HEALTH AND ECONOMIC DEVELOPMENT IN BRAZIL: ANALYSIS OF PUBLIC HEALTH EXPENDITURE IN BRAZIL BETWEEN 1930-1964

SAÚDE E DESENVOLVIMENTO ECONÔMICO NO BRASIL: ANÁLISE DO GASTO PÚBLICO EM SAÚDE NO BRASIL NO PERÍODO DE 1930 A 1964

ABSTRACT

The aim of this article is to examine the debate concerning the health/economic development relation in the course of 1930-64. We intend to show that, specially from the 1950's, the hegemony of the developmentalism ideas implicated in significative change in the discourse regarding the health public expenses, which reflected directly in the managed resources to this area.

Key-words: Health, Populism, Public Expenditure, Developmentalism, Social Policy

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Artigo submetido no dia 07.06.2012 e aprovado em 01.05.2013

Resumo

O objetivo deste artigo é analisar o debate sobre a relação saúde/desenvolvimento econômico, no curso de 1930-1964. Pretendemos mostrar que, especialmente a partir da década de 1950, a hegemonia das ideias desenvolvimentistas implicaram em uma mudança significativa no discurso sobre as despesas públicas de saúde, o que refletiu diretamente nos recursos gerenciados para esta área.

Palavras-chave: Saúde, populismo, despesa pública, desenvolvimentismo, Política Social

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1. Introduction

The intrinsic characteristics and the economic, political, and ideological debate on the populist period were extensively studied and reported in the literature of several different areas of knowledge (WEFFORT, 1980; FULOP; ROEMER, 1982; BIELSCHOWSKY, 1996; ESCOBAR, 1995; SOLA, 1998; RIST, 2007). Particularly abundant is the literature on public policies in terms of the preeminent goal of accelerating the economic growth and shaping the Brazilian to accomplish that goal (HOCHMAN, 1998; CORSI, 2002; IANNI, 1986; LAFFER, 1970; DRAIBE, 1985). Equally significant is the literature related to the role of the government in work relationships (VIANNA, 1978; ALMINO, 1980; PAIVA, 2003). On the other hand, there is a reduced number of studies on the analysis of the characteristics and composition of the social expenditure during this same interregnum (VIEIRA, 1983; BRAGA; PAULA, 1986; OLIVEIRA; TEIXEIRA, 1986).

This study aims at bridging that gap by proposing to investigate the drivers and characteristics of the public expenditure on health during the period between 1930 and 1964. The objective is to demonstrate that the increase in the public expenditure on health during the 1930s and up to the mid-1950s was then interrupted and reverted due to, essentially, the consolidation and hegemony of the developmentist discourse, which consolidated new priorities related to public expenditure management by assigning a different role to the expenditure on health in the budget.

In addition to this introduction section, this paper is divided into three more sections. The following section presents a “sanitarian

perspective”, which was hegemonic in the first half of the 20th century, in which public sector incisive activities in health area were viewed as one of the crucial factors to overcome the underdevelopment status. Such perspective was substituted since the mid-1950s, as demonstrated in section three, for a very different viewpoint, which being adequate to the developmentist discourse, focused on the prioritization of public expenditure associated to the industry growth acceleration as the major condition for population welfare including health. Section four presents, based on IBGE’s data (Brazilian Institute of Geography and Statistics) and on Federal Government General Balance Sheet, the unequivocal impact of the change in perspective on the public sector expenditure on health. The last section presents the final considerations, which summarize the evidences provided in this study.

2. Health and economic development

In the beginning of the 1950s, the theory of the vicious circle of poverty and dissatisfactory health conditions was widely disseminated. Such perspective was immortalized in the renowned fable of Monteiro Lobato, a famous Brazilian writer, called “Jeca Tatu” (a character that represents the rural worker of São Paulo state), and played a determining role in maintaining the miserable conditions of most part of the population due to the existing chronic health deficiencies. In this sense, the public sector intervention as a way to terminate this horrible vicious circle was endorsed (CASTRO-SANTOS, 1985; LIMA; HOCHMAN, 2000)

Implementing this type of idea meant to create a health assistance program similar to

that from developed countries. It was assumed that, in order to terminate the poverty vicious circle and promote economic take-off, one of the fundamental elements was to create the same sanitary conditions in underdeveloped countries. "Sanitarians of that time believed in the causal relationship illness-poverty; and to them, once the illness issue was solved, poverty would be automatically solved" (BRAGA; PAULA, 1986, p. 59).

After World War II, the efficiency and effectiveness of measures directed to the health area increased considerably. The possibility of significantly changing population health indicators that affect economic and social variables became extremely appealing. This fact combined with the urgent popular appeal for measures to deal with diseases and provide better and fair medical assistance, gave rise to the health sector including it in the economic planning in the after war period, as evidenced by the SALTE plan (a government expenditure in four fields: health, food supply, transport, and energy)¹.

The activities developed by SESP (Special Public Health Service), although discouraging, are a good example of the efforts made to implement this concept in Brazil and its results and a part of the state and nation building effort (CASTRO-SANTOS; FARIA, 2004; CAMPOS, 2008).

The interest in establishing health services standards similar to American standards, as proposed by SESP in the 1940s, date from the 1920s. Carlos Chagas, a famous Brazilian physician who discovered Chagas disease or American trypanosomiasis, representing the federal government, and Geraldo Horácio de Paula Souza, famous sanitary physician and founder of the Hygiene Institute and the School

of Hygiene and Public Health, representing the São Paulo state government, were the main supporters of the changes in the focus in the Brazilian public health system. The focus of sanitary campaigns for combating contagious infection diseases that afflicted the most developed region in the country in the first decades of the 20th Century (yellow fever, smallpox, plague, and typhoid fever)², was substituted for the perspective of sanitary education. The presence of health professionals to assist and educate the population about diseases became more important³.

Ideologically, these changes in sanitary practices are characterized by a substitution of the French school (values or thoughts) for the American school. From a bacteriological perspective, in which the sanitary police and campaign were the basic instruments, the sanitary practices begin to change into sanitary-medical practices. (MERHY, 1987, p. 94-5)

In this project, the most important basis of the sanitary policy should be the health centers, "from which the health promoting actions and/or health supporting actions would be disseminated to the social classes, and should remain due to its nature" (MERHY, 1987, p. 99)⁴. This actually did not mean to terminate the earlier institutional organization, based on the bacteriological perspective, but rather to back-burn it. The scientific and technological progresses in the medical field, quickly disseminated from the mid-century onwards, contributed to consolidate the subordinated status of the public health elements in the context of sanitary practices.

Having the support of the Rockefeller

Foundation, SESP established hospitals and sanitary-model units in several regions of the country, which should have had a microscopy and a laboratory expert and a chief-warden (Cf. BRAGA; PAULA, 1986, p. 60)⁵. Once the services were implemented, the intention was to gradually transfer maintenance expenditures and SESP funding from federal government to states and cities.

The costs associated with the implementation and maintenance of health elements, however, escaped from the Brazilian reality or at least from what was considered the maximum compromising level of public resources with public health. The welcomed SESP suggestions that lasted for years were substituted for a more critical view from the mid-century onwards.

3. Economic development and health

The attention was diverted, since then, to the minimum efficiency of the services provided. The reason for such unsatisfactory performance were the disparities between the Brazilian reality and that found in developed countries from which such model was being imported. SESP technicians made the following self-critical statement in 1956:

Several are the reasons for our deficiencies. Among them, however, is the effort to establish foreign programs in our areas without taking into consideration the profound socio-economic differences between the countries with a predominant agrarian economy and those with an advanced industrial and technological level (BRAGA; PAULA, 1986, p. 60).

Addressing the Congress, President Juscelino Kubitschek evidenced the limited financial

resources of SESP by stating that “SESP ventures in some cities are so costly that they can hardly be the municipal government responsibility” (BRAGA; PAULA, 1986, p. 61).

The poor results achieved by SESP and its unsatisfactory performance allowed a new explanation for the illness-poverty relationship, in which illness is not the cause anymore, but rather the consequence of poverty⁶. The subordination of health policies to development policies became evident in public sector rhetoric and practices. Nonetheless, let's take the case of the National Department of Rural Endemic Diseases (DNERu), created during the pro-development government of Juscelino Kubitschek.

In 1956, with the creation of the National Department of Rural Endemic Diseases, the government aimed to change emergency campaigns from sporadic to routine and subject to endemic disease emergencies (Cf. POSSAS, 1981, p. 186-7). The DNERu incorporated the National Malaria Service, the National Plague Service, and the National Yellow Fever Service. Its objectives included:

Organize and provide investigation services and promote the fight against malaria, leishmaniasis, Chagas disease or American trypanosomiasis, plague, brucellosis, yellow fever, schistosomiasis, anchylostomiasis, filariasis, echinococcosis or hydatid disease, goiter, thymosis, trachoma, and other endemic diseases present in the country. The power for investigating and combating diseases was given by the Ministry of State according to technical and administrative conveniences (PINOTTI, 1959, p. 142-3).

The alignment of DNERu proposals with the developmentist ideology and the evidences

of political subordination of health policies to the development plans could not be more eloquent than its region selection criteria: “they should be critical issues of the major transportation infrastructure” and “present economic development evidences (easy energy, transportation, soil fertility, mineral richness, and labor abundance etc.) hindered by poor sanitary conditions” (POSSAS, 1981, p. 186)⁷.

An important evidence of the dissemination of the developmentist concept to health technicians can be found in the following text of Carlos Gentile de Mello, an author with an acute sense of social conscience and who criticized strongly the health care privatization process. Even though, in the beginning of the 1960s, his thoughts were consistent with those of the proponents of health care expenditure subordination to the economic process. He wrote:

[...] although education and public health are critical factors to the economic development, it does not mean that they are such important drivers of the development process that it justifies the concentration of excessive financial resources to the detriment of investments in industries, transportation, machinery, electricity, etc... (MELLO, 1977, p. 47)

The author considered the economic development process as a more efficient process for combating morbidity and mortality than the state health policies since it provided the population with more and better services. This idea seems to be valuable, under some circumstances, however, statements such as “concentrating considerable financial resources in the health care system may result in the reduction of investments that foster economic

development” (MELLO, 1977, p. 49), can justify the recent contempt and reduction of financial resources to health care area in exchange for a supposedly better future, which would be provided by the economic growth.

The relationship between health and economic development level of a population depends heavily on whether health is seen as a end goal or a mean goal. The practices of these two points of view are very different. Considering health as an end goal implies the allocation of public resources, comparing its efficiency, in terms of social welfare, with other social mismatches that similarly constitute themselves an end per se.

Seeing health as a mean goal implies its subordination to the economic growth considering implicit or explicitly that it is capable of solving welfare and health problems in particular. The state actions towards health care become, consequently, subsidiary and poorly effective in improving population health. The only plausible explanation for the expenditure on health, under this perspective, is its contribution to the development since it promotes economic productivity improvement. The expenditure on health begins to compete against expenditures on other areas. “the social mismatches income – if measurable – should be compared to that of other sectors” (BRASIL, 1966, p. 30). The consequences of such point of view are socially disastrous:

[...] in the less developed areas, in which the costs with labor are reduced due to its abundance, part of the health care economic benefits – if seen as a means – would be completely neutralized. This could imply that regardless of the health

mismatches level, its economical benefits would be reduced (BRASIL, 1966, p. 30).

Therefore, developmentalism leads to different views of health and poverty issues: economic growth should be promoted as the only way to solve health issues efficiently. The consequences of this focus shift should not be despised.

No political pressure exerted by workers concerning the expenditure on health was identified. It can be said that during the entire populist period there were no specific claims from workers concerning this issue and

there was a lack of statements on the right to health in the constitutional documents in that period⁸. Indeed, the right to health is not mentioned in any constitutional documents of that period whatsoever. Only those who were affiliated to the health & welfare benefit system were granted this right.

4. Public expenditure on health

All of these factors led to the share of health expenditure in the public sector, which had tended to increase since the 1940s, to reduce sharply in the second half of the 1950s, as shown in Graphic 1.

Graphic 1

Share of health expenditure in the total expenditures: direct administration + welfare system – 1932-1964

Source: Primary Data: FIBGE (1990: 616-7 and 626-7); BRAZIL. MF. General Balance Sheet of the Federal Government. Various years; FIBGE Statistical Yearbook of Brazil. Various years.

Actually, except for a few cases, it can be noted an almost continuous tendency of increase in the rate of expenditure on health between 1932 and 1955. In that period, the direct administration comprising expenditures on health plus the welfare system increased from 3.9% to 6.9% of the total available resources. This rate has greatly reduced in the following

years, reaching the down rate of 5.7% at the end of the period analyzed despite the increase in the share of health expenditure in the welfare system.

Graphic 2, which shows the average medium variation of expenditures on health per year, establishes a pattern of a highly regular change for the period before 1946.

Graphic 2

Health expenditure (real variation): Direct administration (1933-1964)

Source: Primary Data: FIBGE (1990: 616-7 and 626-7); BRAZIL. MF. General Balance Sheet of the Federal Government. Various years; FIBGE Statistical Yearbook of Brazil. Various years.

During the 1932-1946 interregnum, highly positive rates interspersed with some real decreases. In the next period, although there are no records of negative variation, growth rates were equally inconsistent, concentrating on an average level that was clearly reduced. More modest increases were noted in the periods between 1951/52 and 1961/64, around 2.5% on average.

The real expenditure on health behavior allowed that, from 1948 onwards, the share of health expenditure in the gross domestic product (GDP) – which was fairly irregular in the earlier period varying from 0.71% and 1.06% of the GDP – increased consistently until 1957: from 1.0% to 1.28% of the GDP (see Graphic 3). This percentage reached 1.29% in 1964 after decreasing in the years of 1960 and 1962.

Graphic 3

Health expenditure as a percentage of GDP *

Source: Primary Data: FIBGE (1990: 616-7 and 626-7); BRAZIL. MF. General Balance Sheet of the Federal Government. Various years; FIBGE Statistical Yearbook of Brazil. Various years.

* Direct Administration + welfare system: 1932-1964

In order to better evaluate these values, they ought to be compared to the proportion allocated to health care in other countries in the same period. McGreevey e Gomes (1984)

report the following approximate values of GDP percentage spent on health by some countries between 1950 and 1965.

Table 1
Tendencies of Health Expenditure as a Percentage of GDP
Selected Countries: 1950/65

Countries	1950	1955	1960	1965
Australia	...	...	5.0*	5.2*
Canada	4.0	4.3	5.6	6.1
USA	4.5	4.4	5.3	6.2
France	3.4*	4.5*	4.7*	5.3*
Italy	...	...	...	5.0*
The Netherlands	...	4.0*	4.5*	5.3*
United Kingdom	3.9	3.4	3.8	3.9
Sweden	3.4	4.1	4.7	5.6
Switzerland	...	...	...	3.8*

Note: The data with asterisks are approximate values, which are not derived from primary sources

Source: McGreevey e Gomes (1984, p.8)

The disparities between the percentages estimated for Brazil and those found for the developed countries reveals very different levels of priority given to the health sector. Let's analyze another estimate, which includes countries with similar level of economic development and some that have lower level than that of Brazil.

A study carried out by the World Health Organization, including the earlier years of the 1960s, reported the following values of indirect expenditure on health for some countries, "i.e., excluding the non-reimbursed direct payments made by the consignees," as a percentage of the GDP.

Table 2 - Indirect Total Expenditure (Capital and Current) on Health Services as a Percentage of the Gross Domestic Product Selected Countries: beginning of the 1960s

Country	Year	Health Expenditure (% of the GDP)
Yugoslavia	1961	4.8
Israel	1961/62	4.7
Sweden	1962	4.4
Canada	1961	4.0
Venezuela	1962	4.0
France	1963	3.9
United Kingdom	1961/62	3.6
Czechoslovakia	1961	3.5
Holland	1963	3.4
Australia	1960/61	3.3
USA	1961/62	3.2
Finland	1961	3.1
Poland	1961	3.1
Senegal	1961	2.9
Rhodesia	1961/62	2.6
Sri Lanka	1957/58	2.5
Chile	1961	2.5
Kenya	1961/62	1.9
Tanganyika	1961/62	1.9
Côte d' Ivoire	1961	1.8
Jamaica	1961	1.7
Iran	1961/62	1.4
Costa Rica	1961	1.3
Cyprus	1961	1.0
Philippines	1961/62	0.9

Source: Abel-Smith (1967, p. 74).

Therefore, considering these countries, the Brazilian situation was equally uncomfortable. The position occupied by Brazil was only better than that of Cyprus and Philippines and worse, in terms of proportional allocation of public resources to health care, than that of Venezuela, Senegal, Rhodesia, Sri Lanka, Chile, Kenya, Tanganyika, Côte d'Ivoire, Jamaica, Iran, and Costa Rica. Most of those countries have lower economic development level as compared to Brazil.

The low percentage of the resources allocated by the public sector for the health sector as a whole and, most importantly, the slow increase of its share in the GDP, and the fall observed in the second half of the 1950s occurred in spite

of the substantial increase in the resources allocated by the welfare system for health care, even considering the small increase in the relative expenditure of the cities.

With respect to the welfare system expenditure on health, it was resumed, from 1950 and onwards, in a similar way to that of the beginning of the system after the containment of expenses period by the end of 1930s and 1940s. During that time, the percentage with health expenses reduced almost continuously (as shown in graphic 4) reaching the approximate level of 6% in the beginning of the 1950s. From then on, the new expenditure percentage of the welfare system (retirement pensions) reached 14%.

Graphic 4

Share of health expenditure in the total expenditure of the welfare system: 1932-1964

Source: Primary Data: FIBGE (1990: 616-7 and 626-7); BRAZIL. MF. General Balance Sheet of the Federal Government. Various years; FIBGE Statistical Yearbook of Brazil. Various years.

Providing medical assistance in the welfare system, characteristic of the Retirement and Pension Credit Unions (CAPs), was widely debated from 1930 onwards due to the Institutes of Pensions and Retirements (IAPs)⁹, which improved the movement since even before the creation of the first movement in the 1930s, the expenditure was limited to health services within the Retirement and Pension Credit Unions (CAPs)¹⁰.

This fact is a good example of the State view regarding social policies from then on. The efforts were concentrated on developing the welfare system as a capitalization regime. Hence, the medical assistance began to be seen as assistance benefit due to the fact that it was disassociated from the contributions of the members and the difficulty in controlling and forecasting the data.

This view on medical assistance captured the attention of those responsible for pension institutes. Thus, the expenditure on medical care became unequally distributed among the various categories of employees. Nevertheless, some pension institutes, especially the Retirement and Pension Credit Unions that remained until 1953, due to pressure exerted by affiliates, allocated significant amount of their financial resources for medical care. Some institutes, such as the IAPI, offered resistance to provide such

service.

For several years, the former IAPI technicians supported the thesis that health protection and recovering programs were not part of the benefits that should be provided by social insurance systems, although medical assistance was not related, based on the Eloy Chaves law, from 1923, which created the Retirement and Pension Credit Unions aggregated to railroad companies (MELLO, 1977, p. 250).

Hence, IAPI, the major Retirement and Pension Institute, was the last one to provide such service, which began in 1952 and was restricted. In 1963, although the Social Assistance Organic Law (SAOL) had already been promulgated – which includes medical assistance as one of the benefits to be provided by the institutes – only 30% of the IAPI affiliates were provided with medical care (Cf. MELLO, 1977, p. 250). Nonetheless, there was an evident effort to increase the expenditure on health, mainly after the SAOL.

The decrease in the share of health expenditure in the federal and state government budget became unequivocal from the beginning of the 1950s onwards. Such tendency increased in the second half of this same decade, as shown in Table 3.

Table 3 - Share of health expenditure in the total expenditure of the Union, States, Federal District, Cities, and Social Welfare: 1932-1964

Year	Union	Cities	States and Federal District	Social Welfare	Direct Administration	Direct Administration + Social Welfare
1932	3.8	2.9	4.0	12.7	3.8	3.9
1933	3.9	2.3	4.6	12.7	4.0	4.1
1934	3.5	2.5	5.1	13.1	4.0	4.1
1935	3.9	2.8	4.8	12.6	4.1	4.2
1936	3.5	2.7	5.8	11.8	4.2	4.3
1937	3.8	3.7	6.3	11.6	4.6	4.7
1938	3.6	2.4	6.6	10.7	4.4	4.6
1939	4.8	2.1	6.9	10.2	5.3	5.4
1940	4.9	2.3	7.0	13.4	5.4	5.6
1941	4.6	2.3	7.3	7.9	5.3	5.4
1942	4.2	2.8	6.6	6.8	4.9	4.9
1943	4.3	2.7	6.6	5.5	5.0	5.0
1944	6.0	2.5	6.4	5.9	5.9	5.9
1946	3.5	3.6	8.0	5.1	5.1	5.1
1948	4.9	3.4	8.1	7.2	6.0	6.1
1950	5.2	3.6	7.5	6.1	5.9	5.9
1952	4.6	3.3	7.5	15.4	5.8	6.7
1955	4.8	3.8	7.7	14.5	5.9	6.9
1957	3.7	3.9	6.9	13.7	4.9	6.1
1960	4.3	3.6	6.7	14.1	5.2	6.3
1962	3.3	3.5	6.8	12.8	4.7	5.8
1964	2.8	4.1	5.7	16.1	4.1	5.7

Source: Primary data: FIBGE (1990, p. 626); FIBGE. Statistical Yearbook of Brazil. Various years. Brazil. MF. General Balance Sheet of the Federal Government. Various years.

The Union that compromised 5.2% of its budget on health in 1950 managed to decrease this percentage to 3.7% in 1957. After a slight recovery in 1960, such percentage decreased again down to 2.8% in 1964.

The decrease in health expenditure share of the states and Federal District was less sharp following the general tendency: an almost continuous increase in the 1930s and

until 1941 – when it surpassed 7% - and a decrease in the following three years. From 1946 onwards, it recovered significantly, and the share of health expenditure remained between 7.5 and 8.0% until the mid-1950s, when it began to decrease almost continuously down to 5.7% in 1964.

The increase in the expenditure on health and social welfare and the maintenance

of cities expenditure levels around 3.5 and 4.0%, as shown in Table 3, were not enough to revert the relative decrease scenario described by the Union, States, and Federal District.

The example of the Union is the most significant since the percentage of the budget allocated for health care decreased by the end of the 1950s and beginning of the 1960s to levels lower than those of the 1930s.

With regard to the cities, it is noteworthy that the state capitals became more aware of the importance of health care expenditures.

Contrasting the expenditure of cities on education and public health with the top 100 biggest cities (excluding the capitals) and with other cities in the year of 1953, some interesting results are obtained. With regard to public health, the percentages of the total expenditure on public education of the three groups mentioned above were very close to those of the respective proportions of the

total expenditure. Nevertheless, this is not the case of the expenditure on public health.

In such case, it can be noted a preponderant share of the capitals of 40.95% in the total expenditure of the cities. The capitals accounted for 67.53% of the expenditure on health. The top 100 biggest cities, which accounted for 26.65% of the total expenditure, were responsible for 21.27% of the cities' expenditure on health. For the other cities, the discrepancy was larger: 32.40% of the total expenditure. The smaller cities accounted for 11.2% of the cities' total expenditure on health¹¹.

Analyzing the health expenditure proportion for the three levels of government (Graphic 5), it can be noted that the tendency of the Federal District and states is kept for the direct administration, which is expected due to the weight that these two levels of government have compared to that of municipal government.

Graphic 5

Share of health expenditure in the total expenditure of the direct administration: 1932-1964

Source: Primary Data: FIBGE (1990: 616-7 and 626-7); BRAZIL. MF. General Balance Sheet of the Federal Government. Various years; FIBGE Statistical Yearbook of Brazil. Various years.

Thus, after a clear tendency towards an increase during the 1930s and 1940s – despite the decrease observed for some years – stabilized at around 6% by the end of the 1940s and beginning of the 1950s, there was a significant decrease and a slight recovery in 1960. Such recovery was sustained until 1964, when the expenditure on health reached 4.1% of the three government levels' total expenditure.

At the same time that the financial resources for health sector was decreasing in general, the total expenditure on health was reviewed considering the pro-cure individual medical assistance instead of collective health

measures. In 1964, the preponderance of welfare expenditure, with regard to any one of the government levels isolated, was the best result obtained in this process.

Final Considerations

Although not always included in the public budget, social policies play an essential role in the capitalism ideology and legitimacy. The “social issues” and the “government interest in providing the population with better life conditions” have a distinct role in the ideology inherent in capitalism. Nonetheless, the peculiar ideological

debate in Brazil in the 1930s and 1960s, led to different social policies rhetoric.

During the populist period, there was an irrefutable hegemony of the developmentist and nationalist ideas in the political debate. Those ideas were improved and reached the highest status at the end of “São Paulo state democratic period” (1946-1964). This enabled to change the focus of the political discourse from social welfare to a set of different propositions in which the collective welfare, still viewed as the major goal, became dependent on the speed of the economic growth process that the nation could bear. Thus, even rhetoric, the social policies considerations could be conducted to a secondary level, subordinate to the “national goal” of development.

The developmentist focus of the health sector in the 1950s led to an inversion of the terms in illness/poverty relationship considering the former totally depend on the latter. The practical consequence of this argument was the reversal of the ascending tendency of health expenditure share in the total expenditure.

Hence, due to the increase in the social expenditure of the new political context set during the Vargas fall period, in 1945, the health sector faced a decrease in the relative share in the total expenditure from the mid-1950s onwards, a peak period of the developmentist ideology. It can be noted, from then on, a contrary tendency to the sharp decrease and constant health expenditure in the public direct administration budget only at the municipal level since its weight on the total social expenditure was fairly small.

It is worth mentioning that such tendency

towards a relative decrease took place in a context in which the public expenditure on health – either public or individualized medical assistance – was still limited, especially when internationally compared to under developed or developed countries.

This was happening before the hegemony of the developmentist discourse. Despite the prevalence of the diverse discourse on health/poverty, the interest in the expenditure on health was not even close to be considered relevant. From a pure economist point of view, the labor surplus, characteristic of the Brazilian economy, did not require any effort towards the health area. The total public expenditure on health – including the three levels of government and the welfare system – even at its peak, reached only 1.3% of GDP, a value lower than those of most countries whose data are available.

The impact of those facts on the economy, combined with the superiority of the developmentist ideas was evident not only in the decrease in the relative allocation of resources for the health sector, but also in its internal composition. Considering health policies as a whole, public health policies became less important gradually, although continuous, when compared to the individualized curative medical assistance.

The increase in health welfare expenditure clearly enabled the federal government, the major responsible for the expenditure on collective health, to inhibit health expenditures. The Union showed resistance, especially during the populist period, to allocate extra resources for the health sector.

This movement coincided with the new direction imposed by more open public

policies. It enabled to allocate resources for other areas considered more relevant, such as investments in infrastructure and loans to the private sector, and simultaneously meet the demand of specific groups of employees with more bargaining power in terms of providing individualized medical assistance.

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Notes

1) The original version of the SALTE plan forecasted the following expenditure items:

SALTE PLAN FINANCIAL SUMMARY (1949-1953)
(Cr\$ million and relative participation)

I – PLAN SECTORS

1) Health Sector	2.601 (13,84%)
2) Food Supply Sector	2.700 (14,36%)
3) Transport Sector	9.655 (51,36%)
4) Energy Sector	2.245 (11,94%)
Sub-total I	17.201 (91,49%)

II – GENERAL FUNDS

1) Rotary Fund	800 (4,26%)
2) Reserve Fund	779 (4,14%)
Sub-total II	1.579 (8,40%)
GRAND TOTAL	18.800 (100,0%)

The SALTE plan resulted from a combination of recommendations included in the report provided to the government by the first Joint Brazil-United States Technical Commission (Abink Commission) and data collected by some ministries and by the DASP - Public Sector Administrative Department (Cf. CARONE, 1985, p. 77). The plan failed quickly and the literature revealed its low effectiveness almost unanimously.

2) The leading figures were Emílio Ribas and Oswaldo Cruz.

3) On October 1st, 1932, during the inaugural session of the first meeting organized by the SBH (Brazilian Society of Hygiene) at the National Medical Academy headquarters, Carlos Chagas, who was addressing to around 200 congressmen, pointed out the opposition movements to the Rockefeller Foundation actions in the public health area in Brazil, stressed the practical sense of those actions as opposed to the sensationalist sentences in which the extravagant nationalism is exalted" Luz (1982, p. 176).

4) The initiatives related to this project date from earlier years, such as the centers for helminthiasis control, funded by the Rockefeller Foundation in 1916 and then incorporated to the Sanitary Services of the State of São Paulo, and the agreement, signed two years later, between this foundation and the government to establish public health centers in several cities in the state of São Paulo. Cf. Merhy (1987, p. 101).

5) The influence of the Rockefeller Foundation on the Brazilian government from the first decades of the 20th century onwards can be evaluated through the agreements signed in 1929. In January, an agreement between the Foundation and the central government on combating the yellow fever would be the responsibility of the two great regions of the country: The Northern region would be the responsibility of the Rockefeller Foundation; and the Southern region would be the responsibility of the National Department of Public Health (DNSP). A new agreement signed in the last month of that same year limited the power of combating the yellow fever to the central

government only, and the rest of the country became the responsibility of the Foundation. Fundação. Cf. Luz (1982, p. 207).

6) A very good example of adequacy due to the vicious circle of poverty and illness – considering the criticism to the sanitary model which was considered costly and unfit for our needs – and the assumption that development is the only efficient method to improve the general health conditions can be found in the “Partial retrospect of the Brazilian economy in the last twenty years” – d) Sanitary Sector – public health” In *Desenvolvimento & Conjuntura*, (7): 89-96, jul. 1961.

7) According to Possas (1981, p. 186) “The increase of malaria cases seems to be a direct consequence of this new emphasis due to the weak dependence of the dissemination and control of this disease on the actions and omissions of the public sector”. According to the EPEA's report, malaria reached a peak of seven million cases, with the endemic malaria region covering 90% of the geographical area of Brazil and was reduced to 2000.000 cases in 1956. Due to the failure of the Malaria Control Program, mainly between 1958 and 1960, the transmission rates begin to increase again and decreased only from 1962 onwards (Cf. Brasil, 1966, p. 50-1).

11) The hypothesis that no studies involving claims included an integrated action that actually

demonstrated clearly how to deal with health issues. On the other hand, the dominant social classes have always been aware of the economic and political importance of the manipulation of social policies concerning health and welfare (BRAGA; PAULA, 1986, p. 82).

10) Except for the IAPM, created in 1933, which offered medical assistance to its affiliated.

11) According to the decree 20.465 from 01/10/1931, each Retirement and Pension Credit Union could expend up to 8% of the budget with medical assistance. Such percentage was increased to 10% with the decree 21.081, from 24/02/1932. Cf. Vianna and Silva (1989, p. 151). It is worth remembering that before the Eloy Chaves law several companies had already offered medical care to their employees. A survey conducted by São Paulo State Department of Work, between 1911 and 1919, revealed that around half of the 30 companies studied offered that service each year discounting around 2% of the employee's salary. Even after the creation of the Institutes of Retirement and Pensions, the companies continued offering medical assistance. Cf. Possas (1981, p. 185).

12) Cf. MACEDO, Ézio de F. “A situação municipal em 1959 à luz da geografia financeira”. In BRASIL. MINISTÉRIO DA FAZENDA. *Revista de Finanças Públicas*, abr./mai./jun. 1961, p. 30.