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Following the money: study of Management Contracts between Rio de Janeiro and São Paulo Governments and Social Health Organizations

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Introduction

Since the 1980s, there have been substantial changes in public management policies throughout most of the world. Administrative reforms consolidate new discourses and practices derived from the private sector for public organizations at all levels of government (SECCHI, 2009). In the mid-1990s, the Federal Constitution of 1988 - which consolidated the Unified Health System (SUS) in Brazil along the lines of the State of Social Welfare - suffered from the influence of neoliberal thinking that guided the discussion about state administration reform implying the search for alternative management of governmental organizations. This path was based on efficiency in the use of public resources. This reform, named the Director Plan for the Reform of the State Apparatus (PDRAE), occurred, according to its supporters, due to the crisis of governability and the overload of the public agenda. That is, the government perceived itself incapable of making decisions due to the pressure of society's demands (DINIZ, 2001).

Even before this reform of the State, in the formulation of the 1988 Constitution, there was a reaffirmation of the strength of the private sector within public health policies in Brazil (Perim, 2014), which was confirmed institutionally and visibly from article 199¹ of the Federal Constitution. The article exposes the dichotomy "public versus private" in the progressive politics for the SUS, legally opening the possibility of transferring health to the private sector, being considered a "concession to the political weight of capital" (BRAVO; MATOS, 2009).

¹ Article 199 of the Federal Constitution of 1988: "Health care is free to private initiative. Paragraph 1 - Private institutions may participate in a complementary form of the single health system, according to the latter's directives, under a public contract or agreement, with preference being given to philanthropic and non-profit organizations. Paragraph 2. The allocation of public resources for aids or subsidies to private for-profit institutions is prohibited (...)"

According to Pereira (2009), openness to the private sector in health policy is in line with neoliberal thinking and represents the response of governments aligned with the strategy of reducing the role of the state and transferring its attributions and responsibilities to the market. This fact, coupled with criticism of the bureaucratic Weberian model as inefficient, time-consuming, self-referential, and distant from citizens' needs (OSBORNE; GAEBLER, 1992), gave the government of President Fernando Henrique Cardoso in 1995 the creation of the PDRAE. The proposal brought within its framework the reorganization of the state machine, presenting as a principle: a leap forward, in the sense of a public administration called managerial, based on the Classical Theory of Administration, based on the tripod of efficacy, efficiency and effectiveness. This reorganization is characterized by the action of "rearranging" the public machine at all levels of government (BRASIL, 1995).

This reform of the State created the legal basis for the emergence of Social Organizations in Brazil, which came in the wake of an international process of dismantling large social protection systems, strongly influenced by the recommendations of the World Bank (TRAVAGIN, 2017). According to Paula (2005), public management, also known as "New Public Management (NPM)", emerged as the ideal model for state management. The plan incorporates a series of proposals for the redefinition of the state role, especially in relation to the model of execution of the public social services, since it proposes that the executing activities should be considered as merely regulatory activities, that is, that the non-exclusive activities of the State, such as social services, are transferred to the private sector, represented by the Social Organizations.

The transfer of public health activities to Social Organizations, entities that comprise the third sector, is not only an administrative arrangement but it is a political decision situated in a capitalist context. In addition, according to Paim & Almeida-Filho (2014), these new management models are based on the need to overcome the exhaustion of 'direct administration'² and also on some forms of 'indirect administration', such as municipalities and the public foundations of public law, which present numerous administrative, budgetary and human resource problems.

² According to Pinto et al. (2014), in direct management, the state acts in a centralized way through the organs and public executors that make up the direct administration. In indirect management, the State acts in a decentralized manner, delegating responsibilities and executing services to entities that make up indirect administration, such as municipalities, public foundations, public consortia, public companies and mixed capital companies.

In summary, the PDRAE proposals legally translate the mechanism adopted in the reduction of the state apparatus, as well as the transfer of the execution of non-exclusive public services to civil society, signaling the reception of the neoliberal current advocated since the end of the 1980s. In this sense, the NPM appears as a strand, punctuating changes of fundamental values with respect to complex health services. These stem from the paradigm of differentiation between "state and public," since state organization can be driven by private interests that colonize the state through partnerships (PAULA, 2005).

Sharing the same line of thinking that confirms the redefinition of the role of the state, Osborne (2007) brings to the debate the "Paradigm of New Public Governance". It suggests a new political conformation for the state. The government would cease to be the main manager and would act in a pluralistic way, that is, it would increase partnerships between the public and the private sector. The author points out that the State would assume the role of distributing public policies. In this way, the government would empower itself as the regulator of its policies with the task of delivering them to private sector partners or civil society.

Since the Social Organizations are a mechanism of transfer of State function from the NPM, it is urgent to investigate the performance of these entities. Thus, the present article has the objective of mapping and quantifying the financial volumes transferred to Social Health Organizations (SHOs) through the management contracts signed with the health secretariats of two Brazilian states, Rio de Janeiro and São Paulo, between 1998 and 2015, based on the management contracts signed between the SHO and the state governments object of the present study and to identify the SHO that received the most on lending of public financial resources.

It is worth noting that the management contracts established by Law No. 9637/98 are agreements that allow the establishment of commitments between the State and SHO on the objectives and targets for a given management period; grant greater managerial autonomy to the SHO; and release them from the control of the means, which happens to be realized by the results achieved so as not to bring to the public budget great cost.

Methodology

The present is a descriptive and exploratory study based on documentary sources and public domain secondary data with a mixed approach, that is, quantitative and qualitative. The mixed-qualitative-quantitative method (CRESWELL, CLARK, 2013) aims to understand the multiple ways to see more precisely the relationships between the SHO and public actors responsible for health policy planning and implementation.

For the selection of the sample, two criteria were used: the two states with the highest GDP in Brazil and that provided the management contracts and their additive terms in the electronic websites of their respective health departments. The decision by the most important states in Brazil was based on the following premise: the Social Health Organizations that moved the largest volumes of financial resources would probably be present in the states with the most dynamic economy, therefore with higher GDP. Based on these criteria, we restricted our scope of research to the states of São Paulo and Rio de Janeiro.

In order to collect the data, a search was first made for all management contracts and the respective additive terms on the websites of the Secretariats of Health of the States of Rio and São Paulo. Under the Access to Information Act (LAI), all documents should be public (BRAZIL, 2011). In addition, we also verified in the electronic websites of the Social Health Organizations themselves listed by the inclusion criteria of the present research.

Next, spreadsheets with various information about the management contracts and their respective additives were constructed to quantify the financial amounts received by the entities for the provision of service to the public entity. To quantify the financial resources transferred to the SHO of the states of Rio de Janeiro and São Paulo from 1998 to 2015, we used the information contained in 226 management contracts and 978 additive terms. For the data analysis, the main information on management contracts and their additives was extracted and tabulated, namely: quantity of contracts and additives; contract value; period of validity; value of the additives. This information was systematized in Excel worksheets with the purpose of facilitating the empirical considerations about the volume of financial resources transferred to the Social Health Organizations to manage the services of the state public networks of Rio de Janeiro and São Paulo.

Results and Discussion

As a result of the systematization of the data, we were able to verify that 38 private non-profit organizations concluded Management Contracts (MC) with the state health secretariats of the two federal units, Rio de Janeiro and São Paulo, between 1998 and 2015. Of this amount, we verified that 27 entities operate in São Paulo and 11 in Rio de Janeiro.

The Social Health Organizations in Brazil originated in a pioneering way in the state of São Paulo from 1998, in the same year of the promulgation of the Federal Law of Social Organizations. Pahim (2009) in a study on the implantation of the SHO in the health area in São Paulo reports that the expansion happened in different phases so that in 1998 there were

only nine public health services under management of these private organizations and at the end of 2008, this number rose to 46.

In contrast, the state of Rio de Janeiro began the process of qualification of the Social Organizations in the health area belatedly, when compared to the other states of the Southeast region. In 2011 alone, Law no. 6,043 / 2011 was published and in 2012 it began to sign contracts with the Social Organizations (SO). However, in 2012, the State launched 11 selection notices, being the first to administer the Attendance Units (UPA).

It is worth noting that even though the scope of collection of contracts, their additives was limited to only two of the Brazilian states, the number of documents used in the survey of the public financial transfers in the survey was notorious.

Altogether, we analyzed and compiled a total of 226 contracts, being 173 in São Paulo and 53 in Rio and a volume of 978 additives, where 850 are from the state of São Paulo and 128 from the state of Rio. The data show that for each management contract an average of four additives is observed. The additive terms can determine the expansion and / or inclusion and / or reduction of services, extension of term (term) and even include new public health services not provided for in the original management contract (FERNANDES, 2017, p.71). Studies such as Fernandes et al. (2018) point out that the additive can be used at any time during the execution of the contract due to the need to change a contractual clause.

These data highlight the possibility that the final value of a management contract does not appear only in the legal instrument itself. For a more precise study, it is fundamental to observe the number of additives of each contract. The values of the additives end up increasing the value originally foreseen in the contract. Even if there is an expansion or aggregation of new services from the creation of additive terms, this may not be consistent with the proportion of increase in the value of the additives compared to what was contracted initially by the legal instrument of relationship between the SHO and the State. To better observe, it is important to evaluate the financial values of the contracts and their relationship with the additives. This can be seen in Table 1:

Table 1: Identification of the total value of the management contracts (MC) and additives (AD) transferred to the SHO in the states of SP and RJ, in the period 1998 and 2015

State (UF)	Total value of management contracts (in R \$ billion)	Total Value of Additives (in billion R \$)
SÃO PAULO (SP)	20.81	37.65

RIO DE JANEIRO (RJ)	3.35	6.21
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Source: Management contracts and additives of the states SP and RJ with the SHO; Transparency portals of the states of Rio de Janeiro and São Paulo; Electronic websites of the State Health Departments of Rio de Janeiro and São Paulo; Electronic websites of the Social Health Organizations researched.

The following relationship can be established: on average, for each R \$ 1 billion initially estimated in management contracts in São Paulo, more than R \$ 1.80 billion was spent on additives alone. In the state of Rio de Janeiro, on average, for each R \$ 1 billion in MCs, R \$ 1.85 billion was spent only on additives. These data show the formation of an internal market to SUS by the SHO (BORGES et al, 2012).

As an example that shows this mismatch between the contracted initial value and the final cost of the additives, we verified the management contract of the São Paulo Association for the Development of Medicine (SPDM) with the São Paulo government³. The original management agreement, signed and published on June 25, 2012, foresaw R \$ 57.2 million to administer the Hospital das Clinicas Luzia de Pinho Melo for a period of 60 months. However, on December 28, 2012, the first MC addendum was approved in the amount of R \$ 118.9 million for the administration of the same hospital in the year 2013. In total, there were 12 additives to the initial contract until the year 2015. The sum of the values of the additives reached R \$ 553.4 million, that is, almost 10 times that originally estimated in the first management contract. This is in only three years of a contract foreseen for five years.

Detailing the volume of financial resources that were passed on to the SHO in the period from 1998 to 2015, we find the following values of entities that received the most resources from public entities, as shown in Table 2. The three SHOs highlighted below received the total resources, which represents 34.2% of the total transferred to the 38 SHOs analyzed. This indicates a concentration of values for few economic actors, which suggests the formation of oligopolies in the SHO market.

Table 2: Identification of the SHO that received the most public financial resources in the states of São Paulo and RJ, from 1998 to 2015

SHO	Financial total in management contracts	Total Financial Additives	Total (MC + AD)
SECONCI(*)	R\$ 2.431.401.147,08	R\$ 4.945.724.809,30	R\$ 7.377.125.956,38
SPDM(**)	R\$ 3.463.752.063,61	R\$ 3.354.327.501,59	R\$ 6.818.079.565,20
ALSF(***)	R\$ 1.972.726.966,48	R\$ 1.812.227.847,61	R\$ 3.784.954.814,09

³ Process nº: 001/0500/000.041/2012, available on: http://www.portaldatransparencia.saude.sp.gov.br/documento/CG/CG_97_2012.pdf

GRAND TOTAL SP/RJ	R\$ 17.980.160.335,67
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Source: Management contracts and additives of the states of SP and RJ with the SHO; Transparency portals of the states of Rio de Janeiro and São Paulo; Electronic websites of the State Health Departments of Rio de Janeiro and São Paulo; Electronic websites of the Social Health Organizations researched. (*) SECONCI - Social Service of Civil Construction. (**) SPDM - Paulista Association for the Development of Medicine. (***) ALSF - Association and Fraternity Saint Francis of Assisi in the Providence of God.

Analyzing the data, and following the path of significant transfers of public resources, a management contract caught our attention. The management contract between the state of São Paulo and SECONCI No. 001/0500 / 000.175 / 2009, with the purpose of contracting the administration of the State Department of Diagnosis by Image, with a validity of five years (2009-2014). The initial value contracted was R \$ 201.5 million. However, this contract generated 19 additives in the five years in force, ie an average of 3.8 additives per year. Only the additives added had a value of R \$ 1.715 billion. Thus, the actual value of the management contract was R \$ 1.917 billion. An increase of almost 10 times the amount originally forecast.

Finally, it is observed that the values passed on to the Social Health Organizations, according to Table 2, only the SHO SECONCI received R \$ 7.377 billion between 1998 and 2015. This figure is close to the total expenditure of the State Health Department of São Paulo in the year 2010, which was R \$ 11.978 billion.

These transfers of financial resources for the costing of healthcare services by the SHO according to Turino et al. (2016) have increased by up to three more times when compared to direct administration. In addition, they have managerial autonomy to make purchases without being subject to the General Procurement Law⁴ and the General Services Administration System of the Union. The SHO uses public goods and resources, but they administer the services with the logic of the private sector. Thus, they present indications of a privatization mechanism because they can assume both the public face and the private face (CONTREIRAS; MATTA, 2015). Although they depend on the state to receive resources, they function as private companies for their autonomy in resource management and the definition of their internal norms (ANDREAZZI, BRAVO, 2014). Still according to Fernandes et al. (2018), the volume of contracts and their excessive additives, have shown that the contracts omit information legally required and that they have too many additives.

⁴ Law No. 8666 of 1993, in its Article 1, "This Law establishes general rules on bids and administrative contracts related to works, services, including advertising, purchases, disposals and leases within the Union, State, Federal District and Counties (...)"

Juridically, contractual additives are instruments used to formalize the amendment of clauses of the contract signed between the public administration and the contractor (BRASIL, 1993). However, the analysis showed that, mainly, the contractual additives change the clause that determines the amount of financial resources to be passed on to the contractor, which leads to the following hypothesis: the additives act as legitimating instruments of substantial changes in the value agreed upon initially .

In relation to the contractual term, we note that São Paulo provides for a period of 60 months, counting from the date of its signature. According to the clause in which such a forecast appears, the mentioned period may be renewed after demonstration of the attainment of the strategic objectives and goals established and with agreement of both parties. Rio de Janeiro, foresee the term of 12 months. It is worth noting that in the clause that deals with the validity of the contract, SES-RJ makes it clear that the management contract may be renewed by means of an addendum, up to a maximum of five years.

The present paper proposes to think about the relationship between the gradual entry of the Social Health Organizations (SHOs) in the management of public health services in Brazil and the increase of funding directed to this management model. The purpose of this change was to improve the administrative capacity of public health services by transferring management to the private sector. This is close to the idea of privatization, but with an aggravating factor: the State still pays for a private entity to perform a constitutional function of the State itself. However, if, on the one hand, the Social Health Organizations solve some problems in the management, on the other, they can create more complications. According to studies by some authors such as Cohn and Elias (2002), Paula (2005), Turino et al. (2016), Carneiro Júnior and Elias (2006) and Paim and Almeida-Filho (2014), the guarantees of an effective improvement in the method of management of the public do not exist in most of the publications that approach the subject of a SHO.

In view of the above, there is the question of the lack of legal guarantees that the transfer of management of public health services to the SHO will respect the budgetary limits stipulated at the beginning of management contracts. That is, we can consider that by signing partnerships with the SHO, public administration transfers and at the same time empowers the SHO to act as a "perfect solution" metric, especially for states and municipalities.

Conclusion

The data presented lead us to conclude that, firstly, in the management contracts surveyed in the states of Rio and São Paulo, they grant permits that are far from the principles of public administration and legal and administrative norms. It is observed that the contractual additives dilate validity and add object, increasing severely and deliberately the financial lendings. The question remains whether the high number of additives occurred due to the lack of planning of public spending or the conscious decision of the public manager to overstate financial transfers to the private sector (FERNANDES, 2017, p. 129).

The empirical data also show that this market of the Social Health Organizations (SHOs) moves significant values. Between 1998 and 2015, only three organizations received R \$ 17.980 billion from the public coffers of the states of Rio de Janeiro and São Paulo to manage public health services. These three entities received 34.2% of the total amount transferred to the 38 SHOs investigated by the present work in the period. There are, therefore, indications of the formation of oligopolies in this new market created from New Public Management (NPM).

HOs form a new category of private non-profit legal entity, which are enabled to enter into service contracts with public entities, including health services. The SHO operate within the neoliberal model adopted in Brazil in the last 20 years, in the sense that all its strategies - although undeclared and sometimes even deliberately concealed - are geared towards the market.

The management of public health services through the Social Health Organizations is a way of expanding an economic model focused on the transformation of health into merchandise. Therefore, SHO materialize the growing trend of transfer of the management and the provision of state public services to private entities, which are legally classified as non-profit entities. Nevertheless, studies show that these entities have a surplus (TURINO, SODRE, BAHIA, 2018).

Also noteworthy are the advantages for the SHO in establishing service contracts with the State. The law establishes that once qualified as a SHO, they are able to receive financial resources on goals and results and also administer public health facilities already fully equipped and properly equipped. In this way, it is up to the SHO to manage it only. That is, the entities do not run the financial risk nor are they required to equip or build health facilities.

Research into the volume of public resources transferred to private non-profit organizations points to the bottleneck of direct public funding to the benefit of the private sector. It is proposed, finally, to deepen and expand studies on the transfer of financial resources from the State to private institutions for the management of public health services; as well as the elucidation of information contained in the management contracts, since they are of great importance to analyze the forms of privatization and to find out if the high expenditures in health have been transformed into quality and improvement of the access to services by the population.

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