uncovered more serious problems than those noted by the interviewees. As shown in Figure 2.3, the most common problems are the failure to identify the source of funds and the entity responsible for each action or program (80% of the plans), the failure to estimate the cost of the actions (77%), and the absence of mechanisms or criteria designed to evaluate the plan's implementation (or achievement of the goals). One of the plans was 82 pages long, but 73 pages were spent describing the current situation; others included some quantified targets but with no relation to the main content of the plan and the expected actions.

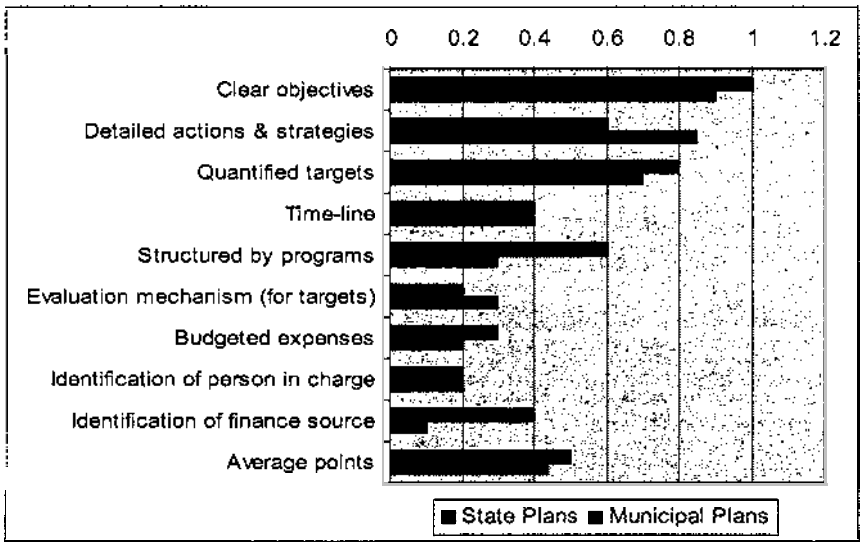
Overall, the planning and budgeting process for the SUS is fragmented, and inconsistent between the various stages of the planning process. Also noteworthy was the lack of attention paid to detailed concrete action plans. A critical problem – though one not emphasized by the interviewees – is the absence of data on the costs of the proposed actions and programs. In this situation, the

[29] The case studies analyzed the quality of the planning and budgeting process through assessing the following features: inclusion of clear objectives for the plan, the itemization in programs and delineation of strategies, the definition of quantitative targets, the definition of deadlines for each activity, identification of a person responsible for the activity, the identification of the source of funding and estimation of the cost or expenditure tied to the activities, the inclusion of a mechanism for evaluating plan execution, and the correlation between the plan and the budget. For each of these items, the plan received a score of 0 or 1 depending on its fulfillment of the criterion. The sum of the scores was converted in a 0-1 scale, as displayed in Figure 2.3.

budget or the plan, or both, run the risk of becoming a piece of fiction, useful only to comply with a legal requirement.

In sum, the planning and budgeting process proves to be sophisticated in its formality and its instruments, but truncated and poorly integrated in practice due to the inconsistency between the documents and the stages that comprise the whole process. The structure of the budget in general is limited to general items/headings, thus hampering the identification of priority programs and actions. This limitation makes it hard to follow and assess systematically the allocation of resources and the process of implementing the budget.

FIGURE 2.3: QUALITY OF STATE AND MUNICIPAL HEALTH PLANS



Budget Preparation in Health Facilities

Lack of autonomy and haphazard budgeting: At the facility level, the availability of financial-budgetary information varies depending on their status as a Budgetary Unit[30] and the degree of administrative and financial autonomy they enjoy. Most small-scale hospitals and outpatient clinics have no budget of their own, nor do they manage most of the financial resources they consume. In addition, management's ability to monitor and control units' expenditures varies. In the sample, only 43% of the hospitals and 15% of the outpatient units possess their own budget. However, an additional 30% of these facilities have some internal financial information. This usually entails petty cash for urgent and small purchases for emergency maintenance, small supplies, etc. Twenty-six percent of the hospitals and 55% of the outpatient units have little or no financial information at all (Figure 2.4). Hospitals with the greater administrative autonomy generally have a much higher level of financial information since they are formally deemed a Budgetary Unit and are responsible for implementing their own budget.

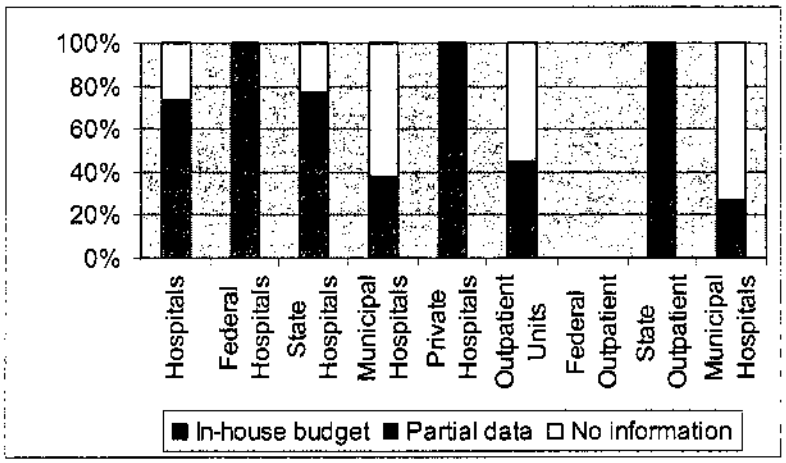
Even in facilities that are budgetary units, managers consider as "their" budget only that portion they execute directly. For example, most of the larger facilities manage – at most – the budget for

[30] A budgetary unit is an administrative unit (e.g., a facility) that receives its own budget allocation, and manages at least part of this budget. Facilities that are not a budgetary unit have no budget of their own, and nearly all inputs are purchased and paid for centrally. In the latter case information on the total spending for the facility is unavailable or difficult to access.

supplies (but usually excluding drugs) and small contract services (e.g., maintenance, cleaning and surveillance) but not their payroll.

Lack of information on personnel is particularly problematic at the facility level. The majority of the facilities have no budgetary or financial information about their expenditures for personnel, because these are managed and paid by a central level secretariat, with little or no involvement by facility managers. For this reason, managers commonly deem personnel expenditures as external to their budget and of little concern regarding managerial responsibilities. In general, managers possess little information about their staff. This situation clearly limits the facility's responsibility for management and expenditure control. Despite the fact that payroll represents about 60% of total costs, managers tend to regard their production costs as excluding personnel spending. Of equal concern, they tend to use these grossly underestimated values when generating cost information.

FIGURE 2.4: LEVEL OF FINANCIAL INFORMATION IN THE HEALTH UNITS[31]



Cost management: At the facility level effective cost management is essential for efficient management of the allocated resources and for determining optimal allocation of resources at the budget phase. Several major hospitals (24% of the sample) set up a system for auditing costs, but only two municipalities have cost or expenditure data itemized by health unit: Cuiabá possesses a general cost auditing system installed in the units, and Rio de Janeiro uses a one-time analysis that estimated the expenditures per facility). All of the Social Organization hospitals in the State of São Paulo have installed cost auditing systems.[32] These systems are standardized, allowing inter-facility service cost comparisons. Nevertheless, these are the exceptions to the general practice, evident the

[25] Partial information is characterized by the unit's recording or having information on part of its expenditures, for example involving some cost items but not others; the unit may have information on the material acquired directly but not on purchases made centrally.

[32] A Social Organization in Health (OSS) is a new organizational form developed for delivery of certain public services through a variant of a contacting-out modality. Under this OSS model, the government provides budgetary transfers to cover the costs of running the hospital, but responsibility for day-to-day administration is delegated to pre-certified, non-profit organizations. The State Secretariat of Health (SES) negotiates and signs a performance contract with each of these hospital managers, granting them greater flexibility than their counterparts in traditional state hospitals to run the hospital in the manner they consider best-suited to meet their performance targets. In 2004, 16 public hospitals in São Paulo were administered as OSS.