The Allocation of Rights and the Supply of Public Services

Basilia Aguirre[1]

Introduction

One of the main bottlenecks Brazilian development faces is its insufficient and biased supply of public services. In a country with low and concentrated income, the supply of public goods configures the only way to create human as well as social capital. This article argues that the allocation of rights on the supply of public services can largely explain many of the undesired results that are observed in Brazil concerning mainly health and education services.

The view adopted in this article is close to what Sen (1999) have been arguing for the last years. According to him development is directly dependent on people's capacity to express their demands and influence the decisions. To do that they have to have the capacity for choose, in this sense empowerment to Sen is a necessary condition for development. And empowering people is a process that means providing the basic needs as education, health, housing, transportation and so on. On the other hand public policy decision making, again according to Sen, but also to North (2005) is a complex process that depends on the structure of the allocation of decision rights. Decision rights are crucial variables on the determination of policies because it establishes whose interests will be considered and in which extension. Social exclusion begins with exclusion from decision rights.

Sen is quite specific about this point while building a positive theory o social choice. He argues that the interests that will be considered are those of the persons who have the right to decide. One of his best examples that appear in his Nobel Lecture (1998) is the Roma fire determined by Nero, who had the power to decide. So to understand why some countries have very poor results in social policies is necessary to understand the rights structure underlining the processes of social choices. Accordingly, to suggest any improvement on the results of social policy is necessary to understand how the balance of

[1] FEA/USP, e-mail: basil@usp.br

interests could be changed. This usually implies that some groups will loose for that others could gain and that is a very complicated task.

Our argument begins by showing how poor are the results of public policies in Brazil. Next we analyse the allocation of rights on a specific public service, meaning health in. Finally we show why any change in the allocation of rights is extremely difficult due to the interests involved.

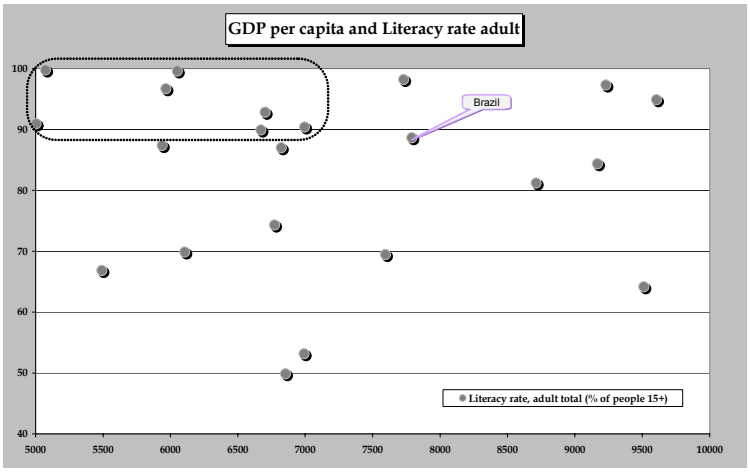
The poor results

Brazil exhibits one of the poorest results in health and education in the world. To ascertain that position it is only necessary to compare Brazil with other countries with more or less similar per capita income. As in 2003 Brazil per capita income PPP was US$ 7,790 we choose to make the comparison all the countries with per capita income ranging from US$ 5,000 and US$ 10,000. In 2003 there were 37 countries in this situation. Using the 2005 Human Development Report we as assembled indicators on health, education, water access, sanitation access. The indicators utilized were: life expectancy at birth, infant mortality rate, maternal mortality ratio adjusted, population with sustainable access to improved sanitation, population with sustainable access to an improved water source, literacy rate, adult total (% of people 15+) and average years of schooling of adults (aged 15+), total. [2]These set of indicators could be considered a representative group of variables assessing the quality of public social services. It gives us a good idea about the position Brazil holds compared to countries with similar per capita income. In the Graphs 1.1 to 1.7 below the indicators are depicted in relation to GDP per capita US$PPP.

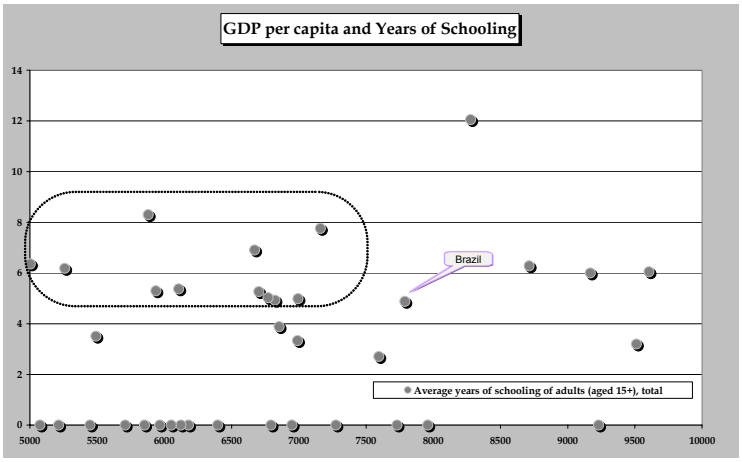
As it is possible to observe Brazilian performance in social services is not very good compared to other countries with average per capita income. For all the indicators it is possible find some countries with lower per capita income and better result. The situation is extremely serious considering maternal mortality, which is one of the best indicators of health system performance.

[2] The complete information could be find in Annex 1.

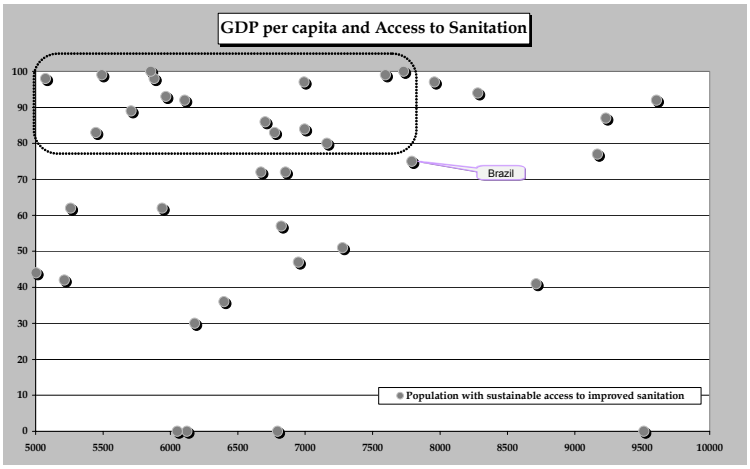
Graph 1



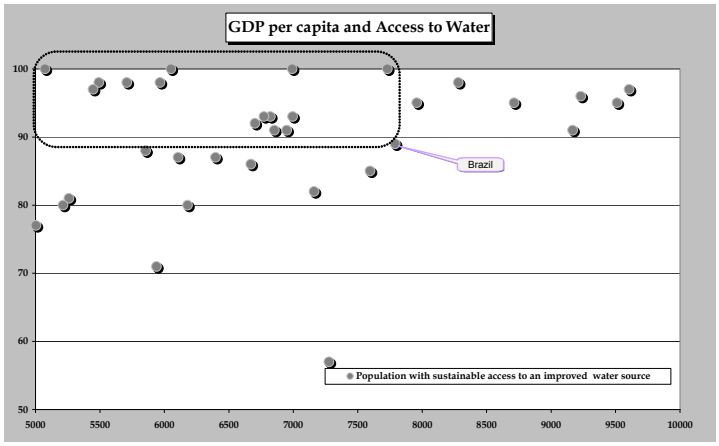
Graph 2



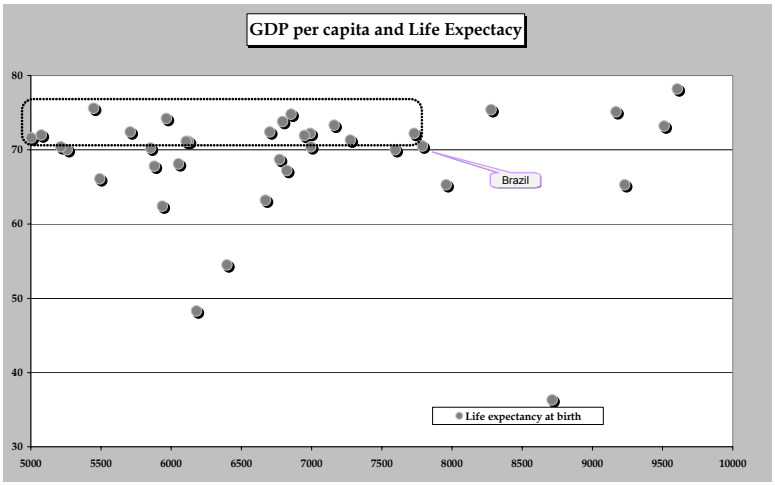
Graph 3



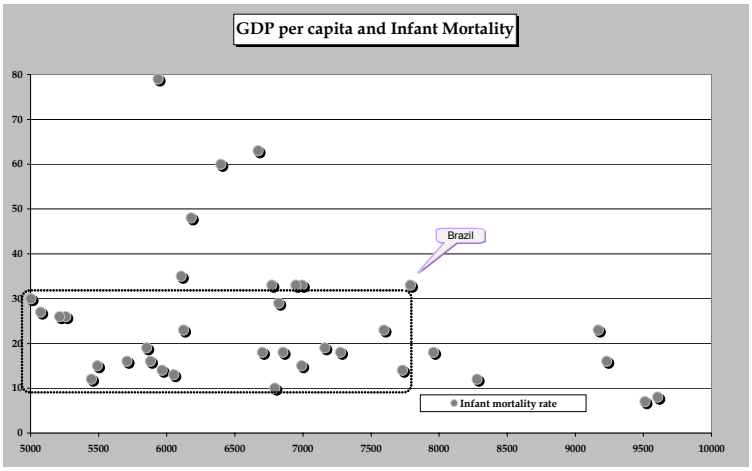
Graph 4



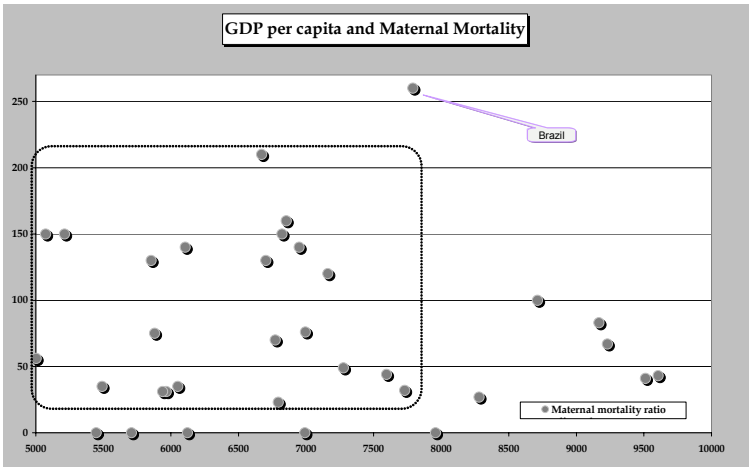
Graph 5



Graph 6



Graph 7



Someone could say that the problem related to the supply of public services in federations like Brazil is very complex and that this could be an element explaining poor performance. If we pick just the federations among this sample the picture that emerges is not quite different. Table 1 presents the same variables only for four federations with medium per capita income.

Table 1. Selected Social Indicators for Four Federations

Country	GDP per capita	Life expectancy at birth	Infant mortality rate	Maternal mortality ratio adjusted	Population with sustainable access to improved sanitation	Population with sustainable access to an improved water source	Literacy rate, adult total (% of people 15+)	Average years of schooling of adults (aged 15+), total
	2003	2003	2003	2000	2002	2002	2003	2003
Russian Federation	9230	65.3	16	67	87	96	97.3	.
Mexico	9168	75.1	23	83	77	91	84.37	6
Brazil	7790	70.5	33	260	75	89	88.62	4.88
China	5003	71.6	30	56	44	77	90.92	6.36

Source: Human Development Report 2005

Brazilian health indicators compared to the other federations are very bad. Considering access to water and sanitation it looses only to China. And, finally, it shows the lower average years of schooling of adults and when literacy rate is considered only Mexico has a worse result.

All these results suggest that the Brazilian poor performance could not be explained only by its per capita income or its basic form of organization as a federation. It indicates that there should be other serious problems, which should be related to the organization of public services. We argue that the peculiar way that decision rights of the supply of public social

services in Brazil are established is one of the main determinants of the poor performance just showed. The hypothesis is that the way these rights are distributed in Brazil contribute to the increase in transactions cost what implies in a non efficient supply of public social services considering the income constraint. To test this hypothesis we choose just one public service: health service. This choice is due first because as we have seen health indicators are the poorer ones and second because health system in Brazil is probably the best organized services, where the responsibilities between levels of government are better stated. The Brazilian structure is going to be compare to federations in developed countries because as their results are much better they should have find better solutions to the coordination problems that arise in federations.

The allocation of decision rights in health care

An important part of the explanation of how a health care system is organized in a federation depends on the federative arrangement itself. In federations the logic of the structure of a service is different from unitary countries because more than one level of government has some degree of autonomy related to the supply of public services. The autonomy degree of each level of government depends on the allocation of decision rights among then. The allocation of these rights differ from country to country so it is important to observe the particular way that the decision rights are allocate in each country to be able to extract conclusions on the effects of a specific form of organization on the transaction costs.

In federations as well as in unitary countries the supply of public services is an eminently political negotiation among groups of interest. However the negotiation channels and forms, the limits of each participant action, the extent and the nature of each decision and the authority each one of the participants is different from case to case. This means that the institutions that establish the logic of action coordination are not homogeneous.

To make the comparison between federative arrangements on health care system we choose 5 federations for which detailed information is available. They are: Australia, Canada, Germany, Spain and USA. We define five basic rights on public health care system that latter will be disaggregate into many more. They are: access to services, legislate on health

matters, funding, expending and provision. In the sequence we are going to compare these 5 federations rights allocation with Brazil.

The right to public health service access

The first observation that should be done is that even in respect to the establishment of the basic right on health care public services the federations considered largely differ. In three federations (Australia, Canada and Germany) this right is established in the law. In Spain and Brazil it is defined in the constitution while in USA the law does not recognizes this as a citizen right. Even where this right is recognized by the law not necessarily the provision should be done independent of some financial contribution from the part of the consumer. In Australia and Germany doctors and hospitals may charge additional fees as long as the patient accepts to pay while in Canada this practice is totally forbidden.

These differences are usually associated to the idea the society has about health services. In USA there is a long-lived discussion about the public or the private nature of health services, while in the other services the public nature of these services is accepted naturally. From different world visions arise different public health services. It is important to emphasize that even thought the right to access to public health services is totally defensible on ethical and distributive grounds it imposes an enormous burden on public services even in developed countries.

Table 2. Right to Access

Rights to health	Constitution	Law
Australia		X
Brazil	X	
Canada		X
Germany		X
Spain	X	
USA		

Source: European Observatory on Health Systems and Policies, Australian Government - Department of Health and Ageing, Health Canada, Medicare and Ministério da Saúde - Brasil

Health rights so defined are established, as Coase or North would agree, from initial elements implicit in former structures, in a path-dependence process. These structures are

products of interest conflicts and its results reflect the distribution of power in the system. That is why it is possible to observe an extensive array of forms organizing the systems. The question that arises at this point is first of all what is the most appropriate structure in a determinate situation and secondly how it is possible to change the situation in search for a better one. The answer will depend on the criteria to judge the appropriateness of the situation. Neo-classical economics will say that the most appropriate structure would be the one that that is Pareto efficient. The criteria utilized by Institutional Economics would be the reduction of uncertainty through the alleviation of conflict and the answer to the second question would be to emphasize the need for a balanced situation in terms of power that would give each stakeholder the capacity to influence the decisions.

Following is necessary to analyze how the other rights over health are distributed between spheres of government. Table 3 indicates the most important rights that should be allocate to levels of government. Health rights could be firstly classified in competencies and responsibilities. Responsibilities define the rights to established norms. Competencies identify who should do what.

Table 3. Health Care Rights Structure

competencies	**legislation**	**system structure**
		financing
		expending
		protocols
		prices
		drugs policy
responsibilities	**collection**	**general**
		specific
	financing	**basic attention**
		middle and high complexity
		drugs
		immunization
	expending	**basic attention**
		middle and high complexity
		drugs
		immunization
	provision	**basic attention**
		middle and high complexity
		drugs
		immunization

Competencies include basically the rights to regulate the various aspects of the system as: its structure, the funding allocation, the expending allocation, the establishment of protocols, prices negotiation. Regulation rights vary widely between federations and they constrained the allocation of other rights. They are higher levels rights and being so, following North (1991), they are more protected than other rights.

The main characteristic of federative arrangements is the definition of political autonomies for all levels of government. Nonetheless these autonomies the nature and extend vary largely between countries. The traditional literature on fiscal federalism discusses the allocation of rights for tax collection and expending but these are not the only rights that should e define in a federation. Beyond these is possible to identify other specific rights that are depicted on Table 3 Any one of those rights could be splited between levels of government. For example it is possible that the right to provide basic attention is attributed to the local level while medium and high attention is a function of middle and high levels. The picture exhibited in Table 3 gives us an idea of the combinations that could be done on the distribution of health rights en federations. Each possibly chosen combination will be the result of a social choice process and will reflect the distribution of decision rights on a specific society.

Health systems have as their main objective the improvement of health conditions of the population. To accomplish this objective it is necessary to execute four tasks: regulation, financing, expending and provision. Let us begin with the right to legislate for as pointed earlier it is hierarchically superior to the others.

The rights to legislate

The right to establish the system guidelines defines the major part of the autonomy degree attributed to each level of government. In the case of health we can go deeper establishing specific autonomies to legislate.

Table 4 disaggregates legislation rights in the system. It is possible to define 6 autonomy kinds: system structure, financing, expending, protocols, prices and drugs policy. System structure is specifies the right to determine which are the responsibilities and the rights of each level of government. Among the countries selected it is possible to recognize tree

forms to organize this right. The first group is composed of the countries where all levels of government could establish these rights, in this group we find USA. The second group comprises the countries where Union and States share in various degrees this right, as in Australia, Canada and Germany. Finally the third group that include Spain and Brazil is the one where the autonomy to legislate is the most concentrate on the Union.

Table 4. Legislation Rights

Legislation rights	Australia	Brazil	Canada	Germany	Spain	USA
system structure	U,S	U	U,S	U,S	U	U,S,L
financing	U,S	U	U,S	U,S	U,S*	U,S,L
expending	U,S	U,S,L	U,S	U,S	U,S*	U,S,L
protocols	U,S	U	U,S	S	U	U,S,L
prices	U,S	U	S	S	U	U,S,L
drugs policy	U	U	S	U,S	U	U,S,L

* 7 of 17 Comunidades Autonomas had the right to legislate in 2003
Source: European Observatory on Health Systems and Policies,
Australian Government - Department of Health and Ageing,
Health Canada, Medicare and Ministério da Saúde - Brasil

Brazil by far exhibits the lower level of autonomy of lower levels of government in respect to the right to legislate. Only the right to legislate over expending is distributed between the three levels of government. For all the others only the Union has the right to legislate. This shows that decision rights are extremely concentrated in Brazil compared to other federations. By the contrary, USA is the less concentrate federation in this respect.

Direitos de Financiar

The provision of health services requires the capacity to expend that by its turn depends on the capacity to finance. Funding rights are also not homogeneously distributed between federations. It is possible to observe different kinds of arrangements between federations. On this matter USA and Brazil are the most decentralized. It is important to remark that while concerning legislation Brazil is extremely concentrate the opposite feature appears in respect to financing. In USA as well as in Brazil all three levels of government could collect and use the resources in all kind of health service. However there is an important

point to be made about transferences[3].

Table 5. Financing Rights

Financing rights		Australia	Brazil	Canada	Germany	Spain	USA
sources	general collection	U,S	U,S,L	U,S	U,S	U,S*	U,S,L
	specific				O**		
uses	basic attention	U	U,S,L	U,S	U,S	U,S	U,S,L
	middle and high attention	U,S	U,S,L	U,S	U,S	U,S	U,S,L
	drugs	U	U,S,L	U,S	U,S	U,S	U,S,L
	immunization	U	U,S,L	U,S	U,S	U,S	U,S,L

* 7 of 17 Comunidades Autonomas had the right to financing in 2003
"O" are organizations like labor union that have the right to collect funds to provide health services
Source: European Observatory on Health Systems and Policies,
Australian Government - Department of Health and Ageing,
Health Canada, Medicare and Ministério da Saúde - Brasil

Canada and Spain are in an intermediate level since in these countries federal and state governments share the right to financing. Germany is a case apart for there other actors as labor unions are involved in the picture. However if we do not taken into consideration this characteristic Germany looks much closer to Canada and Spain than to USA and Brazil. Finally in Australia the majority of the financing for some services is a responsibility of the Union. These patterns are associated to the tax collection structure of these countries. For example, Canada presents a historical vertical unbalance in favor of the states, while in Australia the contrary happens. This could explain why in Canada financing is all shared while in Australia tax collection for health services is mainly a Union matter

We should now turn our attention to the nature of the transferences in public health care services. Table 6 maps the transferences in the six countries considered. It helps the comparison between the Brazilian arrangement and other federations. There are certain aspects on Brazilian structure that are similar to USA and others that are closer to the other countries here analyzed. Usually there are two main kinds of transferences. The first kind is either negotiated for a certain period of time, or either established by the law or even the Constitution, as in Brazil. With the exception of USA, the other countries operate automatic transferences systems between levels of government. However only in Brazil these are a

[3] We will return to this point ahead.

fixed percentage of receipts. Australia, Canada, Germany and Spain utilize a system of ex-ante negotiation between Union and states. In these countries the negotiation is mainly orientate by the equalization principle. This means that the objective is to promote a homogeneous supply of public goods in all states. It is important to highlight that the equalization mechanisms adopted by these countries take into consideration not only the transferences made by the Union but also the expending capacity of each federation member. In Brazil the question of horizontal harmonization is presented only in the Participation Funds of States and Municipalities These funds does not take into consideration the state expending capacity. Besides they are not specific for health care services. The funding that is specific for health is the one established in the health care system structure called SUS. This fund does not take into consideration expending capacity.

No que se refere às transferências constitucionais para a saúde este princípio não está presente, da mesma forma que o princípio não é levado em consideração, também para as demais transferências.

Table 6. Transferences Types among Federations

Transferences		Australia	Brazil	Canada	Germany	Spain	USA
U-S	automatic	X	X	X	X	X	
	contract		X			X	
S-L	automatic	X	X		X		
	contract		X				
U-L	automatic		X				
	contract		X				
U-P	automatic						
	contract						X
S-P	automatic						
	contract						X
L-P	automatic						
	contract						X

Source: European Observatory on Health Systems and Policies,
Australian Government - Department of Health and Ageing,
Health Canada, Medicare and Ministério da Saúde - Brasil

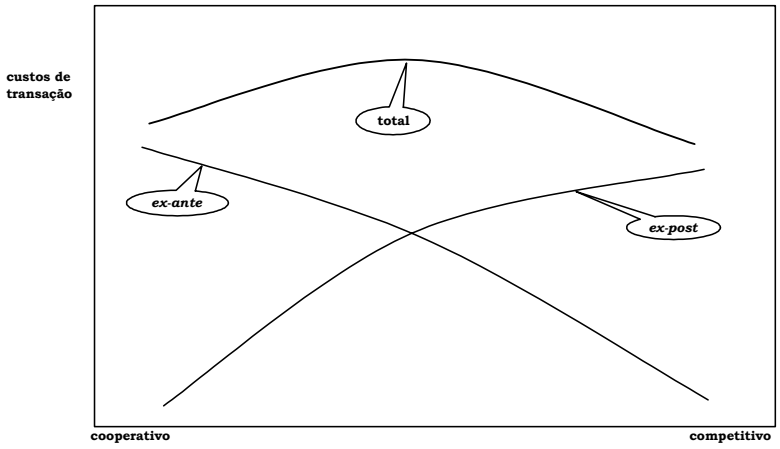
Another point that differentiate Brazil form other federations with the exception of USA is the use of contracts to make specific transferences. The bulk of public services transferences in the USA are made by contracts, as transferences between levels of

government are very rare in this country. Transferences made by contracts presuppose case-by-case negotiation what certainly increase transactions costs.

Comparing the arrangements of the countries selected is possible to observe two major patterns. On the one hand we have the American pattern where the arrangement is extremely decentralized and occurs in case-by-case base with people and firms. On the other there are the other federation where occurs negotiation among federative levels and in most cases automatic transferences. The first case that we will call competitive should at first sight generate a system with low ex-ante transaction costs and high ex-post transaction costs. This result would be explained by the absence of ex-ante negotiation between levels of government. On the case of the other federations, which could be called cooperative, the situation should be the inverse. These results could be displayed as in Picture 1.

Picture 1. TRANSACTION COST BY FEDERATIVE ARRANGEMENT

CASE 1

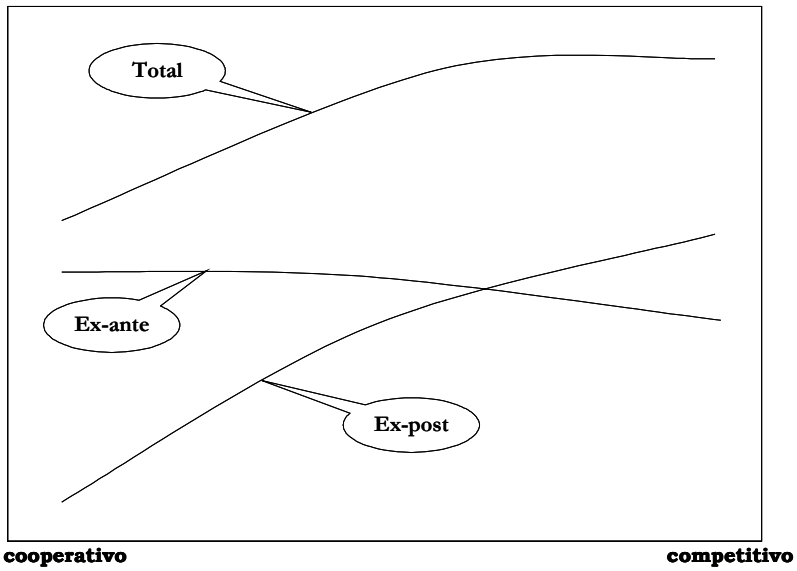


However the picture change if we took into consideration the fact that the competitive federation has to negotiate with various suppliers as well as with various consumers to establish all the contracts needed. Health care services demand an enormous number of services. This fact can reduce the comparative advantage in ex-ante transaction costs that competitive federalism has in relation to cooperative federalism. In this case Picture 2

would display a better representation of the two patterns.

Picture 2. TRANSACTION COST BY FEDERATIVE ARRANGEMENT

CASE 2



In this respect Brazil has a peculiar position. It is similar to Australia or Germany because it has automatic transferences but it is also likely USA for it is usual to make contracts. This Brazilian arrangement should place its structures among one of those that exhibits the higher transaction costs in the world.

Expending Rights

Now we should proceed to analyse expending rights. Expending and provision rights give us a good idea about the system's coordination quality. Again it is possible to observe two configurations. The first includes USA and Brazil and it suggests a very low level of coordination. In USA all three levels of government can spend in whatever service they want independently of what the other levels are doing. In Brazil even though the Unified Health System SUS seeks to coordinate the actions of government levels the degree of coordination is really low. As all federation members can spend in whatever service they like what actually happens is that with exception to basic attention the other services are supplied by all three levels indifferently to what the others are supplying. As an example is

possible to point the case of Sao Paulo State that allocates the bulk of the State Health Department budget to middle and high attention hospitals what should be local responsibility.

Table 7. Expending Rights

Expending rights	Australia	Brazil	Canada	Germany	Spain	USA
basic attention	U	L	S	O*	U or S**	U,S,L
middle and high attention	S	U,S,L	S	O*	U or S**	U,S,L
drugs	U	U,S,L	S	O*	U or S**	U,S,L
immunization	U	U,S,L	S	O*	U or S**	U,S,L

* 7 of 17 Comunidades Autonomas had the right to spend in 2003
"O" are organizations like labor union that have the right to collect funds to provide health services
Source: European Observatory on Health Systems and Policies,
Australian Government - Department of Health and Ageing,
Health Canada, Medicare and Ministério da Saúde - Brasil

The second pattern is exhibited by Australia, Canada and Germany. On those countries each kind of health services expending is responsibility of only one level. This arrangement increases coordination preventing that expending in some kind of services be either too high or too low. Spain has a configuration that indicates that it is going to become quite similar to Australia, Canada and Germany. This is a case in process were the Union is gradually transferring the authority to spend and provide public services to the Comunidades Autonomas since the Moncloa Treaty.

Once more is important to stress that the lower the degree of services coordination the higher should be its efficiency de to high transactions costs and under or over supply of services. So it is quite possible to conclude that among the countries analyzed USA and Brazil should have the least efficient on the supply of public health care services.

Provision Rights

Finally we turn our attention to the provision rights. Again USA and Brazil reveal a decentralized and overlapping pattern while the other exhibit a competencies structure very well defined in terms of who does what. The consequences of these alternative structures are the same as in the case of the other rights.

Table 8. Provision Rights

Provision rights	Australia	Brazil	Canada	Germany	Spain	USA
basic attention	O*	L	O*	O*	U,S**	U,S,L,O
middle and high attention	O*	U,S,L,O	O*	O*	U,S**	U,S,L,O
drugs	O*	U,S,L	O*	O*	U,S**	U,S,L,O
immunization	O*	U,S,L	O*	O*	U,S**	U,S,L,O

* "O" are non for profit private providers
* 7 of 17 Comunidades Autonomas had the right to spend in 2003
Source: European Observatory on Health Systems and Policies,
Australian Government - Department of Health and Ageing,
Health Canada, Medicare and Ministério da Saúde - Brasil

The Brazilian Health Care Arrangement

Federalisms are loaded with trade-offs of multiple natures. It is possible to identify at least five kinds of trade-offs. The first is the classical fiscal federalism trade-off between the three basic public finances functions: allocation, stability and distribution. The second is related to the centralization advantages in terms of action coordination vis-a-vis to the incapacity to take into consideration local demand peculiarities. The third relates welfare gains in decentralized provision to transactions costs of the establishment of independent unities of decision. The fourth confronts ex-ante and ex-post transactions costs of negotiations between levels of government. Finally the fifth deals with central government efficiency and local government accountability.

The analysis of the distribution of decision rights indicates that perhaps only USA has higher transaction costs on the supply of public health care services than Brazil. Probably Brazilian transactions costs are higher than in USA in relative terms. This is because in Brazil part of the actions are coordinate by SUS but this arrangement is not sufficient to prevent isolated members actions that could be overlapping or inexistent. Coordination in Brazil manifests itself mainly in financing but in expending ad provision it is really bad. Besides there is no coordination in regulation what makes lower levels of government totally dependent on what central government decides. This structure should impose a double transaction costs burden to the system.

Another form to demonstrate what have been stressed so far is to analyse the contracts in the system. The analysis of a system contracts requires firstly the actors' identification.

Considering a public health system it is possible to identify 11 groups of actors: consumers, physicians, health sector workers, hospitals, labour workers, pharmaceuticals, analysis clinics, health insurance plans, federal, state and local bureaucracies. These eleven actors could theoretically sign 55 kinds of contracts among then. However not all federation exhibits all these contracts possibilities. The number of contract kind displayed by a federation could be taken as a proxy for the amount of transaction costs it has. Table 9 presents the list of possible contracts.

Table 9. Possible Contracts List among System Actors

No	Actors	Abbreviation	c	phy	ohw	h	lu	pha	cal	hp	fb	sb	lb
1	**consumers**	**c**											
2	**physicians**	**phy**	1										
3	**other health workers**	**ohw**	1	1									
4	**hospitals**	**h**	1	1	1								
5	**labor unions**	**lu**	1	1	1	1							
7	**pharmaceuticals**	**pha**	1	1	1	1	1						
8	**clinical analysis laboratories**	**cal**	1	1	1	1	1	1					
9	**health plans**	**hp**	1	1	1	1	1	1	1				
10	**federal bureaucracy**	**fb**	1	1	1	1	1	1	1	1			
11	**state bureaucracy**	**sb**	1	1	1	1	1	1	1	1	1		
12	**municipal bureaucracy**	**lb**	1	1	1	1	1	1	1	1	1	1	
Total contracts			**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**55**

This list helps us to identify the contracts that are actually made i each one of the federations under analysis. Table 10 displays these contracts. In this table it is present only the contracts that involve public sector since we are analyzing only public health care services.[4]

[4] In the German case the action of labour unions should be considered public since it is constitutionally part of what they call social health care system.

Table 10. Contracts Established

Contracts		Australia	Brazil	Canada	Germany	Spain	USA
fb	sb	1	1	1	1	1	
fb	lb		1			1	
sb	lb		1				
fb	c	1	1				1
sb	c	1	1	1		1	1
lb	c		1				1
lu	c				1		
fb	h		1				1
sb	h	1	1	1		1	1
lb	h		1				1
lu	h				1		
fb	cal	1					1
sb	cal			1		1	1
lb	cal		1				1
lu	cal				1		
fb	pha	1	1				1
sb	pha		1	1		1	1
lb	pha		1				1
lu	pha				1		
fb	phy	1					1
sb	phy		1	1		1	1
lb	phy		1				1
lu	phy				1		
fb	ohw	1					1
sb	ohw		1	1	1	1	1
lb	ohw		1				1
lu	ohw				1		
fb	lu						
sb	lu				1		
lb	lu						
fb	hp						1
sb	hp						1
lb	hp						1
total		8	17	7	9	8	21

In first place we should turn our attention to the relations between members of federations. Only in the USA is not possible to observe transactions between federation members. In the other federations it is observed contracts between central and state government and only in Brazil there is also the occurrence of contracts between central and local governments.

Canada and Spain exhibits a similar structure were the Union transfers resources to the states, which are responsible for the provision through private or public, provides respectively. Australia and Germany exhibits the same number of contracts however their structures differs largely. In Germany provision is concentrated on labour union while in Australia some services are responsibility of states like hospitals and others of the Commonwealth, as pharmaceuticals and physicians. Again USA should be the country with the higher transaction cost not only because it has the higher number of contracts kinds but also because each one of these kinds transforms into hundreds of others in real life. The countries that should present the lower transactions costs level are Canada and Spain each with only 7 contracts kinds.

Once more Brazil displays an odd situation when compared to other federations. By one side it has institutionalized interaction schemes among levels of governments with automatic transferences and the establishment of competencies among levels of government. However on the other side there is no clear responsibilities division between levels of government.

The interests involved

Probably an important part of the explanation of why Brazil exhibits such a bad performance of health care indicators rests in its institutional arrangement that contributed to the increase of transaction costs. These results indicate the need for substantial changes in the system. Two alternative routes of change could be discussed. The first would go through a process of rights redistribution among the three levels of government, establishing much more clearly the role of each one. The second would require the active participation of the population demanding for a redefinition of the actions and an effective monitoring.

Each one of the alternatives presents advantages and disadvantages and they both to be effective would demand appropriate enforcement mechanisms that would prevent opportunistic behaviour of the actors involved. The first alternative advantage is that it would require a relatively reduced actor's number to negotiate what would impose a relatively low negotiation cost. In this scenario the change could theoretically be made in

the Health Care Ministry sphere involving other government levels representation. The disadvantage associated to this alternative would be the resistances impose by the actors be because it would reduce inter-governmental transferences or because it would increase responsibilities for certain governments levels. The main condition for the well functioning of this alternative is the control of the problems of free ridding and principal/agent.

The second alternative has as its main advantage the absence of the resistances pointed in last paragraph. The establishment of health councils does not hurt any actor's interests and so does not faces initial resistances. However it initiates an extremely complex negotiation process in all government levels. In addition, the greater the councils' competencies extent the wider would be the negotiation instances. In this alternative the number of actors is multiplied many times increasing along with the transaction costs. Besides the idea that this solution could work involves the notion that each group representatives would be working solely on the interest of health care services improving. In other words this alternative requires the cooperation problem solution at the councils' level, or the conflict between collective and individual interests inside interests groups.

It is easy to understand that it is not possible to a priori suggest which one of the alternatives could work better. Brazilian society shows a tendency to opt for the second. Implicit in this decision there is the idea that health councils are an adequate form to promote the enhancement of health care services. However up to the moment there is no assessment on these councils capacity to change situations an so there is no indication that any change is about to happen.

Bibliography

NORTH, D., (1990) ***Institutions, Institutional Change and Economic Performance***, Cambridge: Press Syndicate of the University of Cambridge. Caps 9-11, pp. 73-106

NORTH, D (2005) ***Understanding the Process of Economic Change,*** Caps 1 a 6 (Princeton Economic History of the Western World S.) Princeton Unversity Press

SEN, A. (1999) *Escolha Social e Comportamento Individual*, **Desenvolvimento com Liberdade**, São Paulo: Companhia das Letras

SEN, A. (1998) *The Possibility of Social Choice*, **Nobel Lecture**, December http://nobelprize.org/nobel_prizes/economics/laureates/1998/sen-lecture.pdf

Annex 1

Social Services Indicators

Country	GDP per capita	Human development index (HDI) value	Life expectancy at birth	Infant mortality rate	Maternal mortality ratio adjusted	Population with sustainable access to improved sanitation	Population with sustainable access to an improved water source	Literacy rate, adult total (% of people 15+)	Average years of schooling of adults (aged 15+), total
	2003	2003	2003	2003	2000	2002	2002	2003	2003
Costa Rica	9606	0.838	78.2	8	43	92	97	94.87	6.05
Malaysia	9512	0.796	73.2	7	41	.	95	64.13	3.2
Russian Federation	9230	0.795	65.3	16	67	87	96	97.3	.
Mexico	9168	0.814	75.1	23	83	77	91	84.37	6
Botswana	8714	0.565	36.3	82	100	41	95	81.19	6.28
Uruguay	8280	0.84	75.4	12	27	94	98	.	12.05
Grenada	7959	0.787	65.3	18	.	97	95	.	.
Brazil	7790	0.792	70.5	33	260	75	89	88.62	4.88
Bulgaria	7731	0.808	72.2	14	32	100	100	98.2	.
Thailand	7595	0.778	70	23	44	99	85	69.43	2.71
Romania	7277	0.792	71.3	18	49	51	57	.	.
Tunisia	7161	0.753	73.3	19	120	80	82	.	7.76
Iran, Islamic Rep. of	6995	0.736	70.4	33	76	84	93	90.38	4.99
Tonga	6992	0.81	72.2	15	.	97	100	53.16	3.33
Belize	6950	0.753	71.9	33	140	47	91	.	.
Panama	6854	0.804	74.8	18	160	72	91	49.85	3.88
Dominican Republic	6823	0.749	67.2	29	150	57	93	87	4.93
Macedonia, TFYR	6794	0.797	73.8	10	23	.	.	.	.
Turkey	6772	0.75	68.7	33	70	83	93	74.3	5.02
Colombia	6702	0.785	72.4	18	130	86	92	92.8	5.27
Kazakhstan	6671	0.761	63.2	63	210	72	86	89.89	6.91
Gabon	6397	0.635	54.5	60	420	36	87	.	.
Namibia	6180	0.627	48.3	48	300	30	80	.	.
Saint Vincent and the	6123	0.755	71.1	23	.	.	.	.	.
Algeria	6107	0.722	71.1	35	140	92	87	69.87	5.37
Belarus	6052	0.786	68.1	13	35	.	100	99.59	.
Bosnia and Herzegovi	5967	0.786	74.2	14	31	93	98	96.66	.
Turkmenistan	5938	0.738	62.4	79	31	62	71	87.37	5.29
Fiji	5880	0.752	67.8	16	75	98	.	.	8.3
Samoa (Western)	5854	0.776	70.2	19	130	100	88	.	.
Saint Lucia	5709	0.772	72.4	16	.	89	98	.	.
Ukraine	5491	0.766	66.1	15	35	99	98	66.81	3.51
Dominica	5448	0.783	75.6	12	.	83	97	.	.
Peru	5260	0.762	70	26	410	62	81	.	6.18
Cape Verde	5214	0.721	70.4	26	150	42	80	.	.
Lebanon	5074	0.759	72	27	150	98	100	99.75	.
China	5003	0.755	71.6	30	56	44	77	90.92	6.36

Source: Human Development Report 2005