Chapter 2

Charity and Philanthropy in the History of Brazilian Hospitals —The experience of São Paulo Holy House of Mercy and São Paulo Hospital: an outline of historical continuity[1]

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Health care in the Portuguese Empire: a prologue

Portuguese houses of mercy were lay brotherhoods where health care provision was guided by Christian values, and priorities were set by the Crown in relation to the interest of a local elite.[2] The first of them was founded in Lisbon in 1498, and they subsequently spread across the Portuguese Empire. The new houses of mercy were expected to operate in the model of the Lisbon *Misericórdia*, and had to deal with local particularities and the resulting connection with the elite.[3] In spite of these specificities, though, houses of mercy enjoyed privileges of royal protection. Amid the religious wars of the sixteenth century, their statutes were negotiated within the scope of the Council of Trent (1545-1563), which reinforced their Christian/Catholic identities and their autonomy from bishoprics.[4] Furthermore, this autonomy and the royal sanction for the practice

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of charity and the collection of testamentary donations conferred on the houses of mercy a structural governance role in the maintenance of the Portuguese Empire, through the exercise of local power by colonial elites, despite the differences between colonial spaces.[5] In other words, the Portuguese Empire coordinated local powers that were autonomous to a greater or lesser extent, depending on the significance of the local economy for the Royal Treasury, and on possible connections between local elites and those at the centre of the Empire. In addition, the Christian/Catholic notion of charity, with its emphasis on the virtues of poverty, turned the assistance of the poor into a means of salvation for the rich. This took the form of alms-giving while alive and of last wills and testaments benefiting the houses of mercy in death.

The sources of income of houses of mercy for the practice of charity, and, therefore, for the health care of the poor, were not homogeneous. The collection of alms was the privilege and main activity of the houses of mercy. Those houses located in more affluent cities, however, had higher liquidity, since they were engaged in trade. They also owned more real property, as they were recipients of assets linked to services and of testamentary donations that could be publicly auctioned.

During the sixteenth and seventeenth centuries, through the intervention of the Portuguese monarchy, a trend of incorporating hospitals into houses of mercy emerged. Across Europe, and in Portugal in particular, a separation existed between places of hospitality for travelers and pilgrims, and those dedicated to the care of the sick. These latter were fundamental to the activities carried out by houses of mercy, which, for this reason, built infirmaries and hospitals throughout the Empire.

Members of the brotherhoods of mercy were divided into nobles and the 'officials', who, although not members of the nobility,

were business people and merchants not engaged in manual labour. The brothers managed the finances and could therefore use resources for their own benefit in the form of loans. In general, brothers were also members of local city councils, and this explains the frequent loans brotherhoods and city councils extended to one another, as well as the difficulty in collecting from politically influential debtors.[6] The social capital attached to belonging to a house of mercy brought with it political power and the opportunity to manage privately resources collected for the practice of charity. Although such charity was private when it came to collecting and applying financial resources, it was also intended to be public in the fulfillment of its activities. These were listed in the Commitment of the Misericordia, the set of principles and regulations for the operation of the Lisbon House of Mercy, which also guided the colonial houses.[7]

The fact that houses of mercy owned property and had never been taxed to the same extent as other institutions of the Empire, was the object of an injunction by the Marquis of Pombal in the second half of the eighteenth century. At the time, amid the diffusion of Enlightenment thought, it was evident to the Cabinet of the Marquis and the enlightened elites that Portugal should open its markets and take real property out of mortmain, which preserved inalienable rights of ownership in the hands of corporate boards, such as houses of mercy. In this public debate, elites considered that these houses of mercy represented a hindrance to the circulation of goods and workers. The Law of Good Reason, of 18 August 1769, was intended to control the receipt of inheritances by houses of mercy and other brotherhoods.[8] It was urgent to strengthen the nation's workforce by 'improving hygienic, nutritional, pharmaceutical, and medical practices' and by reorganising hospitals and home medical care, a task that would also be carried out by houses of mercy.[9] It was a moment when the Christian/Catholic notion of charity would be harshly criticised in

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the Portuguese Empire. The same criticism had been emerging since the sixteenth and seventeenth centuries in other European countries, such as England, France, and the German principalities.[10]

The tutelage imposed by the Pombaline reforms coincided with a time of discredit for houses of mercy and contributed to curtailing their autonomy.[11] Such discredit, however, was insufficient to change the tax exemption privileges that had always characterised the practice of charity in the Portuguese Empire, which can be explained by the relevance of the assistance services they offered. Neither was it enough to alter the links between houses of mercy and the local powers through which they negotiated and symbolically shared political power, even when the elites intended to withdraw from the boards of directors of houses of mercy at the turn of the eighteenth to the nineteenth century.

As a result, with the establishment of new liberal regimes in the nineteenth century, houses of mercy would have to settle accounts with the new civil powers. They would, though, retain their Christian/Catholic values and their enormous capacity of negotiation with city councils and the state. For this reason, anchored in their social work, houses of mercy would be subjected to modest taxation. In Portugal, *misericórdias* would maintain their central role in providing relief and health care for the poor. In the imperial territories, however, the histories of the houses of mercy took multiple and diverse paths. Even in the great Empire that was taking shape in Brazil, the fifteen brotherhoods founded until 1750 would have different trajectories.[12] The case of the town of São Paulo will be addressed below.

The Brotherhood São Paulo Holy House of Mercy between the Colonial Period and the Brazilian Empire

The Brotherhood São Paulo Holy House of Mercy (São Paulo *Misericórdia*), thought to have been founded in the sixteenth century, grew along with the city.[13] This means that its greatest period of expansion occured in the second half of the nineteenth century, *pari passu* with the coffee economy, but also with the debates arising from the circulation of knowledge and people in the Atlantic.

In the eighteenth century, the city of São Paulo strengthened its position as a gateway to the inland territory, serving as a point of departure and a place where care could be provided both to travelers on their way to the gold mines and to soldiers serving the interests of the Crown and local governments. The small hospital of São Paulo *Misericórdia* was founded in 1714, but would only start operating in premises acquired for this purpose in 1749. It would be much requested as a military infirmary. Many São Paulo citizens enriched in the mines were members of the brotherhood and advocated the foundation and consolidation of the hospital. In their view, the Brotherhood should cover sick care expenses and take actions to collect almsgiving to support its activities.[14]

The Empire's houses of mercy initially enjoyed relative freedom to conduct their activities. Multiple petitions, though, were filed to the Crown by the São Paulo Misericórdia's Board of Directors requesting aid and privileges equal to those granted to the Lisbon *Misericórdia*, since the town, depleted by mining, was short on financial resources.[15] In the late eighteenth century, however, strong imperial interference was imposed by the Marquis of Pombal, which continued for two reigns after Dom José I.[16] This subjected houses of mercy to the sceptical oversight of the legislators of the time, who wanted to exert control over testamentary donations which were falling into mortmain, and thus

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depriving the Crown and the municipality of tax revenue.[17] At the same time, they could not forgo the private charity offered houses of mercy, since these alleviated social problems by means of their hospitals and foundling wheels.[18] In this sense, the Royal Charter of 18 October 1806, which obliged all the Empire's houses of mercy to abide by the Commitment of the Lisbon Misericordia, is emblematic of the centralisation processes taking place in the Portuguese Empire and of the attempts to control local autonomous institutions. The intention was to reorganise care provision by controlling what the Enlightenment called vagrancy and by setting workers apart from those who engaged in begging for unworthy reasons.[19]

It was also in this conjuncture that the *tropeiro*, who had succeeded the *sertanista*,[20] became a predecessor of the farmer who sought to take root in the lands of São Paulo plateau with sugar plantations and, still in their early stages, coffee plantations.[21] Thus São Paulo's modest elite faced an influx of soldiers, royal employees and travellers, and sought new ways to balance its plantation interests and local power with the Crown's injunctions—marked by the arrival of the Majorat of Mateus in 1765.[22] This small elite would combine the exercise of political power in the city council with the practice of charity in the brotherhood. This combination was maintained even in the face of the disruptions arising from the Napoleonic Wars, the coming of the Portuguese court to Brazil, and plans for the independence of Brazil.

Most studies of the brotherhoods of mercy in Portuguese America state that the property and resources of these institutions were derived from donations and bequests from individuals, as had occurred in Portugal. From what can be seen in their statutes, this was a structuring element of their activity.[23] Although São Paulo *Misericórdia* had fewer resources available to conduct its work, it availed itself of public resources and benefited from tax exemption privileges, just like other *misericórdias*.[24] However, at the turn of the nineteenth century, a hygienist discourse

very much in line with the Enlightenment and civilising aspirations of the time, increasingly gained space in some political speeches at the São Paulo City Council. This set out medical justifications for organising the public and private spheres of citizens' lives. Such speeches indicated the path and shape that the State was taking, both locally and nationwide, towards a rational arrangement of the 'turba'—the common people. They represented the limited place of Enlightenment thought that coexisted with police action and with the violence immanent in a slaveholding and unequal society.[25] The implementers of the new politics that emanated from the 1806 Royal Charter were primarily landowners who took back control of the Brotherhood's Board of Directors before the proclamation of Brazilian independence in 1822, due to their dissatisfaction with the Crown's protégés brought in by the Majorat of Mateus.

It was in this context that São Paulo expanded the political and social domain of its house of mercy, which retained its privileges and its role in the development of new precepts aimed at reorganising the hygiene and health practices of São Paulo's citizens. It is possible, therefore, to observe a redesignation of houses of mercy in the Portuguese Atlantic, at once retaining their private origins but also relying on public resources and tax exemption privileges to practice private charity. This state of affairs was made possible by the political influence of colonial elites, which operated in those institutions through the nineteenth and twentieth centuries. After the independence of Brazil the established São Paulo *Misericórdia* elite constructed a building for its hospital in 1824. It then set out its ideals and powers in the Commitment of 1827, passed in 1836 by the São Paulo Provincial Assembly. At that time, the imbrication of the provincial assemblies of the Brazilian Empire, city councils, and houses of mercy was reflected in the composition of the directing boards of brotherhoods, which always included provincial deputies, councilmen, and landowners, configuring a legal and effective articulation between private elites and public powers.[26]

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Throughout the nineteenth century, São Paulo *Misericórdia* would fund its activities with revenue derived from renting out its real estate. This had been obtained through bequests, from donations by the brothers and from public resources in the form of financial aid and tax exemptions, which were justified by its provision to the poor. Nevertheless, the brotherhood was always constrained by the economic and social condition of the city and province in which they were located. This model was also replicated for hospitals not linked to brotherhoods of mercy, which started to be called *filantrópicos*—philanthropic hospitals—in the late nineteenth century, and which also aimed to provide free health care to the poor. Márcia Barros Silva studied the nineteenth-century Annals of São Paulo Provincial Legislative Assembly and found multiple and diverse requests for health care funding from the São Paulo *Misericórdia* hospital.[27] She also found aid requests for the construction of other hospitals:

> 'Other aid requests were intended for the construction and maintenance of leprosariums and mental asylums. The requests were similar to those made by houses of mercy: allocation of direct funds, or creation of lotteries and other fundraising activities were deemed appropriate for this type of institution. These benefits, always insufficient, also had to compete with other solicitations for construction of medical accommodation. For example, in 1872, a project for the creation of a charity hospital in the city of São Paulo, which had been advanced by the physician J. F. dos Reis in the previous year, was rejected on the grounds that the Holy House was already providing health care in the city.' [28]

Thus, in the experience of São Paulo *Misericórdia*, it is possible to observe the maintenance of the exercise of private charity institutional-

ised in the Portuguese Empire, but now in a dialogue with public power that would become increasingly eloquent and effective throughout the nineteenth century. The development of both the city and the coffee economy in the late nineteenth century brought the arrival of immigrants and population growth, lending a new urgency to public health measures. In this context, some noteworthy sanitary measures included dealing with polluted water and 'miasmas', sewage treatment, collective vaccination, and regulation of hospitals and public areas. Another issue was the number of hospital beds, the demand for which increased at the same rate as the city and its population. This problem was worsened by the fact that the São Paulo *Misericórdia* also received patients from other cities of the province. It was not by chance that the Republic, established in 1889, would witness a rise in the number of philanthropic hospitals. The health care provided by houses of mercy was already lacking, and these new hospitals would develop on the same basis established by *misericórdias*: private charity with public funding delivered in distinct ways and in dialogue with local and state public powers.[29]

How did this compare with developments elsewhere? A debate about the advantages of the new philanthropy over older endowed charity had also occurred in eighteenth- and nineteenth-century England, leading to a different rationale for philanthropy. The voluntary hospital institutions established subsequently reduced considerably their level of generosity towards poor people deemed healthy and able for work. Their premise was that philanthropic actions should be guided by the strengthening of the nation's workforce and by their social usefulness rather than by piety. It called for less reliance on individual donors and for greater continuity and for more consistent and effective funding mechanisms.[30] England then developed a two-sided model: one with public institutions funded with tax revenue from the local poor rates; the other with philanthropic institutions that benefited from tax exemptions and whose trustees defined the remit, locations, and the medical

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practices deemed appropriate. On the American side of the Atlantic, the thirteen British colonies replicated this model, maintaining it after independence, even considering a greater presence of the community in the business of local charity.[31]

In nineteenth-century Portugal meanwhile, the Crown exerted strong influence over the administration of houses of mercy, with debate and legislation proposing health measures in the nation's general interest. Despite this, however, the organisation of hospitals remained characterised by Christian charity, whereby private donations by God-fearing citizens were expected to be sufficient to fund these institutions. Such was the case of the most important hospital of the Lisbon *Misericórdia*, São José Hospital, whose directors complained and denounced the insufficiency and irregularity of allocated resources.[32]

However, in the town of São Paulo, the penetration of new ideas from the Enlightenment was not sufficient to subvert the older traditions and mentalities of Christian/Catholic charity in the health care provided by São Paulo *Misericórdia* hospital. Only the Republic would show some vigor in doing so.

Charity and Philanthropy in the Republican Period

In Brazil, it was in the Republican period that the progress of public health actions that claimed to be philanthropic became manifest, especially in the creation of new hospitals.[33] The federal law No. 173, of 10 December 1893, proposed the regulation of associations created for moral, religious, artistic, scientific, political, and recreational purposes, thus laying down the criteria for the foundation of a plurality of non-profit civil associations with diverse interests. The *filantrópicos* were dedicated to providing health care services, and were most often

set up by physicians or groups of physicians. These are the ones addressed in this study.[34] The Republic, therefore, found a legal manner to maintain the institutional arrangement that secured for houses of mercy and other philanthropic institutions the right to use both private and public resources to provide health care and build new premises when needed. The statutory characterisation of a civil association as not-for-profit entailed the possibility of exemption from certain taxes. In the same way, the provision of public health services and free hospital beds to the poor entailed the possibility of applying for public resources. These resources would come in the form of extraordinary revenue or, more commonly from the 1930s on, in the form of subventions approved by federal, state, and municipal assemblies.[35]

The aforementioned federal law No. 173, therefore, gave legal status to a practice that had been developing in the negotiations that led to the construction of the new São Paulo *Misericórdia* hospital, opened in 1884. Reports by Treasury officials pointed to the need for expanding the hospital due to an increase in demand for medical care in the city. Coffee farmers, who were for the most part brothers of São Paulo *Misericórdia*, made contributions and donations for the new building. These same brothers competed for the opportunity to donate the land for its construction, seeking to make the location of their stores and businesses more valuable. Once the hospital and its modern facilities were declared open, the negotiations with federal, state and municipal governments to fund the hospital's services began.[36]

At São Paulo *Misericórdia*, there was an extraordinary increase in revenue coming from public resources, in comparison with ordinary resources (rents, lotteries, donations by brothers etc.) throughout the nineteenth century and into the early twentieth century. This can be verified by cross-checking the reports presented by the Brotherhood and the debates recorded in the Annals of the Provincial Assembly (after 1889, State Assembly) and the São Paulo City Council. This char-

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acteristic would be replicated in the new *filantrópicos*. A public health model was, therefore, being consolidated in which public resources were employed by non-profit private institutions that defined their area of activity and the health care practices to be offered. It should also be noted that this political choice, negotiated by the economic and intellectual elites, resulted in a reduction of public funds obtained through the tax exemptions that such civil associations received due to their non-profit status. Physicians were the most active members of the intellectual elite, keen to influence the paths of public health and the individual medical assistance provided in hospitals.

The framework of Brazilian hospital philanthropy was one in which private institutions fulfilled public purposes in return for tax relief and light regulation. This provided physicians with considerable encouragement to submit proposals for sanitary schemes and new hospital foundations to the public authorities. From the standpoint of collective action, the Republic's first decades were marked by campaigns that aimed to regulate housing, ports, stores, factories, water distribution, sewage treatment, landfill sites and cemetries, as well as to implement large-scale vaccination, all in an attempt to develop salubrious and civilised sanitary practices. Individual medical assistance would only become a matter of concern in the 1920s, when social security medicine took its first steps.[37] The regulation and construction of new hospitals would, therefore, conform to the inheritance and tradition of houses of mercy on the one hand, and with physicians' interests and ideology on the other. Therefore, between the late nineteenth and the early twentieth centuries, the construction of new *filantrópicos* was accompanied by debates concerning the connections between mental illness and criminology. In the city of São Paulo, for example, this trend was typified by Juquery Mental Asylum, founded in 1898, and Pinel Sanatorium, founded in 1929, both of which were the result of projects advanced by physicians.[38] Individual, inpatient and outpatient care for the poor

was still largely reliant on houses of mercy, since more affluent classes benefited from private medical care. The 1930s, however, would bring changes to individual medical assistance, and the experience at the São Paulo Hospital is quite illustrative of them.

São Paulo School of Medicine Civil Association and São Paulo Hospital

In 1933, a group of thirty-three physicians founded São Paulo School of Medicine Civil Association (SPSM). Its 'non-profit' status placed the newly founded educational institution among the so-called philanthropic institutions, which, under this designation, was partially exempt from national taxation. This exemption was justified by the development of a medical course which, as part of its function, would also provide health care for the city's population. In 1936, with this purpose in mind, the Civil Association would establish its teaching hospital, the São Paulo Hospital (SPH), whose first wards would begin to receive patients into provisional premises in 1936, and into its own facilities in 1940.

From the beginning, funding for the new hospital[39] was based on resources obtained by the School of Medicine from a range of different sources, including: (a) monthly fees paid by students; (b) quotas paid by its founders; (c) agreements entered into with federal, state and municipal governments, which released funds in the form of subventions; (d) agreements executed with the municipality and the state to finance the hospital's wards, its emergency department and hospital beds for indigents; and (e) agreements signed with pension funds and institutes, as of 1940. These pension institutes had been in development since the 1920s. In the 1930s, stimulated by the

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Getúlio Vargas administration and linked to the Ministry of Labour, they expanded their coverage and activities.

The transformations that occurred in the Brazilian economy between the 1930s and 1960s attest to an intense urbanisation process that would bring with it a considerable increase in demand for social and hospital assistance. The development of Brazilian social security entailed the provision of medical, hospital and pharmaceutical services to its beneficiaries. Pension funds and institutes hired hospital services for their members. Poor people, who worked in the informal sector, remained dependent on charitable/philanthropic institutions. São Paulo Hospital, thus, followed the tradition of the houses of mercy as a non-profit institution that sought public and private resources to finance its activities. It also sought to attract the social security institutes that were developing and, at the same time, secure the autonomy of action and choice characteristic of a private enterprise.

The 1930s and 1940s saw the reinforcement of a trend in Brazilian hospital care, in which the government purchased and funded services provided by private hospitals, especially the non-profit ones. It was assumed that charitable/philanthropic institutions providing care for the poor and indigents could charge for services offered to public bodies, mainly through subventions and agreements. In the case of the SPH, whose clientele was for the most part composed of indigents, the reliance on public funding would only increase throughout the twentieth century.

The 1940s and 1950s coincided with the development of the so-called *modelo hospitalocêntrico.* This model arose from an increased demand for health care, especially in big urban centres, and from the influence of new technologies, which resulted in more expensive medical services. The hospital became, therefore, the privileged locus of these services, as it concentrated various medical specialties and provided them with the most modern and expensive equipment and infrastructure. In this context, the SPH found a way to finance its creation and the construction

of its infrastructure, but not always to support its teaching activities and services.

The financial hardships faced by the School of Medicine in the 1950s, especially in maintaining teaching beds intended for indigent patients, led its members to adopt a radical solution: in 1956, the SPSM was turned into a federal institution. The SPH, though, remained a private and philanthropic institution.[40] The law that federalised the School did not include the hospital and its enormous liabilities. It made clear, however, that the hospital should offer beds for teaching activities.[41] In this way, the SPSM, now an educational institution of the public federal system, would continue to use beds in São Paulo Hospital to teach medical specialties. The hospital, in turn, would preserve the main characteristics of the original civil association, changing only its name to São Paulo Society for the Development of Medicine (SPDM), from then on considered the sponsor of the hospital. The political intentions behind this change are quite explicit in the minutes of the members' meetings of the original association. It was hoped that the federal school could obtain larger funds to finance teaching beds allocated to indigent patients and that physicians would maintain their autonomy in the management of the private hospital. It should be noted that the members of the SPH/SPDM were the same professors who came to compose the School Governing Council. This was a new articulation of the public-private mix that had been present in the SPSM's history since its inception.

Analysis of the financial statements of the original civil association, including those produced by the new Society, suggests that the professors were able to mobilise great amounts of capital for the construction of buildings, such as the Tuberculosis Dispensary. Resulting from an agreement signed with the National Tuberculosis Service and the Health Department of the Ministry of Education and Health, the dispensary was built by the National Tuberculosis Service on a piece of land owned by the School. After the dispensary's opening in

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1958, the properties were divided between the School and the Society and the land passed to the ownership of the Society. Service provision would be maintained with resources from the School and also the Society, which would have to raise subventions from public authorities in order to carry out its philanthropic activities. These subventions, though, never had the necessary regularity. This can be seen as a kind of 'financial engineering' through which huge assets could be accumulated by means of agreements and loans. However, short-term expenses for the maintenance of health care services were always beset by the inconsistency of the subventions targetted at the needy.

The accounting exercise carried out by the auditor Américo Oswaldo Campiglia in 1957 at the request of the Society and the School makes patent the financing problems reported here. According to the auditor, by *'incorporating the subventions into the total revenue'*[42] as an anticipated but unrealised factor, a surplus was obtained for the period. In other words, this surplus was based on subventions yet to come, but whose regularity could never be confirmed through the accounting records. This practice therefore allowed the hospital to retain its charitable status, wtih accompanying tax privileges.

The creation of the Social Security National Institute (INPS, in the Portuguese acronym) in 1966, which replaced the old pension institutes and concentrated benefits into a single state-managed social security system, would change the role played by subventions from and agreements with the municipality and the State in the SPH/SPDM's financing. In the course of the 1970s, the importance of revenue received from the INPS in the hospital's total revenue increased significantly. A social security system was, therefore, created based on health care provided to the individual, for curative purposes and delivered in a hospital. In this system, philanthropic enterprises had great importance: they were responsible for hospitals all across Brazil and signed agreements with the INPS to provide medical assistance as established in the new model.

This type of 'articulation between public and private' characterised the development of health care in Brazil and promoted 'hybrid forms' of organising these services.[43] The experience at the complex SPH-SPDM/SPSM undoubtedly typified and consolidated the historical trajectory of public health in Brazil insofar as its existence was defined by the shared management of a private philanthropic hospital and a federal medical school.

Thus, the growth of health care funded by social security contributions from workers, employers, and the federal government became popular. Investment by the state in public health and preventive medicine was always proportionally smaller in the 1970s. The political choices that were made and put into effect, and that were evidenced by the decreasing participation of the Ministry of Health in the Union's total budget certainly explain suppressed tragedies, such as the meningitis epidemic that swept the country in the early part of the 1970s. Funds for a vaccination campaign would only be released in December 1974.[44]

This system developed since the creation of the INPS was as fragile as it was large. The charges for care by a private hospital network largely composed of philanthropic institutions, such as São Paulo Hospital and SPDM, were billed by 'Unit of Service', such as a surgical procedure, an item of equipment, an appointment, or hospitalisation costs. This was difficult to control and often became a source of corruption as doctors over-billed. An additional factor was the insufficiency of the subventions granted by the different levels of government for the care of indigent patients at the same hospitals that received social security patients. Rates paid by the INPS for medical services were also low, and the transfer of resources was not free from delays and cancellations due to the reciprocal distrust between the INPS and the contracted hospital network.

The difficulties posed by the INPS's fragile financial structure to the operationalisation of the hospital were as evident as they were

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serious. There were problems paying medical residents, suppliers and employees; the impossibility of providing care of the expected and requisite quality; and constant attempts by the School and the Society to renegotiate contracts with the INPS and obtain subventions that were enough to cover the deficit created by their dependence on its revenue. Moreover, the urgent need to expand the hospital, incapable of serving an ever-growing number of patients who sought treatment in its wards and emergency room, led the School to request resources from the Social Development Support Fund. This fund, created by law in 1974, aimed to 'provide financial support for social programmes and projects that comply with the guidelines and priorities of the social development strategy set out in the National Development Plan.' Through the fund, it was possible to take out loans from the Caixa Econômica Federal, a government-owned savings bank, for 'publicly relevant projects in the areas of health, sanitation, education, labour, and social security.'[45] Bearing in mind that throughout the 1970s the private hospital network, either philanthropic or not, came to be responsible for serving roughly 90% of INPS-funded patients, and that hospitals became the citizens' main gateway into the health system, the government's intentions were clear. Likewise, the difficulties in organising primary care structures, after the creation in 1988 of Brazil's national health service, the *Sistema Único de Saúde* (SUS), can also be explained when one considers the history of public policies formulated in the 1960s and 1970s.

Table 2.1 illustrates the economic difficulties reported here.[46] It is based on records of current assets and liabilities (CA and CL) of the SPH, as well as on the application of the current liquidity ratio (CLR), which signifies an institution's solvency as regards its financial obligations.

Table 2.1: Assets and Liabilities of Sao Paolo Hospital. 1960-1984 (Brazilian currency)[47]

Year	Current Assets	Current Liabilities	Current Liquidity Ratio
1960	8,035,569.8	35,694,918.6	0.22
1961	1,270,151.9	60,050,926	0.02
1962	4,753,944.1	31,666,232.2	0.15
1963	Illegible		
1964	7,401,368	114,561,286	0.06
1965	19,154,265	179,792,110	0.11
1966	88,421,801	382,709,406	0.23
1967	19,547.48	992,984.6	0.02
1968	192,690.5	841,621.37	0.22
1969	289,259.26	929,701.86	0.31
1970	848,261.76	2,504,193.36	0.33
1971	550,556.97	3,172,826.97	0.17
1972	694,885.09	4,523,954.81	0.15
1973	972,196.78	6,018,866.73	0.16
1974	3,887,079.42	5,529,588.09	0.7
1975	6,922,647.91	14,147,606.37	0.49
1976	5,690,139.01	45,749,248.33	0.12
1977	28,884,092.98	63,078,766.77	0.46
1978	57,961,378.03	136,903,243.3	0.42
1979	Illegible		
1980	113,314,806.3	209,185,299.5	0.54
1981	398,832,895.2	361,253,074.7	1.1
1982	551,624,093.9	461,988,054.6	1.19
1983	1,076,610,143	2,056,564,818	0.52
1984	3,220,251,573	6,115,197,279	0.53

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The table shows liquidity ratios mostly below 1, which is evidence of the institution's insolvency. Even the years of solvency (1981-1982) only occurred because of the federalisation of the SPH's employees, which balanced the ratio between revenue and contractual liabilities for two years.[48]

According to the Minutes of the School Governing Council and of the Society Members' Meeting between the 1960s and1990s, the perception of insolvency always led to the following proposals: (a) requests for additional municipal and state funding for emergency care delivery; (b) hiring of new staff via the school, in order not to burden the Society payroll; (c) increases in the number of private hospital beds, in order to balance the finances against the expenses with teaching beds intended for indigents; and last but surely not least, (d) requests to turn the hospital into government property. These proposals, however, had never been a consensus within the community. There had always been those who wanted the SPH to remain a private philanthropic civil association, and those who asserted the impossibility for the SPH to be funded on the historical grounds on which it had been built, thus demanding its complete federalisation.

In the process of transition from the INPS/INAMPS system to the universal and comprehensive SUS, the Society faced a serious financial crisis caused by the indebtedness of the late 1980s and by the aftermath of the economic 'miracle' promoted by the military between 1964 and 1984.[49] The transition to the 1990s would witness strikes and deficits, the likes of which had never been seen in the SPH's history.[50] When the SUS was created, 95% of the SPH's activities were funded with public resources and payments proceeding from the agreement with the INPS/INAMPS. Prior forms of financial engineering would also point the way out of the crisis: expansion, the search for new agreements and new areas of activity to increase revenue. It should be noted that, between the initiation of social security, when the school and the

hospital developed, and the creation of the SUS, the Society remained a private philanthropic institution, signing agreements with ministries, state and municipal secretariats, and receiving subventions to provide public health care. The health system has undoubtedly changed, but the continuance of the SPH/SPDM amid the change indicates the difficulties in consolidating the SUS as a fully public system in which private insurance was unnecessary. These difficulties will be examined below, taking into account the very process of creation of the SUS.

The Construction of the Unified Health System

It was in the years of the military dictatorship, between 1964 and 1984, that the social security health care system reached its apex and also its crisis.[51] The control and distribution of social security resources by the state proved not only inefficient but, more importantly, unable to deliver quality health care to those entitled to it. Nor could it expand health care coverage to patients not covered by social security. A national health system was necessary, with a funding model that met citizens' needs. Sanitary Reform was also necessary. This was a movement that brought together several other social movements in the late 1970s to demand universal public health care and the country's democratisation.[52] The SUS was created by the 1988 Constitution and became a legal obligation with the 1990 laws No. 8,080 and 8,142.

> As a historical process, the SUS had its practical beginning in the 1970s, with social and political movements against the dictatorship and in favour of the democratic freedoms and the democratisation of the State. These movements were expanding

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> and intensifying their fight for a just and solidary society, and for a State with universal public policies on basic human rights. In health, these libertarian movements were strengthened by the Sanitary Reform, anticipating what would become, years later, the constitutional directives of universality, equality and community participation.[53]

As a result of the Sanitary Reform movement and the defeat of the military dictatorship in 1984, the new Constitution, promulgated in 1988 and known as the Citizen Constitution, stated:

> **Article 198.**Public health activities and services are integrated in a regional and hierarchical network and constitute a single system, organised according to the following directives:
>
> I – decentralisation, with a single management in each sphere of government;
>
> II – comprehensive service, priority being given to preventive activities, without prejudice to assistance services;
>
> III – participation of the community.
>
> Paragraph 1. The unified health system shall be financed, as set forth in article 195, with funds from the social welfare budget of the Union, the states, the Federal District and the municipalities, as well as from other sources. (...)
>
> **Article 199.** Health assistance is open to private enterprise.
>
> Paragraph 1. Private institutions may participate in a supplementary manner in the unified health system, in accordance with the directives established by the latter, by means of public law contracts or agreements, preference being given to philanthropic and non-profit entities.[54]

This research is concerned particularly with the effects of Article 199 in relation to the principles laid down in Article 198 of the Constitution. In order to offer a full health service with the participation of the community in the making of choices and decisions, the regionalised, hierarchical and decentralised network must provide three levels of service: primary health care, which is the gateway to the SUS; medium-complexity care; and high-complexity care. Primary care is evidently provided in higher numbers and is allocated a proportionally greater amount of resources. The thirty years of existence of SUS have undoubtedly seen a substantial increase in the number of primary care service providers. This has made it possible to include a large proportion of the population in the registers of the Basic Health Units (BHU), as well as to connect BHUs with nearby medium- and high-complexity service providers. The urgency in constructing SUS, however, entailed the execution of agreements and contracts with private hospitals, as suggested in Article 199. The Society would integrate with the hospital network serving SUS patients. The same would happen with hospitals of the brotherhoods of mercy and with all other *filantrópicos* in the country. There were differences here, though, that need to be pointed out.

Among Brazilian philanthropic hospitals today, including those belonging to houses of mercy, some are characterised as general hospitals and offer services that range from outpatient care to highly-complex care. In these hospitals, some admit any type of patient in their emergency departments, whereas others are exclusively dedicated to one specialty (orthopedics, pediatrics etc.) and only receive patients for that specific specialty. Hardly any philanthropic hospital or house of mercy receives only SUS patients; most also have beds reserved for privately insured patients. In this aspect, though, hospitals differ immensely from one another. Some, like the SPH, allocate few beds for private patients. Others seek to provide services equally to SUS and private patients in an attempt to balance their finances, since payments from the SUS are

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allegedly insufficient. Still others, in order to secure the number of SUS beds required by law for their certification as *filantrópicos*, operate as social organisations (SO), managing public service providers. These may be either BHUs or hospitals, located or not in their vicinities. In their financial statements, these SOs record inpatient and outpatient services offered by the public service providers they manage, as if provided by themselves as their mandatory share of public services. Public patients, however, rarely make use of the private hospital's services.

At present, it is a fact that SUS is harmed by policies of underfunding, but it is also a fact that this situation affects primary care service providers more seriously than general and special hospitals. Having in mind that private health insurance plans pay more, it is easily understandable why medical corporations on hospital management boards want the expansion of private plans, leaving the SUS only for people considered extremely poor. It is important to reaffirm that, when one speaks of certification as a charitable and philanthropic entity, the legal possibility of a tax waiver by the government is involved. In other words, the legislation grants exemption from certain taxes in exchange for public services, provided for the needy population and funded by the SUS. The tax waiver necessarily entails the provision of these services, and it is in this aspect that medical corporations have great relevance. In their political actions, these corporations associate the demand for a tax waiver with the argument for the expansion of private health insurance and the decrease of their obligations towards the SUS, an attitude that compromises the universalising principles stated in the Brazilian Constitution.

Researchers of the role played by philanthropy in the SUS have drawn a distinction between traditional philanthropic entities and those following an entrepreneurial model.[55] The former, true heirs to the Christian charitable practices, provide services almost exclusively to those in need and are all but fully funded by the SUS and

by supplementary public funds. This is the situation in which houses of mercy find themselves, especially those in inland towns in the state of São Paulo. The others, which generally separate facilities intended for SUS patients from those for private patients, operate politically as described above. This is the case, for example, of São Paulo *Misericórdia*, which has built facilities to receive private patients exclusively. On the other hand, São Paulo Hospital has never had, in all its history, more than 5% of its revenue derived from fully private resources, even though the Minutes of the Society Members' Meetings show the need to increase the number of private beds so as to improve funding for its activities. After the creation of the INPS, in 1966, the dependence on resources from social security was very heavy, as has been pointed out. These resources, however, were distributed and managed by the state, according to the military dictatorship's intention of universalising health care through social security, although this never materialised.

Therefore, Brazilian health care would continue to be regulated by public powers, but provided through multiple types of agreement involving institutional obligations between the public and private spheres. This historically constructed trend would be further consolidated with the 1990 Managerial Reform of the State, which gave legal status to the juridical entity of the Social Organisations.[56] These were private institutions which could also benefit from its philanthropic status, and which were incentivised to apply for the management of public service providers.

In 1994, the Society started operating joint primary care programmes with municipalities and states, independently from the activities of the Hospital. This would lead to the SPDM's certification as a SO in 1998. This expansion process of the Society, which would turn it into the most important manager of public service providers in the state of São Paulo in the early twenty-first century, was based

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on the SPDM's relations with the School and on its management of São Paulo Hospital, since the public medical school and its teaching hospital offered academic support that justified that expansion.

Final Considerations

Throughout the twentieth century, philanthropy was defined as publicly relevant action which was not for the pursuit of profit. According to this definition, direct-management public institutions and philanthropic institutions could be considered qualified to provide public health care services funded by the INPS/INAMPS or, after 1998, directly by the SUS. This pattern of expansion of individual health care activities resulted in the growth of the private hospital network and blurred the distinction between public and private in the Brazilian health care system.

A hybrid system was, thus, historically created which is explained by the pervasiveness of *misericordia* and *filantrópicos* in Brazil and by the urgency of structuring a unified health system after 1988.[57] This situation also opened a private gateway into SUS which competes with public spaces and services, within these very hospitals, for public funding. This competition takes place in different ways, since the SPH, as discussed here, has always received patients coming mostly from the INPS/INAMPS or the SUS, whereas *Albert Einstein Hospital*, for example, despite being considered a philanthropic hospital according to the same regulations, gives preference to private patients. A single group of laws promotes distinct inequalities. This is possible because large philanthropic hospitals can be accredited as SOs and remotely manage public service providers, leaving their own beds out of the equation.

Any assumption that Brazil has transitioned from philanthropy-linked charity, which characterised its early health care experience, to public health, is refuted by the resilience of historically constructed medical practices and public service management practices. What is more, these practices have been sanctioned by the same Constitution that stated the universality of the right to health. In this context, the connection between private charity/philanthropy and public funding explained private charity's difficulty in collecting enough donations. At the same time, the government considered that building hospitals and organising health care for the entire population with physicians, assistants and nurses directly paid by the Treasury was too steep an investment.

The Christian and private origins of charitable and/or philanthropic practices impacted the contemporary construction of citizenship, given that Brazilian hospital provision has always been located between citizenship entitlement and hierarchical benevolence, between the possibilities of creation of public spaces and the permanence of private actions that establish themselves as public, thus taking the place of the state. These private activities receive tax exemption privileges and select their clientele and their areas of operation without regard to the public interest. Moreover, Christian compassion, the basis for charitable actions, brought with itself a hierarchy between charitable givers and receivers. These latter never participated in the political decisions concerning how to relieve suffering caused by poverty and disease. Most of the time, it was nothing but charitable compassion enfolded into social hierarchies that were thus legitimised.[58]

If solidarity was at the basis of what some Enlightenment thinkers proposed for a world based on the pact among equal citizens, the survival of Christian charity in the health care structures developed in Brazil since the nineteenth century has hampered the under-

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standing of health care as a universal right. The idea of Christian private charity had a public dimension and became, in the Brazilian experience, a political motivation for segmentation of clientele and for obtaining private advantages. This, however, is history under construction. The SUS, Brazil's greatest social achievement after the end of the military dictatorship, belongs to all Brazilians, who are still awaiting its effective consolidation.

1. This research is funded by Fundação do Amparo à Pesquisa do Estado de SãoPaulo (FAPESP), Process 2017 / 16721-0

2. For an overview of recents research, see Isabel dos Guimarães Sá, Quando o rico se faz pobre: Misericórdias, caridade e poder no Império português (1500-1800) (Lisbon: CNCDP, 1997); Idem As misericórdias portuguesas – séculos XVI a XVIII (R. J.: FGV, 2013); Laurinda Abreu, The political and social dynamics of poverty, poor relief and health care in early-modern Portugal (N. Y.: Routledge, 2016).

3. Renato Franco, Pobreza e caridade leiga – as Santas Casas de Misericórdia na América Portuguesa (PhD thesis, School of Philosophy, Languages and Human Sciences, University of São Paulo, São Paulo, 2011).

4. Sá, op. cit. (note 2).

5. Sá, op. cit. (note 2); Charles Boxer, O Império marítimo português (1415-1825). (Lisbon: Edições 70, 2011).

6. Boxer, ibid.; A. J. R. Russell-Wood, Fidalgos e filantropos – A Santa Casa de Misericórdia da Bahia, 1550-1755 (Brasília: Editora da UnB, 1981). It is important to highlight the relevance of Russell-Wood's work for the understanding of the misericórdias in the Portuguese Empire. In the case of São Paulo, however, even if one considers the structuring role of mercies in the Portuguese Empire, the poverty of the village suggests cautions in the analysis. When São Paulo began its economic expansion at the beginning of the nineteenth century, we were already experiencing the winds of independence. And that is why the misericódia of the village of São Paulo connected the contents of Christian charity with the new political guidelines of the free Province, also led by an elite that changed itself, appropriating the experience of the misericórdia.

7. R.T.Santos, 'Social Innovation Oriented towards Solving Pratical Problems. The Case of the Santa Casa da Misericórdia de Lisboa', in C.Ruiz, Viñals and C. Parra Rodríguez (eds), Social Innovation: New Forms of Organisation in Knowledge-Based Societies (Abingdon: Routledge, 2015), 84-108, at 95-6.

8. Maria Antónia Lopes and José Pedro Paiva, 'Introdução',Portugaliae Monumenta Misericordiarum – Sob o signo da mudança: de D. José I a 1834 (Lisbon: União das Misericórdias portuguesas, 2002, Vol. 7).

9. Lopes and Paiva, ibid., 31.

10. Frances Fox Piven and Richard Cloward, Regulating the poor: the functions of public welfare (N. Y.: Vintage Books, 1993).

11. Isabel dos Guimarães Sá and Maria Antónia Lopes, História Breve das Misericórdias Portuguesas, 1498-2000 (Coimbra: Imprensa da Universidade, 2008); Maria Antónia Lopes 'A intervenção da Coroa nas instituições de protecção social de 1750 a 1820', Revista de história das Ideias, 29 (2008), 131-176.

12. Russell-Wood, op. cit. (note 4).

13. For an overview of important research about the Brotherhood of the São Paulo Holy House of Mercy, see Laima Mesgravis A Santa casa de Misericórdia de São Paulo (1599?-1884) – Contribuição ao estudo da

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assistência social no Brasil (S. P.: Conselho Estadual de Cultura, 1977); Glauco Carneiro O poder da Misericórdia – A Santa Casa de São Paulo (S. P.: Press, 1986). For an overview of recent research about São Paulo in this period, see Rafael Mantovani Modernizar a ordem em nome da saúde: a São Paulo de militares, pobres e escravos (1805-1840) (R. J.: Fiocruz, 2017).

14. Mesgravis, ibid.

15. Mesgravis, ibid.

16. Maria Antónia Lopes, 'A intervenção da Coroa nas instituições de protecção social de 1750 a 1820', Revista de história das Ideias, 29 (2008), 131-176.

17. Maria Antónia Lopes, ibid.

18. Foundling wheels were mechanisms embedded in an aperture in the wall of an institution whose purpose was to receive abandoned infants. They were usually found in brotherhoods of mercy which cared for the children. Child-rearing costs were usually shared between the houses of mercy and city councils.

19. Lopes and Paiva, op. cit. (note 6); Isabel dos Guimarães Sá and Maria Antónia Lopes ibid.
Laurinda Abreu has stressed the similarities between Portuguese and English legislation against vagrancy during the sixteenth and seventeenth centuries. This is an important historiographical debate that will not be considered here, where the focus is on the Christian aspects of the Luso-Brazilian experience of the mercies and their inflections during the Enlightenment era. See Abreu, Laurinda, *ibid.*

20. During the Brazilian colonial period, the sertanistas were men who ventured into the sertões (lands of the hinterland of the colony) in search of richness and indigenous populations to imprison. In São Paulo, the sertanistas were called 'bandeirantes'. Tropeiro is the designation given to Paulistas who, from the seventeenth century onwards set up commissions, or caravans, to trade horses, mules, and other products of daily use.

21. Sérgio Buarque de Holanda, Caminhos e fronteiras (S. P.: Cia das Letras, 1994).

22. Luiz Antônio de Souza Botelho e Mourão, known as the Majorat of Mateus, ruled the São Paulo Captaincy between 1765 and 1775. Ana Paula Médicci 'De capitania a província: o lugar de São Paulo nos projetos de Império, 1782-1822', in: Wilma Peres Costa and Cecília Helena de Salles Oliveira (eds), De um Império a outro – Formação do Brasil, séculos XVIII e XIX, (São Paulo: Hucitec/Fapesp, 2007); Alcir Lenharo, As tropas da moderação (São Paulo: Símbolo, 1979); Maria Odila Leite da Silva Dias A interiorização da metrópole e outros estudos (São Paulo: Alameda, 2005)

23. Franco, op. cit. (note 2); Luciana Gandelman Mulheres para um Império: órfãs e caridade nos recolhimentos femininos da Santa Casa de Misericórdia—Salvador, Rio de Janeiro e Porto – século XVIII (Campinas: Unicamp, 2005, PhD thesis); Tânia S. Pimenta 'Hospital da Santa Casa de Misericórdia: assistência à saúde no Rio de Janeiro dos Oitocentos',Anais do XXVI Simpósio Nacional de História – ANPUH (S. P., July 2011. Available on: http://www.snh2011.anpuh.org/resources/anais/14/1300881656_AR-

QUIVO_TaniaPimentatexto.pdf Accessed in February 2015).

24. Márcia Regina Barros da Silva, 'Santa Casa de Misericórdia de São Paulo: saúde e assistência se tornam públicas (1875-1910)', Varia História, 26 (44) (2010), 395-420; Idem 'Concepção de saúde e doença nos debates parlamentares paulistas entre 1830 e 1900', in: Maria L. Mott and Gisele Sanglard (eds.), História da saúde em São Paulo: instituições e patrimônio arquitetônico (1808-1958) (Barueri, SP: Minha Editora, 2011), 63-92.

25. Mantovani, op. cit. (note 10).

26. Laima Mesgravis, ibid; Wilma Peres Costa and Cecília helana de Salles Oliveira, ibid.

27. Silva, op. cit. (note 17).

28. Ibid., 70. (Author's translation)

29. There is a huge body of different studies on the First Brazilian Republic philanthropy that points out its patterns. I highlight just a few: André Mota Tropeços da medicina Bandeirante – Medicina paulista entre 1892-1920 (São Paulo: Edusp,2003); Gisele Sanglard Entre os salões e o laboratório – Guilherme Guinle, a saúde e a ciência no Rio de Janeiro, 1920-1940 (R. J.: Fiocruz, 2008); Cláudia Maria Ribeiro Viscardi 'Pobreza e assistência no Rio de Janeiro na Primeira República', História, Ciências, Saúde – Manguinhos, 18 (2011), 179-197.

30. Donna T. Andrew, Philanthropy and police (Princeton: Princeton University Press, 1989); Andrew Wear (ed.), Medicine in society (New York: Cambridge University Press, 1998).

31. David Rosner, A once charitable enterprise (Cambridge: Cambridge University Press, 2004); David J. Rothman, The Discovery of the asylum (Boston: Little Brown, 1971); American charities (N. Y.: Thomas Y Crowell Company Publishers, 1894).

32. ANTT, Hospital de São José, Livro 0947; Lopes and Paiva, op. cit. (note 6); Sá and Lopes, op. cit. (note 13); Maria Antónia Lopes, 'Os pobres e a assistência pública', in: Luis Reis Torgal and João L. Roque, História de Portugal – O liberalismo (Lisbon: Editorial Estampa, 1998), 427-437.

33. Gisele Sanglard, ibid.

34. Maria Lúcia Moot, Henrique S. Francisco, Olga Sofia F. Alves, Karla Maestrini and Douglas C. Afonso da Silva 'Assistência à saúde, filantropia e gênero: as sociedades civis na cidade de São Paulo (1893-1929)', in: Maria L. Mott and Gisele Sanglard (eds.), História da saúde em São Paulo: instituições e patrimônio arquitetônico (1808-1958) (Barueri, SP: Minha Editora, 2011), 93-132.

35. Ana Nemi (ed), EPM/SPDM – Histórias de gente, ensino e atendimento à saúde (São Paulo: Editora Fap/Unifesp, 2012); Ana Nemi Entre o público e o privado: Hospital São Paulo e Escola Paulista de Medicina (1933 a 1988) (São Paulo: Hucitec, 2020).

36. Silva, op. cit. (note 17); Mesgravis, op. cit. (note 10).

37. Maria Alice Rosa Ribeiro, História sem fim ... Inventário da saúde pública (São Paulo: Ed. da Unesp, 1993); Rodolfo Telarolli Jr. Poder e saúde – As epidemias e a formação dos serviços de saúde em São Paulo (S. P.:

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Editora da Unesp, 1996); Gilberto Hochman A era do saneamento (São Paulo: HUCITEC, 2006).

38. Ana Nemi and Ewerton L. F. M. Silva, 'Imigração portuguesa e psiquiatria na capital paulista dos anos 30: modernidade e nacionalismo no atendimento à saúde', in: André Mota and Gabriela Marinho (eds.), Saúde e História de Migrantes e Imigrantes. Direitos, Instituições e Circularidades (São Paulo: FMUSP, UFABC & Casa de Soluções Editora, 2014), 43-58.

39. In order to understand the origin of the resources used by the SPH, its Accounting Books and Financial Statements have been analysed, as well as the Annals of the São Paulo municipal and state assemblies, and of the National Congress.

40. Ana Nemi, 'A federalização da Escola Paulista de Medicina: imbricações de origem entre a norma e a experiência (1956-1970)', Tempo Brasileiro, v. 178 (2009), 165-213.

41. Act No. 2,712 of 21 January 1956. Available on: http://legis.senado.leg.br/sicon/#/pesquisa/lista/documentos
Accessed in April 2019. According to article 2 of the law: *'For the teaching of the São Paulo School of Medicine's specialties, the São Paulo Hospital's sponsor will ensure, through a clause in the deed referred to in this article, the use of its general wards, facilities and equipment, regardless of any payment.'*

42. Governing Council Minutes, Book VI, Minute No. 100 (02 August 1957), 46. UNIFESP President's Office Archive. An explanation was requested from the auditor about the SPSM's and the SPH's balance sheets regarding the years before and after the federalisation, in addition to a study of their respective properties after part of the SPSM's assets were incorporated into the Union.

43. Telma M. G. Menicucci Público e privado na política de Assistência à saúde no Brasil: atores, processos e trajetória (Rio de Janeiro: Fiocruz, 2007), 34 and 46.

44. Gastão W. S. Campos, Emerson E. Merhy and Everardo D. Nunes, Planejamento sem normas (São Paulo: HUCITEC, 1989); José Carlos de Souza Braga and Sérgio Goes Paula, Saúde e previdência: estudos de política social (São Paulo: CEBES/HUCITEC, 1981).

45. Law No. 6,168 of 9 December 1974. Federal Senate's Archive. Available on: http://legis.senado.leg.br/sicon/#/pesquisa/lista/documentos. Accessed in April 2019.

46. The table was constructed from the reading of: a. São Paulo Hospital's Accounting Books, Books 1565-1606, b. Minutes of the São Paulo Society for the Development of Medicine's Annual Meeting, 1960-2015. SPDM Archive.

47. From 1960 to 1984 Brazil had two different currencies: cruzeiro (1964-1967 and 1970-1984) and cruzeiro novo (1967-1970).

48. The SPSM, as a federal public school, negotiated with the Ministry of Education and Culture (MEC) the inclusion of part of the SPH's employees on the Union's payroll. The aim was to cut costs with SPH/SPDM personnel and improve the quality of the teaching at the hospital beds available for this purpose.

49. In 1977, the dictatorial military government divided the INPS into two institutions: the National Social Security Medical Assistance Institute (INAMPS, in the Portuguese acronym), an agency responsible for public health services, and the Social Security Financial Administration Institute (IAPAS, in the Portuguese acronym), responsible for finance management. In this study, we opted for using the combined acronym INPS/INAMPS to make the continuity clear.

50. 'Strike impacts school and hospital in São Paulo', in: Folha de São Paulo, 14 August 1991; 'Health crisis: ER closure causes chain reaction', in: Jornal da Tarde, 24 December 1991.

51. Braga and Paula, op. cit.(note 34).

52.Sarah Escorel, Reviravolta na Saúde: origem e articulação do movimento sanitário (Rio de Janeiro: FIOCRUZ, 1999); Jairnilson Paim O que é o SUS (Rio de Janeiro: Fiocruz, 2009).

53. Nelson Rodrigues dos Santos, 'SUS, política pública de Estado: seu desenvolvimento instituído e instituinte e a busca de saídas', Ciênc. saúde coletiva [online], vol.18, n.1, (2013) 274. (Author's translation)
54. Constituição da República federativa do Brasil (1988). (Brasília: 2008). (Author's translation)

55. Ministério da Saúde, Rede hospitalar filantrópica no Brasil: perfil histórico-institucional e ofertas de serviços (Belo Horizonte, 2001); Instituto de Pesquisa Econômica Aplicada). Financiamento Público da saúde: uma história a procura de rumo (Rio de Janeiro, 2013); idem, Radiografia do gasto tributário em saúde – 2003-2013 (Brasília, 2016).

56. Ministério da Administração Federal e Reforma do Estado, A Reforma do Estado dos anos 90: Lógica e mecanismos de controle (Brasília: 1997); Ana Nemi and Lilia B. Schraiber, 'Luiz Carlos Bresser-Pereira: o Sistema Único de Saúde (SUS) e a Reforma Gerencial do Estado dos anos de 1990', Interface (Botucatu. Online), v. 23 (2019), 1-13.

57. Margareth C. Portela, Sheyla M. L. Lima, Pedro R. Barbosa, Miguel M. Vasconcelos, Maria Alícia D. Ugá and Silvia Gerschman, 'Caracterização assistencial de hospitais filantrópicos no Brasil', Revista de saúde pública, 2004; 38 (6): 811-8.

58. Hannah Arendt, A condição humana (R. J.: Forense Universitária, 1993); idem, Sobre a revolução (S. P.: Companhia das Letras, 2011).

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