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EFFECTS OF CONSTITUTIONAL AMENDMENT Nº. 29/2000 ON HEALTH LEASE IN BRAZIL

[1]Armando Pereira Grell, *[2]Márcia Mello Costa De Liberal and [3]Chennyfer Dobbins Abi Rached

[1]Department of Health Sciences; Nove de Julho University (UNINOVE), Sao Paulo/SP, Brazil
[2]Department of Medicine, Discipline of Economics and Management in Health, Federal Universityof São Paulo (Unifesp), Sao Paulo/SP, Brazil
[3]Career Guidance Department, Nursing School, Universityof São Paulo (USP), Sao Paulo/SP, Brazil

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****Corresponding author:***
Márcia Mello Costa De Liberal

ABSTRACT

Objectives: The Constitutional Amendment nº 29 of 2000 (CA nº 29/2000) was approved to guarantee financial resources for public health and to involve and hold the three governmental spheres responsible for financing the public health sector in Brazil and to analyze the allocative decisions of the States and the Federal District. **Methods:** inferential, explanatory, quantitative, and qualitative research, approached with the use of the empirical method to analyze historical series of allocations of expenditures destined to health by the States and the Federal District concerning CA nº 29/ 2000. The data had analyzed through the application of mathematical methods and statistical techniques used in econometrics. **Results:** the differences in the socioeconomic and tax environments of the states had been found to produce different decisions in the public health sector. In the period analyzed, CA nº. 29 and net revenue per capita influenced the variability of the percentages applied in health. However, the financial resources obtained were not able to ensure improvement in public health services. **Conclusions:** managers do not have the necessary training to promote changes that aim to improve effectiveness and efficiency, in addition to the interference of political factors in the sector that compromise technical and operational criteria.

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INTRODUCTION

Considered as the Citizen Constitution, the Constitution of the Federative Republic of Brazil of 1988 created the Unified Health System (UHS), establishing the decentralization of the system to improve the efficiency of public health services (Faveret, 2002). This Constituent allowed the creation of the bases for the emergence of UHS based on a universal, comprehensive, and participatory health system. During the period of implementation of UHS, the national and international scenario was unfavorable for this initiative, since the fiscal retraction of the time resulting from the economy and the predominant conservatism demanded the reduction of public spending, cooling the ideological objectives of a more expansion emphasis on health services to guarantee the state's redistributive function (Menicucci, 2009). Another point to be considered is that, in this period of Brazilian history, health has been defined as a social right of the population by the Constitution.

As European and American social protection standards have created before the Brazilian model, they were been developed in a context in which industrial capital governed the movement of capital. Although the Constitution established the mandatory application of at least 30% of the Social Security Budget in health actions, it did not define the minimum standards for the application of resources for States, Municipalities, and the Federal District. This lack of clear rules for financing has hindered the process of decentralization of services and access to the public health system in the municipalities (Faveret, 2002). In its long journey through financial resources, the health sector even resorted to loans from the Workers' Assistance Fund on an emergency basis. This generated the search for financing solutions for the sector that culminated in the creation of the Provisional Contribution on Financial Transactions in 1996 (Law 9,311, of October 24, 1996) (Gadelha, de Noronha & Pereira, 2012). Thus, efforts culminated in the elaboration of a Constitutional Amendment

Proposal for health, which, after being revised and adjusted, was approved by the National Congress and promulgated by the Federal Senate as Constitutional Amendment nº 29 of 2000 (CA29/2000) (Faveret, 2002). CA 29/2000 was been approved on September 13, 2000, and it established the roles to be exercised by the Union, States, Municipalities, and the Federal District in financing public health. In its text, the criteria and minimum percentages of federal, state, and municipal revenues to be applied in public health actions and services were defined (Sambiase, 2003). With the definition of these rules, the public health system obtained more stable and secure sources of financing. The great merit of CA 29/2000 was to involve and to commit the Union, the States, the Municipalities and the Federal District to the universality of health (Dain, 2007). The criteria for participation in health financing highlighted in the Amendment were union and commitment equal to the amount spent on health in the previous year plus a minimum of 5% and for the following years, the value of the previous year corrected by the nominal variation of the Product Gross Domestic Product. For the States and the Federal District, in the year the amendment was introduced, the application was at least 7% of their total tax revenues (transfers from the states to the municipalities should be deducted from their binding base), reaching 12 % over five years. In the case of Municipalities and the Federal District, the same criteria applied to States that, during the five years, should invest at least 15% of their revenues.

According to CA 29/2000, the criteria for the Federal District obey both the minimum equivalent percentages on the revenues of the States and the minimum equivalent percentages on the revenues of the Municipalities (Sambiase, 2003). In addition, the Amendment served as a basis for new policies for calculating and collecting Urban Territorial Tax and defined the role of the National Health Councils in the new Brazilian health scenario (da Rosa &Grell, 2015). Although CA 29/2000 established the rules for the application of resources, it did not define which health actions and services would be cover by the Amendment. This task would be contemplated by Complementary Law Nº 141 of 2012 (CL141/2012). CL141/2012 came into effect in January 2012. The standard established the minimum percentage of application in health by the spheres of government and what would be the actions and public health services contemplated in the execution of CA 29/2000. This law also conceptualized spending on health actions and services that could or could not be financed with funds from CA 29/2000 deposited in health funds. This law also established the norms for the regulation of the allocation of minimum resources by the Union, States, Municipalities and the Federal District in public health, making paragraph 3 of article 198 of the Constitution.

The focus of CA29/2000 and CL 141/2012 was the financing of public health. The definition of services and actions in the sector aimed to guarantee and regulate the adequate use of financial resources applied in health. There was no concern with the effectiveness of the operation itself in the federal units and their respective municipalities. Even so, CL141/2012 did not guarantee the minimum financial resources to operationalize the country's public health subsystem, and the problem of under-financing in the sector continued to live in the daily routine of SUS. In its Article 4, Law 8,142/1990 defines that States, Municipalities, and the Federal District to receive, regularly and automatically, the federal resources described in Article 3 must constitute a health fund. CA 29/2000 establishes the Health Fund as the management unit of the public health budget. In this respect, it is the mechanism for the application of financial resources in health actions and services. Thus, a public health budget is necessary to operationalize the fund's resources. The budget of this fund must be part of the budget of the State, Municipality, or Federal District with the approval of the respective Health Council (Falcão Filho, 2007). CA 29/2000 also defined the calculation basis, the criteria and the minimum percentage to be applied in public health actions by the Federal Government, States, Municipalities, and the Federal District, leaving the allocation of resources free (Menicucci, 2009). It is worth mentioning that CA29/2000 did not establish the financial ceiling, but the minimum resources to be applied in health actions, leaving public managers to seek other additional sources of funds to ensure a more effective health policy for the local population (Ribeiro & Bezerra, 2013). The Federal Government implemented the percentage of health expenditures by the States to guarantee the financing of the sector, but there is no effective control or punishment if the proposal in CA 29/2000 has not fulfilled. The greatest effort to comply with CA29/2000 had carried out by municipalities that experience the problems of implementing this system up close. Because of this, it is important to present the changes that occurred in public health expenditures before and after the application of the Constitutional Amendment and the Pact, in addition to seeking to understand the application process of these resourcesconsidering the role of health managers in the decision-making process in an environment with limited financial resources.

METHODS

A review of the academic literature has carried out involving the three theoretical poles of this work: the Sources of Funding in Public Health, the Regulation of Funding Sources, and the Decision Making in Public Health Management. Initially, the theoretical aspects of the sources of health financing in Brazil had analyzed, tracing a historical panorama of the uncertainties and difficulties to finance this sector and guaranteeing, in this way, the principles of Universality, Equity, and Integrality. Then, aspects of the Brazilian regulation of health financing sources have studied, contemplating the Constitution of 1988, the CA29/2000, the LS141/2012, theOrdinance 399/2006, and the LC 101/2001. Until October 1988, public health care services have been linked to the availability of liquid financial resources, after meeting insurance requirements (pensions and pensions). Nowadays, public health care is a universal right without ties to the condition that the citizen is a taxpayer. In Brazil, this theme has gained relevance due to the insufficiency and the uncertainty of financial resources. The financing of the health system comes from three sectors: Public Health, in which services are provided with resources from the three spheres of government; Private Health, in which resources they may be public or private and the organizations involved may or may not be profitable; and Supplementary Health, in which the resources come from families and companies and may or may not have tax subsidies (Paim, et al, 2011). Concerning the financing sources of the Brazilian health system, they originate from general taxes, social contributions, direct disbursements, and company expenses with their employees. The public health subsystem of the Union, States, Municipalities and the Federal District has financed through tax and social contribution revenues. If we considerthat the

values of financial resources from social contributions are higher than those from taxes that have been shared between the three spheres of government, we have a situation of under-financing by the public health sector (Paim, et al, 2011).Public health financing plays an important role and can influence the country's social policies and development policies, because, on the development side, the Government, as a major buyer, can regulate and foster the productive sector of medicines, supplies, and equipment for hospital doctors. On the other hand, in the social aspect, it can expand and improve the population's access to the public health system, in addition to reducing prices and increasing the supply of medicines contemplated by HUS (Dain, 2007). Regarding its objectives, it is an inferential, explanatory, quantitative, and qualitative study. For that purpose, an empirical methodological approach was applied to analyze the historical series of allocations of expenditures for health by the States and the Federal District about CA 29/2000. The study used data declared by the 26 states and the Federal District in the different sources surveyed for the period from 1998 to 2014. The historical period was chosen because the CA 29/2000 was approved in 2000. Thus, the study seeks to understand the period before the Amendment, 1998 to 2000 until December 2014. Given the data collection procedure, this work used the technique of descriptive and inferential statistics, since the data collected were organized, summarized, and described for the construction of the tables and analyses performed. During the research, 9,639 data were collected and/or processed (21 variables x 17 periods x 27 UFs) and used public collection sources. To assess health expenditures under the Constitutional Amendment, this research has divided into three distinct stages: the first refers to data collections. The second phase refers to the qualitative and descriptive analysis of health expenditures in the periods before the CA 29/2000, that is, 1998, 1999, and 2000. The third stage concerns the period from 2001 to 2014. It is important to note that this study intended to evaluate health expenditure allocations decisions, considering the economic, social, and tax structure of the States and the Federal District of Brazil. To eliminate the effect of time on the value of money, all data in local currency were been converted into hard currency using the Purchasing Power Parity criterion. The hypothesis proof and the presentation of the results have elaborated through the application of mathematical methods and statistical techniques used in econometrics.

RESULTS

Before the promulgation of CA 29/2000, the percentages allocated to public health with net current revenues varied widely from one state to another, as each state adopted a criterion according to the decisions of your managers. In 2000, the behavior of managers to public health varied from one extreme to the other, ranging from an allocation percentage of 1.51% in Maranhão to an application of 18.49% in Acre. In some states, these annual variations increased sharply, while in others, they declined sharply. This seesaw in application rates showed the lack of criteria in the process of allocating financial resources in public health, in addition to indicating the absence of a coherent policy in Brazilian public health. As the proposal of CA 29/2000 established a minimum of 7% applied in health in the year of its beginning, in 2000 several states had not yet reached this mark. For example, in the period before CA 29/ 2000, the state of Rondonia invested 132.8 million dollars in health in 1998. This amount represented 14.20% of its Net Current Revenue (NCR). However, in 2000, it reduced spending to $ 68.2 million, which meant 7.79% of its NCR, that is, a -48.64% drop in resource allocations in the sector. In contrast, Acre in 1998 invested US $ 141.8 million (19.30% of NCR) in health and, in 2000, despite having applied 18.49% of NCR, the fall was -4.20%. In terms of values, their spending increased by 38.86%, to $ 196.5 million.

In the state of Pará, in 1998, 9.00% of NCR has allocated in the health sector and increased to 7.33% in 2000, a negative variation of 18.56%. In the Northeast Region, Maranhão was the state with the most critical situation concerning CA 29/2000 and would have to make a greater effort to adapt to the new legislation. In 1998, it applied 5.00% of its NCR to shares and services in the state, in 1999 1.51%, and in 2000, it fell to 1.50%, registering a variation of -70.00% in this period. In terms of dollars, it spent 62.9 million, 88.8 million and 35.9 million, respectively, in 1998, 1999 and 2000. In 2000, Piauí, Ceará, Paraíba, and Sergipe were also far from the legal requirement for application in health defined by the Amendment, with 5.02%, 2.60%, 3.60%, and 3.32%, respectively. In 1998, Rio Grande do Norte already applied 15.10% of NCR in health. Thus, its effort to accommodate the minimum percentage has reversed, since, in 2000, health expenditure was 12.60% of the NCR, showing a reduction of -16.56%. Even so, its investment in dollars, shares, and health services increased from 245.4 million to 380.0 million. Of the Southeastern States, at the time of the Amendment, Espírito Santo was the one with the most comfortable situation. The State would have to make less effort to adapt to the new rules, because it allocated 12.40% of the NCR in 1998, 11.40% in 1999, and 13.59% in 2000.

On the other hand, Minas Gerais was far from the target of the minimum percentage of application, since it allocated 5.40% of NCR in health in 1998, 4.60% in 1999, and 4.78% in 2000. Rio de Janeiro, in 2000, spent 7.73% of its NCR in the sector, far from the target, but better than the 5.20% spent on public health in 1998. São Paulo increased its application percentage by 8.50% over the NCR in 1998 to 9.58% in 2000, a variation in the indicator of 12.71% but which represented an increase of 593.5 million dollars in the state's health. In 2000, the amount of 4.6 billion dollars had been spent in the sector. In the southern region of the country, all states had indicators below the minimum percentage of CA 29/2000. In the region, Santa Catarina was the one with the highest percentages of health allocation, 8.70% in 1998, 8.60% in 1999, and 9.34% in 2000. Next, came Rio Grande do Sul, with 4, 80% in 1998, 6.40% in 1999 and 6.82% in 2000. In 2000, Paraná spent 253.5 million dollars more on public health than in 1998, despite the effort, still applied only 4.06% of its NCR in the sector. An example of the effect of state managers' decisions on health actions and services in the State of Mato Grosso do Sul, which, in 1998, applied 1.90% of its NCR to public health, but in 2000, increased its spending to 8, 88% of NCR. This variation in the percentage rate of 367.3% represented an increase of 97 million dollars more in spending on actions and health services.

In the period leading up to the Amendment, the state of Mato Grosso maintained its decision to allocate to the health sector a percentage well below the minimum application target established by the legal provision. In 1998, it allocated 4.20% of the NRC, in 1999, 2.10%, and 2.75% in 2000. Thus, to

comply with the Amendment by the year 2004, that state would have to make a major effort in redirecting its financial resources for public health, but in 2004, it already applied 11.01% of its NCR in health, still below the legal target. To reach 11.01% of the NCR, to the 1988 expenditures, it was necessary to increase health expenditures by an additional 399.4 million dollars. Comparing 2004 with 1998, health expenditures varied by 599.10%, while tax revenues changed by 145.96% and current transfers by 26.52%, which demonstrates the redirection of financial resources from other sectors for public health. Goiás and the Federal District maintained similar behaviors in the percentages applied in health, where the first allocated 10.10% of NRC in the health sector in 1998 and reduced to 7.88% in 2000, a reduction of financial resources of the 59 million dollars. The Federal District applied 10.30% of the NCR in 1998 and this application dropped to 6.16% in 2000. However, the state spent 148.3 million dollars more than the amounts spent in 1998.

DISCUSSION

In this study, the issue of different environments that generate divergent decisions was confirmed in the individual analyzes of the 27 federative units. Two states with allocation behavior and with a contextual environment at the opposite ends were Maranhão and São Paulo. Despite the finding of regional disparities, the public health system had the same operational standards for the states of the federation without considering the differences in health demand, available resources, and local infrastructure. It was from this highly diversified contextual environment that the analysis of socioeconomic and tax factors and their influences on the decision-making process for the allocation of financial resources in public health was carried out. In the analyzes of the States and the Federal District, two independent variables evaluated had to evidence that they contribute to increasing the value of the variable. Both, in the general analysis, including all state levels, and the individual analyzes by state-level: CA 29/2000and spending capacitymeasured by the current net revenue per inhabitant. CA 29/2000influenced the decisions of state managers and guaranteed more financial resources for the public health of the states, even though some states did not reach 7.00% of the NRC in 2000 and 12% of the NRC in 2004. The intensity of the variations in the NRC percentages applied in public health by the States and the Federal District that occurred in most places, where some states sharply increased their spending, while others reduced them, strengthens the concept that CA 29/2000 interfered in the way managers made decisions and deal with health expenses.

From 1998 to 2000, the first target of the Amendment (7.00%), the average percentage applied to health actions and services by the states was 8.25% of the NRC, although some states were below 7%. In the period from 2001 to 2004, the second stage of the Amendment (12.00%), the average percentage of application in health by the state spheres was 10.53% of the NRC similarly some states have not met the 2004 target. From 2005 to 2014, the average percentage applied by the states rose to 13.32% of the NRC. Effectively, the state level increased its participation in spending on health actions and services, in the evaluated period, the average RCLA (2005 to 2014) grew 61.4% to the average of 1998 to 2000. In the analysis of all states although the average obtained from the independent variable Commitment of Net Revenue with Personnel Expenses in the periods 1998 to 2000, 2001 to 2004 and 2005 to 2014 was 48%, 57%, and 58%, respectively. Therefore, below the LRF 60% criterion after the LRF approval, several states did not respect this limit and spent on personnel above 60% of their net revenues according to the criteria of this study. It includes Pará, Maranhão, Ceará, Rio Grande do Norte, Paraíba, and Pernambuco (with values above 70%), Alagoas, Sergipe, Bahia, Minas Gerais, Espírito Santo and São Paulo (in 2013 and 2014), Paraná, Santa Catarina, and Rio Grande do Sul (above 70%), Mato Grosso do Sul, Mato Grosso, Goiás and Federal District (in some years above 80%).

This means that the net revenues of the states were committed to personnel expenses and there has very little left to invest in the various social policies of the states. In part, personnel expenses and charges stemmed from political party factors that adopted public office as their currency. As the Economic and Tax Development Index measures the capacity to generate state tax revenues concerning current federal transfers (includes FPE, federal taxes generated in the state, and other transfers), the greater than 1.00 times, the lower the political influence of the federal sphere in the process of transfers to the states. In contrast, less than 1.00 times, the greater the exposure to political influence. In the analyzed period, this variable presented the lowest value of 0.12 times and the highest value of 13.64 times (the revenues from state taxes are 13.64 times greater than the current transfers made by the Federal Government). In this sense, the statistical analysis of the data collected for the states in the seventeen years of the study showed evidence that two variables (CA 29/2000 and spending capacity) of the seven independent variables have significance with the dependent variable and contributed to their behavior over the period. However, the independent variable CA 29/2000 derives from a legal obligation that forced states to review their allocation decisions in the health sector.

Conclusions

In summary, HUS has always had problems with insufficient financial resources to finance its actions and services in public health. However, money is not the only condition to improve the quality, efficiency, and productivity of the health operation to guarantee the universality of the population. A condition as important as the financing of the sector is the training of staff, especially managers. Thus, it is necessary to eliminate the political patronage that exists in the sector, where strategic management positions have held, people without the necessary qualifications to perform the function, including making the public health system more vulnerable and less controlled irregular management practices. Finally, it has recommended that managers who work or intend to work in the public health area seek the appropriate training to face the new challenges of the globalized economy. They need to keep in mind the changes required to develop the country's public health system, making it more productive, agile, and effective with visible improvements in the quality of services offered to Brazilian society in general.

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