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MANAGERIALISM AND HEALTH: CONTRIBUTIONS TO THINKING ABOUT THE BRAZILIAN CONTEXT

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Summary

At the end of the 1970s, in response to the crisis in the fall in the rate of profit in the core countries of capitalism, there were a series of reforms of the state that aimed to reduce the cost of running public services. The public-private partnership with non-governmental non-profit organizations for management, through the transfer of state resources, was the model found in order to make services more efficient and at a lower cost. This ideology came to be designated as managerialism. In Brazil, managerialism gained institutional shape with the reform of the state, in 1995, carried out by the Ministry of Administrative

Reform. In health, this model gained expression with the transfer of health service management by entities called social health organizations.

Keywords: Capitalism; Managerialism; State Reform; Social organizations; Health.

GERENCIALISMO E SAÚDE: CONTRIBUIÇÕES PARA PENSAR O CONTEXTO BRASILEIRO	**GERENCIALISMO Y SALUD: CONTRIBUCIONES PARA PENSAR EL CONTEXTO BRASILEÑO**
Resumo: No final da década de 1970, em resposta a crise na queda da taxa de lucro nos países centrais do capitalismo, houve uma série de reformas do estado que tiveram por objetivo reduzir o custo de funcionamento de serviços públicos. A parceria publico-privada com organizações não governamentais sem fins lucrativos para a gestão, por meio de transferência de recursos do estado, foi o modelo encontrado com intuito de tornar os serviços mais eficientes e com menor custo. Esta ideologia passou a ser designado como gerencialismo. No Brasil o gerencialismo ganhou corpo institucional com a reforma do estado, em 1995, realizada pelo Ministério da Reforma Administrativa. Na saúde este modelo ganhou expressão com a transferência de gestão de serviços de saúde por entidades denominadas como organizações sociais de saúde.	**Resumen:** A fines de la década de 1970, como respuesta a la crisis de la caída de la tasa de ganancia en los países centrales del capitalismo, hubo una serie de reformas estatales que apuntaron a reducir el costo de funcionamiento de los servicios públicos. La alianza público-privada con organizaciones no gubernamentales sin fines de lucro para la gestión, a través de la transferencia de recursos del Estado, fue el modelo encontrado con el objetivo de hacer los servicios más eficientes ya un menor costo. Esta ideología llegó a ser designada como gerencialismo. En Brasil, el gerencialismo ganó cuerpo institucional con la reforma del Estado, en 1995, realizada por el Ministerio de la Reforma Administrativa. En salud, este modelo tomó expresión con la transferencia de la gestión de los servicios de salud por parte de entidades conocidas como organizaciones sociales de salud.
Descritores: Capitalismo; Gerencialismo; Reforma do Estado; Organizações sociais; Saúde.	**Descriptores:** Capitalismo; Gerencialismo; Reforma del Estado; Organizaciones sociales; Salud.

INTRODUCTION

To understand how the managerialist model reaches the instances of organization and management of the health system today, it is necessary to understand the context of **prescription** of the management model in the health sector. Managerialism emerges as a response to the crisis of maintaining capital's profits.

Didactically, we could understand the evolution of the stages of capitalism, throughout its history, in the following sequence: mercantile capitalism, entrepreneurial capitalism, managerial capitalism and rentier-financial capitalism.

Mercantile capitalism covers the period from the XVI to the XVIII century and is marked by the transition from feudalism to capitalism. In this period, the emergence of nation States took place, as well as the Industrial Revolution, with England as its stage. The second epoch, entrepreneurial capitalism, includes the period from the XIX century to the crisis of 1929 with the crash of the stock markets and the collapse of the discourse of liberalism.

At the end of the XIX century, the stock market crisis was a propitious ground for the emergence of a true organizational **revolution** of capitalism and led to the rise of managerial capitalism. The protagonism of managers of companies in the private sector, the strengthening of a bureaucracy in the public sector, commanded by technocrats, is gradually replacing entrepreneurs in the management of companies.

The United States becomes the disseminating nation of this new way of conducting the expansion of capitalism. In this period, after the Second World War, we are living in a time of fruitful development of social welfare, especially in European countries, generated by the expansion and strengthening of capitalism, in the face of high rates of return. It could be considered that it is the period where some democratization of gains occurs, generated by capital that in that historical period demonstrated a robust development.[1]

In the late 1970s and early 1980s, with the rise of Ronald Reagan in the United States and Margaret Thatcher in the United Kingdom, and in response to the reduction in the rate of return on capital, as well as a process of stagflation in the American country, there was an economic scenario for the emergence of a neoliberal vision of the economy, and consequently, the rentier financial character of the economic model in central capitalist countries gained prominence.

This relevance of capital, not industrial, but financial, gives rise to a situation in which the entrepreneur, the owner of the means of production, loses importance in relation to the rentier, and the investment consortiums/funds that become relevant in the world capitalist system.

The market, and more specifically, the capital market, becomes the driver of the dynamics of capitalism. There is a growing reduction in the process of industrialization, particularly in countries on the periphery of capitalism, or as it is conventionally attributed, developing countries. Financial instability and inequality between nations and interpopulation becomes the rule of economies.

In the most recent period, the financial crisis of 2008 turns out to be an example of this logic. With the bankruptcy of financial institutions, previously considered solid, and the indebtedness of a large portion of the American population.

This process of financialization of the economy, which we see today, has its beginning in the 1980s in the United States, which from a developmental and industrial nation, began to adopt a liberal logic, not only in the political discourse, which it already was, but in the conduct of the economy. The idea of managerialism, that is, of "teaching" how to manage, emerges with increasing argumentative force. Management, in the core nations of capitalism, becomes the mantra and, obviously, an export product.[2.3]

MANAGERIALISM

Managerial State, New Public Management, or finally, managerialism is a term that tries to define the structural and conceptual political changes that result from from the rise of Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States.

The assumptions of this vision were: to free market forces from State control, to reduce the tax burden on citizens, to reduce the size, scope, and cost of the State. This logic has become widespread in several countries and has been adopted as a recipe for economic management by organizations such as the International Monetary Fund (IMF). Could we argue that this proposition of new economic-political rules for the functioning of the State breaks with the commitment to sustain a welfare State, common to European countries in the post-World War II period? Maybe it's more than that. It is the emergence of a new culture of functioning of a collective entity: the State.

The substrate that precedes these changes, of proposing the functioning of the State and the fulfillment of its social duties, occurred from the economic crises of capitalism in the mid-1970s and, as a result of the fiscal crisis of nations and their financial difficulties in maintaining the social agreements previously established.

In the post-war period and due to the social and economic repairs of the populations and nations involved in the conflict, the idea of creating multilateral organizations and promoting economic growth and social well-being emerged. This "social" concern of the developed nations lost ground when the return to profitability of the capitalist model began to have difficulties at the end of the 1970s, accelerated or aggravated by the export crisis of the oil-producing nations.[4]

The political agreement between capital and labor needed, from this moment on, to be adapted, or even revised. The **weight** of the State on the markets should be removed, liberating them towards a freer, less regulated and supposedly, based on a managerial view, more efficient functioning.

Market-centric ideas and propositions, or the functioning of services by the logic of the market, a mixed economy of providing services that would be freer to act, gained many defenders. Freer than what? Free from whom? Free from the regulation of the State, its laws, norms and, ultimately, from its interests, which strictly speaking, must be the interests of the citizens who sustain it.

The belief was that the State, by reducing its presence in the provision of services, would emerge institutions that would perform this function and would be managed by directors, managers, who, once **free** to act, would act more efficiently, quickly and at a lower cost. In other words, the main figure of this new culture of functioning of services, even if public, becomes the manager and no longer the politician, the career public servant. The manager becomes the figure who brings with him, from this new culture, the quality of efficiency, preparation, objectivity, innovation, modernity, as opposed to the archaic vision of the bureaucrat, stuck with excessive regulations and the so-called paternalism.[5]

THE DECREASE IN STATE POWER AND MANAGERIALISM IN BRAZIL

The flexibility of institutions to function by managerial logic leads to a progressive loss of influence of the State in the formulation of policies, in the sector in which new agents will start to act. In other words, once freed from the controls of State bureaucracy, we have the emergence of another State, said to be freer, which we could define, as the managerial State.

Therefore, the State, **assuming** its inability to conduct services that should be provided to the population and that are mandatory and inherent to the condition of public power, cedes its prerogatives to private institutions, said to be quasi-market for conduction, organization of these services. In other words, management implies a concept of "fixing" what is not working properly.

Something very different from what Frederick Winslow Taylor proposed for managerial activity. According to Taylor, it was essential that the managerial authority had three basic conditions: to apply scientific research to the exercise of work; respect for the interests of workers and cooperation between capital and labour. However, in the current model, every individual aspiration for well-being must be linked to the company or organization to which I belong.[7]

The objective is the progress of the organization, at the lowest possible cost, which in the provision of services inherent to the state, this ideology clashes, most of the time, with the interests of the collectivity.

The idea of qualification and the formation of a professional class that could perform the functions inherent to the State was very well explained in the Constitution of 1967, during the military regime, which was established in Brazil in 1964. In its article 6, it already demonstrated a certain managerial ideology, which is clear in the provisions that describe the principles that should underpin public administration in Brazil. They were: Planning, Coordination, Decentralization, Delegation of competence, Control.

Article 26 argues that public administration should be guided by the efficiency of policy execution. Therefore, ideas dear to managerialist ideology had been present in our midst for a long time.

As we have seen above, managerialism is an ideology that gained strength from reforms carried out in the United States, England and other countries, such as Australia and New Zealand. The function of any public administration and by constitutional duty, is

to provide citizens with services, which are inherent, or even that should be primarily offered by the State. However, what should and should not be the exclusive attribution of the State is the subject of permanent debate in the world, and in Brazil, in particular.

The way in which the administration of the Brazilian State will offer services suffers direct economic and political interests, therefore subject to changes in vision and execution, depending on the ideological profile of the political power in charge.

In 1989, at a meeting in the city of Washington, and called by economist John Williamson the Washington Consensus – there were a series of recommendations for the economies of countries on the periphery of capitalism, especially in Latin America, where the countries were indebted and were under the arc of influence of the United States.

The main recommendations: fiscal adjustment, cuts in public spending, tax relief of capital so that it could be more competitive in the international market, more open and competitive than those of those indebted countries. The labor and financial markets should be totally deregulated, privatization, commercial openness and the guarantee of private property should be promoted.[8]

In Brazil, the reform of the State apparatus went beyond what can conventionally be called administrative reform. The idea was to recreate a model of action of activities that are not exclusive to the State. This model was based on the British, New Zealand and Australian experiences, and even consulted by people who worked on the reform of the British State. Education, health, and culture were, therefore, areas where the State could transfer management to non-profit entities, which would operate in the logic of private initiative.[9]

Since the beginning of the propositions in defense of the reform of the State, from 1995 onwards, the discussions proposed the need to make the State and the execution of its policies more efficient, faster, seeking an evolution from the bureaucratic model to a managerial model, not giving up the social management of the State's duties. The entities that would qualify for the performance of these functions, once exclusive and carried out by the bureaucracy of the public power, would be governed by a management contract whose focus was the fulfillment of goals initially established in this contract. There should be a budget allocation based on the fulfillment of the provisions of the contracts.[10]

MANAGERIALISM IN BRAZILIAN HEALTH

In 1986, the VII National Health Conference argued that a Brazilian health reform should include the principles of equity, decentralization, integrality and universality. These pillars marked the first universal public health system in Brazil.[11]

The Federal Constitution enacted in 1988 consolidated the universal access of Brazilians to the public health system. It considered it to be a citizen's right and a duty of the State. According to article 196 of the Brazilian Constitution

> health is a right of all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other health problems and universal and equal access to actions and services for its promotion, protection and recovery. [12]

Also in article 198, public health actions and services are part of a regionalized and hierarchical network and constitute a single system, organized with the following guidelines: I – decentralization, with a single direction in each sphere of government; II – comprehensive care with priority for preventive activities, without prejudice to care services; III – community participation.

To finance the system, it was defined that the resources would come from the social security budget, the Union, the States, the Federal District and the Municipalities, in addition to other sources.[12]

From 1990 onwards, the organic health law regulated the system that had been implemented by the recent 1988 Constitution. Health financing comes from contributions on revenues and net income and also percentages of tax revenues collected by municipalities (at least 15%) and states (at least 12%).

After the promulgation of the constitution, and with its determination of universal access to public health services, the tension in the system was characterized by two fundamental pillars: building and financing universalization.

The need to meet these two obligations to the Unified Health System (SUS) remains today and is the subject of continuous discussions in Brazilian society. Is the biggest problem of the SUS one of financing or management? This false duality remains, even today, and serves as a debate between various ideological currents of the Brazilian political scenario.

The financing of the SUS would take place, according to a constitutional law, through resources from contributions from employees and employers, contributions on revenues, contributions and the Contribution on Net Income (CSLL) of companies and also on part of the revenue of each sphere of government. There was, therefore, no specific allocation of resources to the health system. Social security, expressed in the federal constitution, treated Social Security, Assistance and Health as part of a social protection that should be conferred on the citizen.

The health budget in the years 1990 and 1991, when the law on the costing of social security had not yet been approved, it was determined that the resources of the Social Investment Fund – FINSOCIAL would be primarily linked to health and the revenue from the CSLL would also be directed, in priority, to assistance programs. Of the social security resources, 30% should be allocated to health financing.[13]

From 1993 onwards, the Ministry of Health stopped receiving transfers, corresponding to 15.5% of the collection of contributions from employers and employees. This reduction demonstrated that the Brazilian public health financing formula was vulnerable, aggravating chronic problems. In October 2000, with the approval of Constitutional Amendment 29 (EC29), states and municipalities should allocate 7% of revenues from taxes and constitutional transfers. This percentage would need to grow annually until it reaches, for the states, 12% in 2004 and 15% for the municipalities. The federal government would contribute, in the first year, with 5% of the budget of the previous period and for the following years, the amount defined in the previous one would be corrected by the nominal variation of the Gross Domestic Product – GDP.[14]

In January 2012, Complementary Law No. 141 to EC 29 was enacted, which better defines the obligations of the Union, States and Municipalities in the financing of health, as well as clarifies what should be considered public spending on health.

Public health actions and services are considered to be those aimed at health promotion, protection and recovery. Among the determinations of the law, the public power must provide comprehensive, universal health care at all levels of complexity, including therapeutic assistance and recovery of nutritional needs.

Regarding the percentages of the budget for health, the complementary law ratifies EC 29 and defines that 12% of the tax collection of the states and 15% of the tax collection of the municipalities must be applied in health.

The linking of health resources to the percentages of revenue has enormous variability in periods of economic crisis, like any budget. However, in the health area, the irregularity of transfers to the sector very often clashes with greater demands from society for new therapies, procedures or even diseases that need to be faced in the area.

Mendes and Carnut[15] in an article on underfunding and managerialism in Brazilian public health, question, in the introduction, the reason for trying to make a diagnosis of the institutional crisis of curtailment of social rights, instead of seeking to understand the nuances, and consequently, the tendency of recurrent crises of the capitalist system in which we are inserted. Why do the proposals for improvement in the functioning of the SUS, which are always made during electoral periods, directly confront the logic of private initiative that has been preponderantly adopted in the conduct of public health services?

Therefore, if we understand that the fall in the rate of profit of capitalist economies directly affects public policies, whether by political decision to contract goods and services, through budget restriction, combined with the option for a managerialist model to the detriment of a bureaucratic view of state services, we have, therefore, a very explanatory scenario of what happened to SUS in the context of the crisis of capitalism.[15]

The logic, therefore, is configured with the following actions: chronic underfunding of the SUS and transfer of management to non-governmental organizations, considered non-profit, among them: Civil Society Organization of Public Interest (OSCIP), Social Health Organizations (OSS) and public state foundations of public and private law.

Entities that Miranda[16] conceptualizes as third sector entities that operate in dynamics and terms of (almost) market, where the provision of services that was once understood and emphasized as a social right of the citizen, is reinforced as a right to consume procedures and services that will be managed by these organizations that operate on the basis of a private system, where the competition, cost-effectiveness relationship even defines more or less transfers of public resources to them. Emphasis is placed on the value of services, and a frankly utilitarian application of public resources is adopted as an ideology and application, where the discourse of competitive rationality, of

competition rules, which resemble those of the market, of efficiency, and of the quality of services, supplants the notion of coverage for the target population of these services.

This model, which is characteristic of managerialism, was taken as the only possible way to offer health services, but not only that, to expand the offer, ensure accessibility and guarantee quality.

The State, therefore, transfers to these organizations, of an (almost) market nature, resources for funding as opposed to the provision of services. The basis for this combination is the formulation of management contracts between the health secretariats and non-governmental organizations. However, the character of a reduction in public space in the health area, or a movement with a privatist profile, goes beyond the transfer of responsibilities from the state to non-profit entities, it goes through the logic of subsidies for private health services, either by tax waiver of individuals and legal entities, or by the characterization of some services as philanthropic and, therefore, exempt from taxation, despite a selectivity of clientele, that is, the little coverage in the service.

This scenario has created an increasingly common situation, in which philanthropic or non-profit entities or institutions truly dispute the management of public health equipment, as a strategy to expand tax exemption and, consequently, expansion capacity.[16]

This managerialist view of public health is reinforced in association with the chronic underfunding that the health sector has faced for many years.

According to Mendes and Carnut[15], the Ministry of Health's spending between 1995 and 2016 remained 1.7% of GDP, while spending on interest on the public debt grew by 6.6% of GDP in the same period. The authors emphasize the importance of the creation of the SUS, but it is noteworthy that in 2015 spending on the SUS was 3.9% of GDP (Union; 1.7%; states: 1%; and municipalities: 1.2%), while in European countries that have universal health systems, this expenditure reaches 8% of GDP. It can be understood, from these data, that the low budget of public health and of our SUS leaves it weakened from the point of view of inclusion, in an operational and ideological way, as it opens space for the managerialist discourse to propose alternatives and establish itself as if it were the only path.

Giovanella and Almeida,[17] in an article on comprehensive primary care and segmented health systems in Latin America, draw attention to the fact that since the 1980s, with the implementation of structural economic adjustments, social outreach services have been provided by non-governmental organizations in the private sector. When publishing data, whose sources are the World Bank and the Pan American Health Organization – PAHO, in 2014 data, they show that Brazil, with a population of 203 million inhabitants, GDP *per capita* of 14,750 dollars, has an expenditure of 937 dollars *per capita*. 46% was public spending, which corresponded to 4% of GDP.

Chile, with 17.9 million people, GDP *per capita* of 21,060 dollars *per capita*, spends 1,137 dollars *per capita* on health. 49.5% was public spending, corresponding to 3.7% of Chilean GDP. Uruguay has 3.4 million inhabitants, GDP per capita is 18,940, *per capita* spending on health is 1,442 dollars. 71% is public spending, corresponding to 5.9% of GDP.[17]

According to the WHO, Brazilian spending on health, in 2020, was 701 dollars per capita. Public spending was reduced compared to 2014, and in 2020, it was 44.8% of all health spending.[18]

In response to the lack of funding of public health in Brazil, caused by a reduction in the budget and, consequently, in *per capita* spending, aggravated by tax waivers for individuals who have private health plans and by tax concessions to private non-profit entities, the managerialist model has been deepened as a way to manage resources for the health sector. Mendes[19] points out that the crisis in the financing of the health sector is actually a reflection of the crisis of capitalism itself, due to the fall in its rate of profit, and the preponderance of financial capital, and that in this situation the system has as its approach the adoption of three basic pillars: the increase in the rate of exploitation, forcing workers to accept precarious working conditions; the reorganization of new production lines; and the devaluation of the stock of accumulated capital. The public financial incentive granted to private capital in the health sector, through tax exemptions without any replacement of part of the resources, is a true transfer of income and a way to ensure the financial sustainability of private capital, and has occurred in increasing volumes, 3.67 billion in 2003, reached 19.98 billion in 2012.[15]

In Brazil, in the public health sector, in particular, the managerialist ideology had and has its core with the state reform movement carried out by the Ministry of Administrative Reform, which took place in 1995. This reform provided a legal basis for public services in the health area to be managed by non-profit organizations, through management contracts focused on results, and variable remuneration for performance.[20,21]

Gaulejac,[2] in his book "Management as a Social Disease", argues that the instruments in charge of measuring the financial value of companies are not reliable because they are made up by impolite managers and that accounting data do not always give a clear and reliable view of the company's financial situation.

Performance evaluation in the public sector is the subject of much debate. Defenders suggest that there is an improvement in results when the evaluation is carried out, while those who criticize it claim that it is an instrument for evaluating the private sector, transposed to the public sphere. That is, taking the private management model as superior to public management. Therefore, the contracting of results represents a form of control, and establishes positive and negative sanctions. The risk, in the public sphere, is that the evaluation of performance and results becomes an end in itself, and is not accompanied by the main objective, which is to offer a quality public service to the largest number of citizens.[22]

In the administrative reform of the State from 1995 onwards, social organizations gained a leading role in health management. The model has expanded throughout Brazil, which has made more and more organizations qualify as social entities capable of managing the public health budget, this is the most evident model of the managerialist ideology, which excels in remuneration based on performance and results. But it is worth asking: what performance? How to measure the results? The defense of efficiency and autonomy has always been clear in the management model proposed in the administrative reform of 1995.

In an article for the newspaper Folha de São Paulo, on May 22, 1995, about social organizations, the then Minister of Administrative Reform, Luiz Carlos Bresser Pereira, states:

> one of the most important projects of the Fernando Henrique Cardoso government is to guarantee financial and administrative autonomy to the

> social services of the State, that is, universities, technical schools, museums, hospitals and research centers so that they can carry out their function more efficiently. [23(8)]

Therefore, there is no doubt about the purposes, it incorporates the logic of private initiative to the management of public goods, with a public budget, whose control of the application of these resources can be difficult to execute. We return, therefore, to a central question: is the difficulty of the State in providing its obligations to citizens inherent to the State or to the economic model adopted?

Carnut and Mendes[24] argue that the Brazilian State, being an integral part of the capitalist relations of production, exercises its collaboration for the model by adopting the managerialist spirit within the direct public administration, with its logic based on results and performance, the latter based on exceeding the expectations of workers in this sector, which is often confused with the amount of work to be performed.

FINAL CONSIDERATIONS

At the end of the 1970s, central countries of capitalism, such as England and the United States, in order to face the crisis of the fall in the rate of profit of their economic models, promoted a reformist movement of the State. The ideological basis of this process was the reduction of the size of the State, the transfer of part of the so-called non-exclusive obligations to non-profit civil society organizations.

The transfer of these obligations was based on the assumption that entities not belonging to the state bureaucracy would have more agility, autonomy and, consequently, efficiency in the management of the provision of services demanded by the population, especially in the areas of culture, education and health.

The relationship between the State and the health sector has several nuances, which other sectors do not present. In Brazil, the emergence of the SUS as a comprehensive and universal system established by the 1988 constitution was an advance in offering care, both in primary care and in highly complex treatments. However, its financing has, since its origin, suffered from the scarcity of resources, due to the lack of regulation of mandatory transfers or even by tax and tax exemptions that directly impact the amount of resources that should be allocated to health. The result is chronic underfunding of the system.

The scenario of contraction of resources, pressure from developed countries, for fiscal adjustments and reduction of the size of the state of indebted countries, arises the 1995 proposal carried out by the Ministry of Administrative Reform, which proposes to social health organizations the management of budgetary resources and the provision of services that were previously provided by the health system linked to direct administration.

These organizations had as their basis of operation, the managerialist ideology, based on results and performance that would be defined by management contracts signed between public authorities and non-state organizations. In other words, the SUS, the tail of discussions that had been going on since the 60s, and which in the Brazilian case, is part of the expression of social well-being that the State should provide to its citizens, becomes, in its important part, a managerialist ideology, which is more suited to the private initiative and not to a health model that should be integral, universal and broad enough to meet the most fundamental health needs, as well as to be ready to incorporate new techniques and knowledge that will guarantee health and better quality of life for Brazilians.

AUTHORIAL CONTRIBUTION

LSS contributed to the conception and writing of the manuscript.

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