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ACCOUNTABILITY FOR HEALTH EQUITY: GALVANISING A MOVEMENT FOR UNIVERSAL HEALTH COVERAGE

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Reducing Health Inequalities in Brazil's Universal Health-Care System: Accountability Politics in São Paulo*†

Vera Schattan Coelho

Abstract Brazil relies on the Sistema Único de Saúde (SUS), a public health-care system used by nearly 65 per cent of the population. This article analyses the role played by accountability mechanisms in expanding access to primary health care in the municipality of São Paulo, Brazil's largest city. Two accountability mechanisms are described and discussed: political competition and outsourcing. The article shows that from 2001 to 2016 the supply of primary care grew and the disparities in access to public health services decreased across the city areas with both the best and worst indices of income, education, and health. These distributive results are striking given how difficult it is to reverse inequalities, as attested by the findings of a number of studies in different parts of the world which indicate that the richest populations tend to persistently benefit more than the poorest from public spending on health.

Keywords: Brazilian public health system (Sistema Único de Saúde), primary care, policy process, health inequities reduction, political accountability, managerial accountability, Universal Health Care.

1 Introduction

In Brazil, the issue of inequalities in the distribution of health services and in health status among different population groups has figured in public debate since the late 1970s, and has received considerable attention from the Ministry of Health since the early years of implementation of Brazil's universal national health-care system, the Sistema Único de Saúde (SUS).[1] The SUS was enacted by the 1988 Constitution, which restored democracy in the country after a period of military dictatorship. The health-care system offers all Brazilians free access to appointments, tests, hospitalisation, and a wide range of medicines, in addition to vaccination campaigns, and prevention and health surveillance actions.

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The SUS defines national policies, which are implemented in a decentralised manner by states and municipalities and are financed by the three spheres of government: federal, state, and municipal.[2] The implementation of primary care is a municipal responsibility, which means that political accountability for primary care is located principally at the municipal level.

This article profiles the distribution of primary health care provided by the SUS from 2001 to 2016 among the 31 sub-municipal boroughs that make up the municipality of São Paulo. The municipality has 12 million inhabitants, with 6.6 million of them exclusively using the SUS.[3] In 2001, distribution of public health services in the city was heavily concentrated in the central areas, which also had the best socioeconomic indicators (Coelho and Silva 2007). This situation changed over the years that followed, spanning four municipal administrations whose mandates were exercised by mayors from political parties with very different political orientations; chronologically, the left-wing Workers' Party (PT), the centrist Brazilian Social Democracy Party (PSDB), the right-wing Democrats (DEM), and then the PT again. Despite this left–centre–right oscillation, during this period, service distribution consistently tended towards greater equity. There was also a consistent trend towards increased use of outsourcing to deliver primary care services, despite the parties' very different ideological positions on outsourcing.

These results are not negligible and can hardly be explained solely by the arrival of new federal programmes and funding in the municipality:[4] had these programmes simply been implemented, and new funding used, according to the same logic reflected in the distribution of existing health facilities, this would have easily led to the inequalities already present being maintained, or even worsened. Therefore, with a view to explaining the results, this study examined the role of political and managerial accountability mechanisms present in the municipality of São Paulo in the period 2001–16.

This article's two main contributions to the literature are that it: (1) profiles the distribution of SUS services within the municipality of São Paulo over a 16-year period spanning four complete administrations, and analyses that profile in terms of its distributive impact; and (2) discusses this impact in light of the presence of the accountability mechanisms in place in the city during the period: electoral competition, as a tool for political accountability, and outsourcing, as a tool for managerial accountability.

The remainder of this article is organised into four sections. Section 2 presents the debate concerning the role that accountability may play in tackling health inequalities. Section 3 describes the main primary care policies implemented between 2001 and 2016 by the various political parties in office in the São Paulo municipal government. Section 4 describes the changes that happened in the distribution of primary

health facilities and services in the 31 boroughs during the period, and Section 5 discusses the role of accountability mechanisms in establishing the policies that helped to address health inequalities.

2 Conceptual and methodological approach

The findings of a number of studies in different parts of the world indicate that the richest populations tend to persistently benefit more from public spending on health than the poorest populations (World Bank 2004; Huber *et al.* 2006; Liu, Hotchkiss and Bose 2007; WHO and UN-HABITAT 2010). More recently, a growing body of literature on accountability, aligned with its definition in terms of answerability and sanctions, argues that accountability approaches may help to break this vicious cycle (Brinkerhoff 2004; Fox 2015).

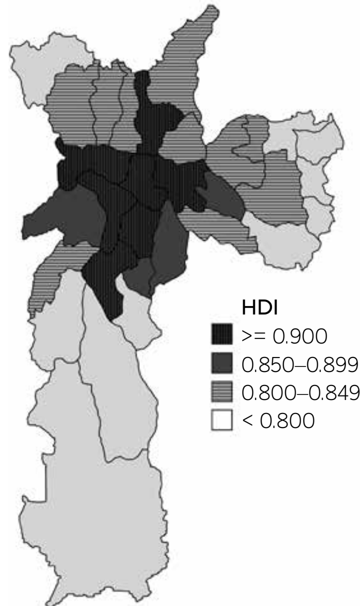
Brinkerhoff (2004), in particular, distinguishes three types of accountability related to health systems that may play a role in effectively informing policy and programmes: financial, performance, and political/democratic. According to Brinkerhoff, in the realm of financial accountability, provider payment systems can be important mechanisms for enforcing increased financial accountability and cost control among participating private providers, while performance accountability refers to demonstrating and accounting for performance in light of agreed upon targets.

Political/democratic accountability, in turn, has to do with ensuring that government delivers on electoral promises, lives up to public trust, and responds to ongoing and emerging societal needs and concerns, with the political process and elections being the main avenues for this type of accountability.

In this article, we explore the relationship between changes to the distribution profile of health services offered by the SUS in the municipality of São Paulo and two types of accountability – electoral and managerial – which relate to the three spheres indicated by Brinkerhoff.

In the Brazilian debate, these topics have been discussed in parallel. Political scientists analyse the importance of decentralisation in making politicians and public policies more responsive to citizens, as well as association between party orientation – right, centre, and left – and preferences for more redistribution, or more state or market (Arretche and Marquez 2002; Viana, Fausto and Lima 2003; Ouverney and Fleury 2017). Specialists in public management have explored the capacity of different contractual arrangements to promote greater efficiency in public services (Barradas and Mendes 2007; Ibañez and Vecina Neto 2007; La Forgia and Couttolenc 2008; Sano and Abrucio 2008; Médici 2011; Greve and Coelho 2017),[5] while authors connected to public health have made efforts to demonstrate the connections between advances in primary care and improvement, whether in health indicators or in reducing inequalities (Hone *et al.* 2017; Macinko *et al.* 2007; Landmann-Szwarcwald and Macinko 2016).

Figure 1 **Human Development Indices by borough, municipality of São Paulo, 2013**



Source Author's own, based on data from the São Paulo Municipal Department of Urban Development.

This article tries to bring these debates closer, to shed light on the connections between the mechanisms of answerability and sanctions in the political and managerial spheres and their relationship with changes to the distributive profile of the supply of public health services. To explore these connections we have systematised: (1) the primary health-care policies implemented by each of the four municipal administrations of São Paulo in the period 2001–16; (2) the types of contracts adopted in these administrations to implement the policies; and (3) the distribution of health facilities and services in all the municipal boroughs during the period.

The policies implemented by each municipal administration were analysed systematically through a qualitative study which included participant observation at health facilities and 28 interviews in which São Paulo Municipal Health Secretariat managers, health service providers, and politicians responded to closed and semi-open questions. Official documents and academic and press articles were also collected.

Analysis of the distribution of health facilities and services was carried out by ordering the 31 boroughs by their Human Development Indices (HDIs), which are calculated by the municipality using the United Nations Development Programme (UNDP) methodology and census data on income, education, and health. Higher HDI indicates better socioeconomic conditions (see Figure 1).

For each borough, the percentage of the total population that exclusively uses SUS services is calculated by the São Paulo Municipal

Health Department of Epidemiology and Information.[6] Peripheral areas of the city present the highest percentages of SUS users, as those who exclusively use the SUS tend to be poor. Quantitative data on service provision were obtained from the SUS Department of Information Technology (DATASUS).[7] From there, two indicators related to primary care supply were calculated for the population of each borough that exclusively used the SUS: (1) provision of primary care appointments per year, and (2) percentage of live births with provision of seven or more antenatal appointments. To facilitate description, the boroughs were grouped into quartiles according to their HDI scores; lower quartiles include boroughs with lower HDIs.

The supposition explored in this study is that in a context of strong electoral competition and modest access to public health services in poor and densely populated areas, the promise of improving services for the poor represents an attractive programme that could garner votes for parties with different ideological orientations. The institutional conditions found in the city – financial and managerial capacity located inside the Municipal Health Secretariat to contract private, not-for-profit social health organisations (*organizações sociais de saúde* – OSSs) and the presence of these organisations already delivering primary care – explain 'how' this programme could be achieved. In short, the presence of claims for answerability and the possibility of sanctions at both the political and managerial levels played a crucial role in facilitating the expansion of public primary health services in the poor peripheries of São Paulo.

It should be noted that our analysis of the role of accountability mechanisms in generating policies with distributive impact in favour of areas with worse socioeconomic indicators was constructed from a single case. This limits the study's claim to validity. In that light, we offer one plausible explanation of relations among distributive gains and political and managerial accountability mechanisms; causal relations among these events remain an open question. After all, variables omitted from our analysis may be more strongly associated with these distributive gains than those examined here. The possibility of replicating this type of study in other large cities certainly offers scope for advancing, beyond what was possible in this study, our knowledge of the role of accountability mechanisms in reducing inequalities in the distribution of public health services.

3 Politics and policies

3.1 Baseline

From 1988, through the SUS, municipalities were given greater responsibilities in the area of health policy. In São Paulo it was up to Eduardo Jorge, the Health Secretary in the Luiza Erundina (Workers' Party – PT) administration (1989–92), to begin implementing the system in the city. Jorge was a historical leader of the health reform movement that had led the creation of the SUS. His work was marked by investments being directed towards providing services in peripheral areas of the city.

Health districts and regions were created, a situation that guaranteed relative autonomy for expenditure since districts were budgetary units (Junqueira 2002; Pinto, Tanaka and Spedo 2009; Coelho, Szabzon and Dias 2014). From 1989 to 1992, 50 rounds of civil service exams were made available, nearly doubling the number of Municipal Health Secretariat civil servants. After Erundina's term was up, the staff at the Secretariat included 42,000 civil servants, which reflected this administration's preference for expanding services through direct contracting of health professionals (Junqueira 2002). This expansion followed the traditional management model used in public administration, where there are several bureaucratic controls, but no sanctions if performance targets are not achieved.

The election of Paulo Maluf (1993–96), of the right-wing Social Democratic Party (PDS), represented an about-turn in this trajectory and a clear setback for the SUS in the city. The mayor-elect decided to interrupt implementation of the system and create his own Health Care Plan (*Plano de Atendimento à Saúde* – PAS) focused on contracting medical cooperatives to provide care services. This programme, the object of great controversy and many grievances, was maintained by his successor, Celso Pitta (1997–2000) of the right-wing Brazilian Progressive Party (PPB) (Junqueira 2002; Coelho *et al.* 2014). Paulo Maluf and Celso Pitta drastically cut the number of Municipal Health Secretariat civil servants: in 2000, there were just 29,000 direct civil servants – a little over half as many as during the previous administration – because the PAS contracted medical cooperatives to provide services (Junqueira 2002).

A parallel action began in 1995, when the Ministry of Health and the State Health Department – both controlled by Brazilian Social Democracy Party (PSDB) administrations – together with David Capistrano, a leader of the health reform movement and former PT mayor of Santos city, began to support implementation of a pilot Family Health Program (FHP) in the peripheral areas of São Paulo. The programme was given the name *Qualis* (Qualidade Integral em Saúde) and was implemented with the participation of non-governmental organisations (NGOs) that already had experience of providing health services.[8] By late 1999, *Qualis* comprised approximately 140 family health teams, providing care for about 400,000 residents in the city's peripheral areas (Capistrano Filho 1999).

In short, between 1989 and 1999, as political control of the São Paulo municipal government changed between left and right, the public health policies implemented in the city also changed. These changes help to illuminate the close relationship, to which we are calling attention, between political competition and the concepts and guidelines that have been structuring municipal health policy.

In the 2000 election, all of the candidates with the exception of Paulo Maluf were in favour of terminating the PAS and moving forward with the SUS. Marta Suplicy (PT) was already the front runner in the early

weeks of the electoral calendar, remaining in this position and winning in a run-off election against Paulo Maluf, with 58.51 per cent of the vote. With this, in 2001, the PT took back control of the city. At the time, the PT and PSDB were both in opposition to the PDS and PPB. However, after 2000, the PDS and PPB lost ground and were eventually replaced by another right-wing group, the Democrats (DEM), while the PT and PSDB began to fiercely dispute municipal elections – with the PSDB eventually allying itself with the DEM party. Below are the main policies pursued by each of the four municipal administrations between 2001 and 2016.

3.2 Policies pursued, 2001–04

In 2001, Suplicy took over as mayor and Eduardo Jorge was again appointed as Municipal Health Secretary. At that time, while the SUS user population was concentrated in the periphery, the supply of public health facilities and services was still predominantly allocated to the more central, older areas of the city. That is, SUS user populations living in areas that enjoyed better socioeconomic indicators were favoured by better service supply than those living in peripheral areas (Coelho and Silva 2007).

Eduardo Jorge's arrival at the Municipal Health Secretariat brought a series of important changes to this situation. He resumed the SUS project that started during the Erundina administration, beginning with the creation of 41 health districts, which were later incorporated into the city's 31 borough administrations.[9] At the same time as this structure was being set up, Jorge invested in expanding the FHP, at the heart of national policy on primary care. Family health teams comprised of a medical general practitioner, nurses, and community health workers delivered a wide range of comprehensive and preventive health-care services to defined local populations (approximately 3,400 individuals).

When Jorge took over the Municipal Health Secretariat, there were some 180 teams and his plan was to increase their number tenfold, to the order of 1,700 teams by 2004. However, the Fiscal Responsibility Act, enacted in May 2000, posed a serious obstacle to this plan. According to the rules of the Act, municipal expenditure on active and inactive personnel cannot exceed 60 per cent of its net current income, and the municipality had already practically reached this limit. Faced with this constraint, Jorge chose to implement '*convênios*' (service agreements) with private OSSs, several of which already provided primary care services in the municipality. Under these agreements, a government agency disbursed funds to an OSS that had committed to perform the activities contained in the work plan and, later, would account for the use of these resources. This solution resulted in an increased supply of services without qualifying as direct hiring.

By 2002, when Eduardo Jorge left the Municipal Health Secretariat,[10] the number of teams had more than doubled. This expansion was made possible by *convênios* signed with 12 OSSs that had a tradition of social assistance and health service provision.

By the end of Marta Suplicy's administration, in 2004, the number of primary health care centres (PHCCs) had grown by 70 per cent. The criterion used for distributing these facilities was 'one for every 20,000 users, with no facility being more than 30 minutes away by foot from the user's residence.'[11] In placing these centres, priority was given to areas where health facilities were scarcest and where health, education, and income indicators were worst. These measures helped, as will be seen in Section 4, to trigger a process that was to change the profile of health service distribution in the city of São Paulo.

The 2004 elections were polarised between Marta Suplicy of the PT and José Serra of the PSDB, former health minister for Brazilian President Fernando Henrique Cardoso. Health was a prominent topic in electoral debates, with José Serra winning the elections with 54.86 per cent of run-off election votes.

3.3 Policies pursued, 2005–08

In 2005, José Serra took over as mayor. He held the position from 2005 to 2006, when he ran for governor, leaving his deputy, Gilberto Kassab (from the DEM party – now allied with the PSDB) in his place.

Investment in the FHP continued and an important innovation was introduced: outpatient care facilities (*assistência médica ambulatorial* – AMAs). These facilities were intended to meet demand for low-complexity urgent and emergency care cases, which the public system was unable to cope with, and which was acknowledged to be a chronic problem that ended up encouraging these types of patients to turn to accident and emergency facilities in the hospital system.

Starting in 2005, the service agreements with OSSs for staffing the FHP indirectly via labour contracting were replaced with management contracts; a management tool largely used by the PSDB when it was at the helm of the federal and state governments. In these contracts pre-certified OSSs were chosen, based on public call processes, to manage public facilities and provide services that were pre-defined by health authorities, receiving government funding granted on the basis of results-based oversight.

This type of contract established a more demanding process than the *convênios* that had been used up to that point. These stricter demands applied to the health authority, which now had to plan what would be demanded from units, price the contracted services, and monitor the performance of these services on a quarterly basis; they also applied to the provider, who now had to deliver the previously agreed-upon results. These contracts also began to be used at AMAs. In 2007, 39 PHCCs and four AMAs were being managed under contracts of this kind.

Januário Montone took over the Municipal Health Secretariat in November 2007, and was tasked by Kassab with extending the OSS-administered management contract model. That task was to be facilitated by new regulations that the government had just managed

to enact through the Municipal Council, relaxing the OSS selection procedures and easing the requirements social health organisations had to meet in order to participate in the arrangement. This legislation was passed amidst heated debates between groups in favour of and against contracting OSSs.

These shifts in direction meant that between 2005 and 2008, important changes were made to the profile of the municipal public health system. From 2008 onwards, the city saw AMAs proliferate and the numbers of urgent and emergency appointments grow in all regions.

The 2008 elections were competed between the PT, PSDB, and DEM. Candidates from these three parties promised to expand the primary care network and FHP teams. Marta Suplicy moreover proposed strengthening the Municipal Health Council, while Geraldo Alckmin and Gilberto Kassab promised to add more OSS contracts. The dispute was heated between the three candidates in the first round of voting, with Kassab (DEM) taking 33.6 per cent of the vote, Suplicy (PT) 32.7 per cent, and Alckmin (PSDB) 22.48 per cent. Kassab won the run-off election with just over 60 per cent of the vote.

3.4 Policies pursued, 2009–12

From 2009 to 2012, Kassab and Montone continued as mayor and head of the Municipal Health Secretariat respectively throughout the entire administration. During Montone's mandate, outsourcing processes intensified and OSSs started to be engaged under contract to manage both health facilities and micro-regions. In his own words,

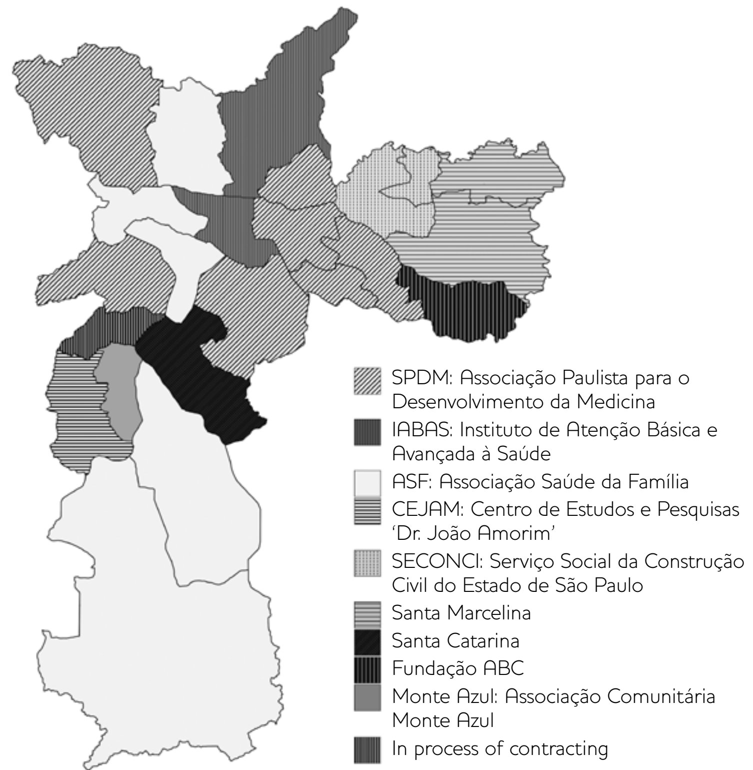
> *I know of no other municipality in Brazil that has invested as much in partnering with non-profit enterprise as São Paulo. This was due not only to the city's enormous size, but also to the ongoing endeavour to develop this model, which had been started at the state level in 2001 and adopted by the capital in 2005.*[12]

Disputing the 2012 election were Fernando Haddad of the PT, ex-President Luiz Inácio Lula da Silva's former Minister of Education; José Serra (PSDB), once again running in the municipal election; and Celso Russomanno (Brazilian Republican Party), a reporter and host of popular TV programmes. While Serra was the ruling-party candidate, forced to defend and propose continuing Kassab's legacy, Haddad used party propaganda to criticise the PSDB candidate's health policy and OSS contracts, proposing that rounds of civil service exams be held to reinforce health civil servant staff, in addition to effectively decentralising management of the health system and strengthening mechanisms of control and social participation. Celso Russomanno did not present any health proposals. Haddad defeated Serra in run-off voting with 55.6 per cent of the vote.

3.5 Policies pursued, 2013–16

In 2013, Fernando Haddad (PT) took over as mayor and in 2015, Alexandre Padilha, the Health Secretary and a former Minister of Health in the national PT-led government of Dilma Rousseff,

Figure 2 **OSSs responsible for territorial health-care system management in the municipality of São Paulo, 2017**



Source Adapted from Municipal Health Secretariat/CEInfo, www.prefeitura.sp.gov.br/cidade/secretarias/saude/acesso_a_informacao/index.php?p=178347.

expedited migration of OSS contracts to a new management model aimed at promoting quality and guaranteeing better management accountability. With this, the four types of OSS contracts used up to that point – micro-region, municipal hospital management, boroughs, and emergency care contracts – began to be replaced with integrated health-care system contracts. At the time, a public call for bids was held for OSSs to apply to manage the 22 territorial systems that were then instituted. These contracts had a five-year term, with the work plan renewed every 12 months. At the same time, this innovation contradicted one of Haddad's campaign promises to reduce the presence of OSSs in the city, and recovered the PT's traditional stance on territorialisation, aimed at promoting intersectorality[13] based on a territorial focus. Figure 2 shows the OSSs responsible for these 22 territorial systems.

An expansion of the supply of emergency care units (*unidades de pronto atendimento* – UPAs) was also planned. The UPAs are somewhat more complex units than the AMAs and were launched in 2003, under a PT administration, as part of the National Urgent and Emergency Policy.

Table 1 **Number of public health facilities, municipality of São Paulo, 2000–16**

Public health facilities	Mayor																
	Suplicy					Serra/Kassab				Kassab				Haddad			
	2000*	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Hospitals	51	50	53	51	51	52	53	53	55	53	55	55	54	54	49	54	54
PHCCs	135	225	237	236	382	392	407	407	416	434	438	439	442	443	454	449	451
AMAs[14]	0	0	0	0	0	10	33	55	116	130	131	133	139	134	133	53	42
UPAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1

Note * Entries start in 2000 to show the pre-existing figures.
Source Author's own, based on data from the Municipal Health Secretariat.

The election of 2016 was once again polarised between the PT and PSDB, with João Doria (PSDB) promising to increase basic health coverage in the city from 61 per cent to 70 per cent and to reduce waiting times for examinations and other more complex procedures. Doria was elected in the first round of voting with 53.29 per cent of the vote.

The distributive impacts of the policies described above are explored in Section 4.

4 Changes in distribution of facilities and services

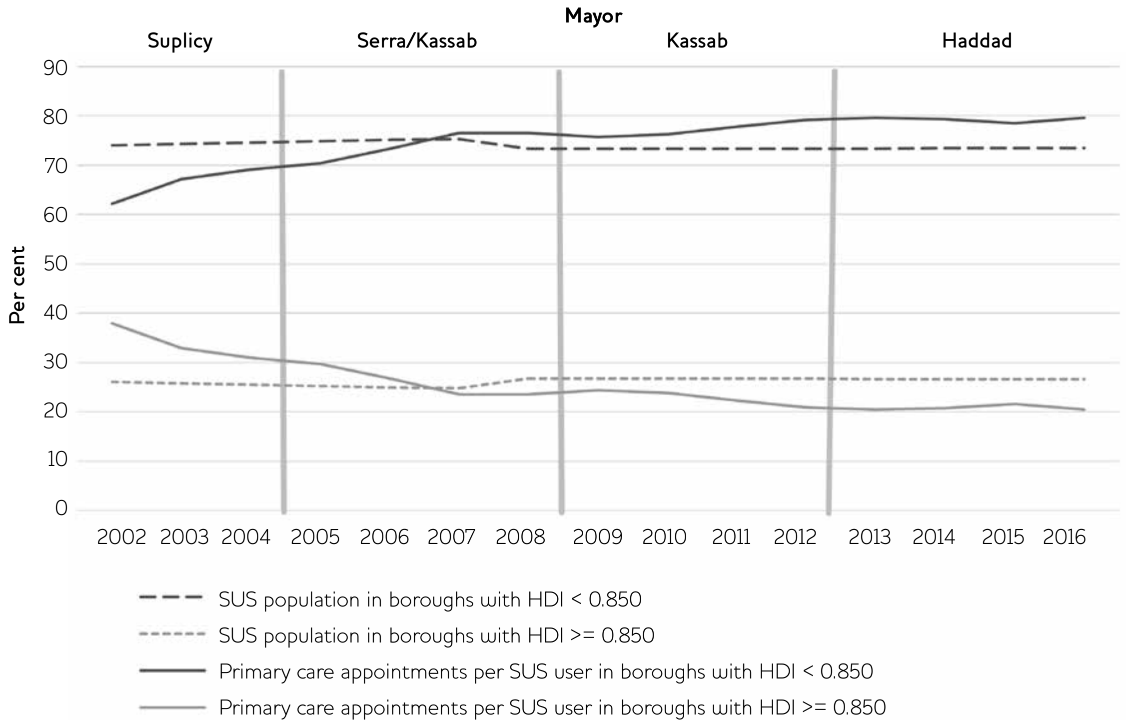
As mentioned in Sections 1 and 3, in 2001 there was a strong distributive bias in favour of central areas of the city, which also enjoyed the best socioeconomic and epidemiological indicators. In this section, evidence is sought on what impact the policies applied by the municipality between 2001 and 2016 had on that profile. To do this, we chose indicators that describe the distribution of health facilities and primary care services over the period: (1) provision of primary care appointments per year, and (2) percentage of live births with provision of seven or more antenatal appointments.

4.1 Facilities

Table 1 shows that health facilities, particularly the number of primary health care centres (PHCCs), expanded significantly during the period.

The Marta Suplicy administration saw substantial growth in PHCCs. These were FHP centres offering primary care through priority programmes and scheduled appointments. Under Serra and Kassab, growth was in the number of AMAs, which offered urgent and emergency care and low-complexity tests and treatment. Haddad introduced the UPAs. Expansion of the PHCCs was initially made feasible through service agreements, and later, starting in 2008, through management contracts with OSSs.

Figure 3 **Percentage of primary care appointments offered to SUS population, grouped by borough HDI, municipality of São Paulo, 2002–16**



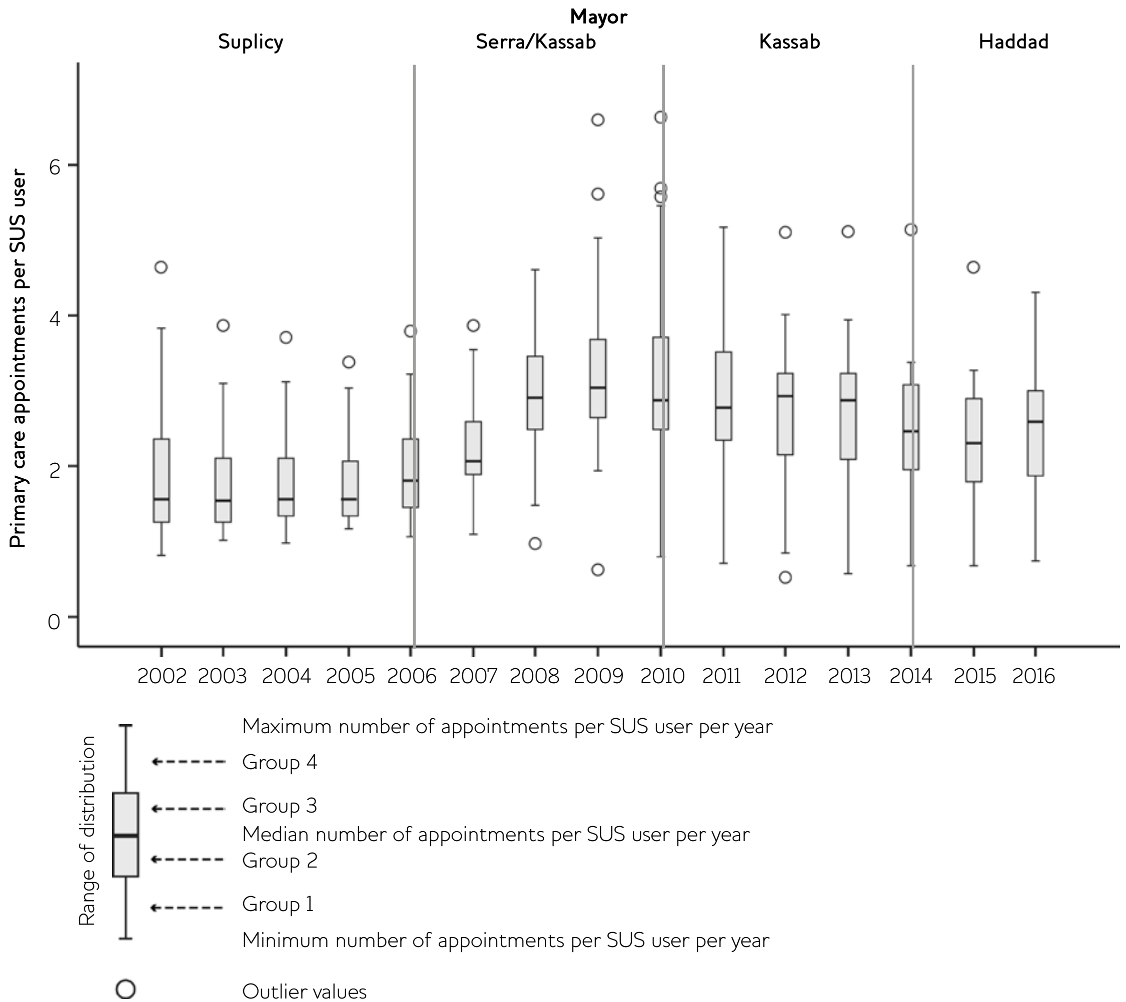
Source Author's own, based on data from the Municipal Health Secretariat.

4.2 Service supply

Figure 3 shows the percentage of primary care appointments offered to the population who exclusively used the SUS, grouped by the HDI of the borough they lived in. It can be seen that the percentage of SUS users living in boroughs with the worst indicators remained constant during the period, while the percentage of primary care offered to the SUS users in these low-HDI boroughs grew significantly.

The average number of primary care appointments per SUS user per year grew significantly in the 31 boroughs during the period, increasing from 1.8 in 2002 to 2.6 in 2016. Figure 4 visualises the distribution of primary care appointments during the period based on boxplot. It shows the 31 boroughs ordered by number of appointments per SUS user per year, from lowest to highest, and split into four equal groups – Group 1 includes the boroughs offering the lowest 25 per cent of appointments, Groups 2 and 3 the middle 50 per cent, and Group 4 the highest 25 per cent. These groups are represented along the range of distribution for each year in the period, with the median number of appointments shown by the black line in the grey box. It shows that in 2002, the median was below two primary care appointments, an amount corresponding to the parameter recommended by the Ministry of Health; while in 2016, over 50 per cent of boroughs offered appointments in excess of this parameter.[15]

Figure 4 **Primary care appointments per SUS user per year in boroughs of the municipality of São Paulo, 2002–16**



Source Author's own, based on data from the Municipal Health Secretariat.

Table 2 shows that, for the population of the municipality as a whole, the percentage of live births with provision of seven or more antenatal appointments increased by 24.1 per cent between 2001 and 2012. In this period, the boroughs in the first and second quartiles posted increases greater than the municipal mean. These increases in excess of the mean occurred during Marta Suplicy's administration and also, to a lesser degree, during the Serra/Kassab administration. As a result of that trend, by 2016, the situation had changed, with the values of the three lower quartiles converging strongly.

Overall, considering the profile of service distribution in 2001 among the boroughs ordered in quartiles by HDI, the fourth quartile can always be seen as better placed, followed by the third, second, and first quartiles. By 2016, the situation had changed, with the values of

Table 2 **Percentage of live births with provision of seven or more antenatal appointments, by quartile,* municipality of São Paulo, 2001–16**

Municipality/ Quartile	Mayor								Variation (%)
	Suplicy		Serra/Kassab		Kassab		Haddad		
	2001 (%)	2004 (%)	2005 (%)	2008 (%)	2009 (%)	2012 (%)	2013 (%)	2016 (%)	2001–2016
Municipality	60.0	65.4	69.8	73.3	74.0	74.5	75.8	77.9	29.8
1st Quartile	51.5	58.7	65.5	69.9	71.5	71.0	72.2	75.3	46.3
2nd Quartile	58.0	63.7	67.0	70.5	71.3	74.0	75.2	77.6	33.7
3rd Quartile	61.9	67.5	72.0	74.3	73.7	73.6	75.1	77.0	24.3
4th Quartile	73.8	77.9	80.0	81.8	82.4	81.8	83.8	84.8	14.9

Notes Dates refer to the beginning and end of each mandate.
* Quartiles represent boroughs grouped by HDI, as described in Section 2; lower quartiles include boroughs with low HDIs.
Source Author's own, based on data from the Municipal Health Secretariat.

the three lower quartiles converging. These results show that public health services expanded considerably during the period to areas of the municipality where socioeconomic conditions were worse.

5 Discussion and final remarks

This article contains an analysis of the primary care policies implemented in the municipality of São Paulo from 2001 to 2016. As can be seen above, the physical infrastructure of the SUS, particularly PHCCs and AMAs, expanded considerably over the period, as did the volume of primary care provided to the city's residents. The inequalities in access to those services were also found to have diminished, with rates of service delivery converging among the three quartiles of boroughs grouped by lower municipal HDIs. These results, as pointed out earlier, are not trivial and deserve attention as they represent a rather unusual pattern.

The supposition explored in this study is that these results were made possible by strong electoral competition and modest access to public health services in poor and densely populated areas. In this context, the promise of improving services for the poor represents an attractive programme that could garner votes for parties with different ideological orientations.

The institutional conditions found in the city – financial and managerial capacity located inside the Municipal Health Secretariat, and the presence of OSSs already delivering primary care – explain 'how' this programme could be achieved. In short, the presence of claims for answerability (from the poor to politicians and from public officials to OSSs) and the possibility of sanctions (losing elections and contracts) at both the political and managerial levels played a crucial role in facilitating the expansion of public primary health services in the poor

peripheries of São Paulo. The closeness of the contest waged between the PT and the PSDB/DEM alliance for the municipal government is clear from the electoral results: none of the successful candidates took more than 61 per cent of votes in the four run-off ballots. Added to this is São Paulo's importance in Brazilian national politics and the value the parties ascribe to their electoral performance in the city. There is also the politicians' aspiration to leave their mark on the history of public health in the country's leading economic and cultural hub.

Eduardo Jorge, Marta Suplicy's Health Secretary, strongly supported the FHP, investing in primary health care and betting on the possible electoral returns that might accrue from a programme implemented quickly and that would reach a considerable portion of the population, particularly in the city's underserved areas. In order to carry that plan forward and in the face of the limits on direct hiring imposed by the Fiscal Responsibility Act, he invested in expanding installed capacity and signing agreements with 12 OSSs, several of which had already operated in the city's primary care programmes.

The Serra and Kassab administrations continued to invest in the FHP, but the Serra/Kassab flagship was the AMAs, which concentrated on urgent and emergency care, with a view to both electoral gains from decongesting and rationalising the service network and an SUS that was more closely aligned with the model of care applied by the private sector. The underlying alignment of interests supporting this project rested on strengthening service supply via OSSs.

The Haddad administration maintained investment in the FHP and also, contrary to electoral campaign promises, the alliance with OSSs. However, it sought to redefine the management model, focusing it more on the concept of integrated management of the territory, which sounded more like a PT-type platform.

To better understand how managerial accountability worked, it should be considered that outsourcing made it easier to both hire new staff when health units were opened or expanded and to lay off staff when performance was not satisfactory, or even to hire staff in the case of high turnover. This mechanism made an important contribution to guaranteeing that there were health professionals, and especially physicians, in the periphery and hard-to-access areas of the city. The fact that health-care providers linked to these partnerships had more incentive to accurately deliver, as their contracts were dependent on achieving pre-defined goals, was also a significant factor. Finally, the Municipal Health Secretariat invested in establishing management capacity in relation to contracts.

In 2001, the Municipal Health Secretariat expanded the FHP, initially using service agreements (*convênios*), a looser form of contract and a type of accountability mechanism focused on accountability for money. In 2005, at the start of the Serra administration, these agreements began

to be replaced by performance contracts with OSSs, which introduced a new logic into the relationship between public managers and providers, based on the possibility of these organisations managing equipment and providing public services. At that point, contracts focused on service outputs and indicators. Finally, in 2015, the various types of management contracts in effect were replaced by those where a single OSS would manage the contracts for a health region. The rationale was to shift from a service-centred evaluation to accountability for health outcomes in a given territory. In parallel, investments were made in establishing management capacity in relation to these contracts, with the creation of a Technical Center for Contracting Health Services to plan, define, and assess OSS contracts and performance in the regions.

These movements to expand service supply by offering continuing care, urgent care, and emergency care to poor peripheral areas of the city were aligned with the programmes of left-wing and centrist parties, which since the 1980s had called attention to the need to expand the offer of public health-care services to those areas. In the 2000s, at a moment where it was important for the PT, PSDB, and DEM to ensure the votes of the poor, this flagship appeared as a political priority. Nevertheless, political priority alone does not explain the distributive changes described in this article. It was the combination of the political environment with the existence of experienced OSSs in the city, as well as financial and managerial capacity in the Municipal Health Secretariat that worked together to promote the changes described. Demands for answerability – from the poor to politicians and from public officials to OSSs – and the existence of sanctions – the possibility of losing elections and contracts – were core to explaining how the changes described in the distributive profile were made possible.

In short, if the presence of political accountability mechanisms contributed to making the health equity agenda attractive to municipal politicians, it was the ability of these same politicians along with the Municipal Health Secretariat to mobilise OSSs – several of which were already present in the city and had know-how in relation to implementing primary care programmes – and hold them accountable under service delivery contracts that made it feasible to expand the supply of services to areas on the periphery of the city. Ultimately, these accountability mechanisms make it possible to understand why and how the new policies were adopted and were able to contribute to the distributive changes examined in this article.

Notes

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1 In 2010, CEBRAP's Citizenship, Health and Development team joined CEM's project Inequality Trajectories in Brazil, which revisited 50 years of official data produced by the national census. The project team agreed to use the notion of inequalities instead of inequities, as it avoids the normative content of the concept of equity, which is highly disputed in political debates in Brazil. The team use the term 'health inequalities' to refer to the differences, in descriptive terms, in levels of health among population groups identified on the basis of socioeconomic, gender, race, colour, and ethnic characteristics.

2 By law the federal government and the municipalities are obliged to spend 15 per cent of their revenues on health promotion and service delivery, while states are obliged to spend 12 per cent of their revenue.

3 Information on the number of SUS users is estimated using data on the number of people with private health insurance. An SUS user does not have access to private health insurance. Information on private health insurance is available from the Agência Nacional de Saúde Suplementar (National Agency of Supplementary Health).

4 For the period 2001–16, changes to how official expenditure was registered hindered construction of historical series showing total amounts spent by the three spheres of government on health in the municipality of São Paulo. Nevertheless, we know that between 1995 and 2010, health-care spending in Brazil rose from 6.7 per cent to 8.9 per cent of gross domestic product (GDP), with the public sector portion of that total rising from 43 per cent to 47 per cent. In addition, the amount spent on primary care grew from 10 per cent of total public sector spending in 1995, to around 18 per cent in 2011 (Mendes and Marques 2014). Consolidated data on São Paulo for the period 2013–15 show stability in expenditure, even with a fiscal crisis occurring, and primary care received 13 per cent of total expenditure, which is a significant amount when it is noted that São Paulo holds the highest concentration of services for high-complexity care in Brazil (Xavier 2017).

5 In informal conversations, it is usual to hear that the services provided by private not-for-profit social health organisations (*organizações sociais de saúde* – OSSs) in São Paulo are more expensive than direct administration services. The little work that has tested this relationship suggests that greater expenditure is accompanied by gains in

efficiency, which would be reflected in lower costs per unit offered (Barradas and Mendes 2007; Medici 2011). These observations are interesting since they are in opposition to the international debate, which associates the use of outsourcing with constraining costs.

6 The SUS population is calculated from the population who exclusively use the SUS, which means those without private health insurance. For the Municipality of São Paulo, see: www.prefeitura.sp.gov.br/cidade/secretarias/upload/saude/arquivos/boletimeletronico/n01popsus.pdf.

7 The information is provided by the Ministry of Health and the São Paulo Municipal Health Secretariat.

8 *Qualis* was implemented in the East Zone by Casa de Saúde Santa Marcelina, in the North and Southeast Zones by Fundação Zerbini, and in the South Zone by Universidade Santo Amaro and Congregação Santa Catarina (Coelho *et al.* 2014).

9 According to the 2010 census, these boroughs had populations ranging from 139,441 to 594,930.

10 Gonzalo Vecina took over as Health Secretary when Jorge left.

11 Interview with Gonzalo Vecina, 16 November 2011.

12 http://saudeweb.com.br/22516/gestao-com-oss-e-ppp-e-modelo-de-sucesso-diz-januario-montone/.

13 Intersectorality is an approach that is meant to bring together different policy areas such as health, sanitation, education, urban policies, environment and so forth. The idea is to break the strong vertical hierarchy present in these policies (where decisions in each policy area are made independently) and promote more horizontal connections between them.

14 AMAs here include Ambulatório Médico de Especialidades (AMEs – outpatient facilities designed to handle medium-complexity cases in various specialities). In 2012, there were 16 AMEs in the city.

15 The Friedman Test shows that the distribution of primary care appointments per SUS user in the boroughs in 2002 was different to the distribution in 2012.

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