

Impact of recent decisions and discussions on the Brazilian Public Health System financing

Implicações de decisões e discussões recentes para o financiamento do Sistema Único de Saúde

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ABSTRACT This article aims to analyze the impact of decisions and discussions on the Brazilian Public Health System financing. Brazil's public health spending data are presented and compared to countries providing universal health care, as well as are tax expenditures data, which easy to create an incentive in favor of the private health sector. Recent topics discussed by the National Congress are approached due to risking the Brazilian Public Health System and the consolidation of the right to health in the Country.

KEYWORDS Welfare state; Right to health; Public policy; Unified Health System.

RESUMO Este artigo tem por objetivo discutir as implicações de decisões e discussões para o financiamento do Sistema Único de Saúde (SUS) no âmbito dos Poderes Executivo e Legislativo. Apresentam-se dados sobre os gastos com ações e serviços públicos de saúde no País, comparando-os aos de países com sistema universal de saúde, bem como sobre renúncias fiscais, inclusive de receitas da seguridade social, as quais favorecem o setor privado de assistência à saúde. Abordam-se os temas recentes tratados pelo Congresso Nacional considerados riscos à consolidação do SUS e à efetivação do direito à saúde no País.

PALAVRAS-CHAVE Seguridade social; Direito à saúde; Política social; Sistema Único de Saúde.

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Introduction

The European social well-being, based on the pillars of social cohesion and solidarity, was strengthened after the World War II with the aim of ensuring a high degree of social protection to citizens, and took different models of organization in each country. After being quite questioned in years 1970 and 1980, it underwent renovations in years 1990, being once again under discussion as to its ability to respond to new risks and new social realities, as well as to its financial sustainability.

In the current context of globalized economies, new risks are presented as relevant challenges (CHIODI, 2015), such as: the labor market hiring and firing; the precarious work condition of young people; employees obsolescence or lack of competences, as well as the new social realities, such as the aging of the population (and its increasing demands for care services); the search for quality services; the changes in the family configuration; the women absorbing by the labor market; structural unemployment and lack of social protection for specific groups, showing a little contributive history for the labor market (young people, women and immigrants).

In Europe, despite the neo-liberal questioning as for the social expenditure inefficiency in years 2000, the thinking that social policies are at the service of economic growth is reassured. Thus, they are understood as instruments of integration and promotion of individuals' capacity to face the risks in unreliable labor markets and driver of competitiveness among companies, due to the fact that these policies qualify and update workers (CHIODI, 2015).

According to Kerstenetzky (2012), the new winds in Europe led to qualitative changes in social policies, making cuts in programs, especially in the social security, while expanding other programs, mainly services. However, the social well-being resists,

because, in the democratic process, the workers and the middle class do not accept the reduction of social services, and because, from an economic point of view, there is greater work productivity in environments less unequal and more solidary.

In Brazil, the social well-being late arrived in relation to European countries and marched towards the 1988 post Constitution universalism. But it did not happen without being much questioned. In health scope, there have been advances in the implementation of the Unified Health System (SUS), although there is still room for significant improvements in the broadening of people access to and quality of health services. In addition, the current economic crisis imposes restrictions on public budgets, highlighting the debate on fiscal adjustment and social expenditure in the Country. In this regard, this article aims to discuss the consequences of recent decisions and debates as for SUS funding from the perspective of the right to health assurance defined in the 1988 Constitution.

SUS financing: a chronic failure

Regarding the discussion on SUS financing, it is important to rescue issues relating to the social security funding, which, in Brazil, is consisted of social assistance, social welfare and health areas. The 1988 Constitution (CF) defined its sources of funding, whose resources comprise a specific budget fund – Social Security Budget –, of which 30%, excluding unemployment compensation should be allocated to the health sector until the approval of the budgetary guidelines bill (LDO).

That allocation of these resources to health never actually occurred. For this reason, SUS experienced a serious financing crisis in the years 1990, a crucial decade for the organization of health actions and services to face the growing demand for care.

That conjuncture compelled the Health Ministry to borrow from the Workers Assistance Fund (FAT) so to pay for services provided by public and private health organizations. Such reality gave rise to various projects of Constitutional Amendment (EC) with the aim to define the rule concerning the Union funds to be applied in health. That ended with the approval of EC n° 29/2000, which also defined the investment rules by states, Federal District and municipalities (BRASIL, 2013A), and concurred for the Health Ministry to develop a system that enabled the financing monitoring by subnational entities called Information System on Health Public Budgets (Siops) (BRASIL, 2013B).

In a study aiming to discuss the strategy results of health bonding resources concerning SUS financing within the period 1995-2010, Servo *et al.* (2011) highlighted the important role of EC n° 29/2000 on ensuring greater budget stability and growth in the three levels of Government, especially by the increasing in participation of States and municipalities. The authors emphasized that SUS financing would have been larger if states and Union governments had fulfilled all such Constitutional Amendment prescriptions.

The issue is, after solving the formula to calculate the minimum resources to be invested in Actions on Public Health Services (ASPS), the problem became the very definition of ASPS, since many federated entities would account the costs with retired people, infrastructure works next to health establishments and with sanitation, for example. Therefore, accounting these expenditures as ASPS ones, they would be included for verification of compliance with the minimum allocation of resources. Such situation prompted a series of discussions at the National Health Council (CNS) meetings, as well as the issue of Administrative Rule GM/MS n° 2.047, from 11/5/2002, by the Health Ministry and the Resolution CNS n° 322, 5/8/2003, defining the guidelines as for EC

n° 29/2000 implementation.

More recently, after twelve years of debates on SUS underfunding and the hope the regulation of CF Article 198 would bring a new rule to be applied by Union, apart from additional resources, the Supplementary Law n° 141, of 1/13/2012, was approved progressing the definition of costs that could be considered within ASPS scope, but without changing the resources allocation or establishing new sources of SUS financing (BRASIL, 2013A).

Due to that conjuncture, entities composing the Health Reform Movement gathered signatures so to take before the Congress a bill of popular initiative in defense of the allocation of resources in ASPS by the Union, in a percentage of at least 10% of its Gross Revenue (RCB). It resulted in the signing of 1.9 million people and in the reading before the Chamber of Deputies of the Popular Initiative Bill – PLP n° 321/2013 (SAÚDE+10, 2013). In response, the Government and allies in Congress disregarded the proposition and prioritized the processing of alternative projects in which the financing by Union is defined from a phased percentage of its net revenue (RCL), which, in practice, would result in smaller amount of resources compared to what would had been if PLP were approved. In the end, the Union application rule was changed in the midst of the discussion concerning the Amendment to the Constitution Project n° 358/2013, which became known as imposing budget (the Union's obligation to perform parliamentary amendments resources), resulting in the Constitutional Amendment n° 86/2015.

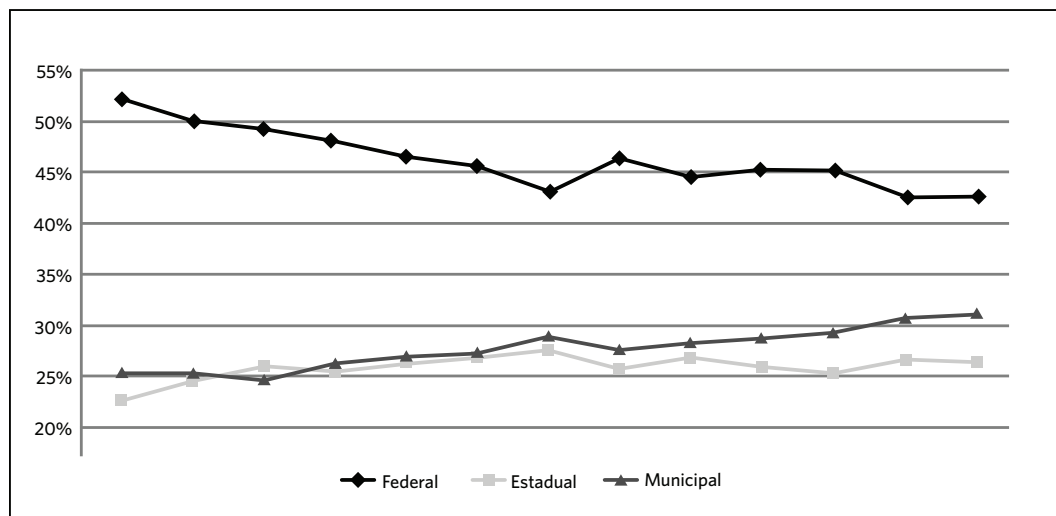
CNS recent analyses estimate that the Ministry of Health will suffer a loss, in 2016, of at least nine billion reais greater than estimated by the previous rule set by EC n° 29/2000 and LC n° 141/2012, given that EC n° 86/2015 predicts, in the first year, the financing by the Union of 13.2% of RCL and that the current economic recession leads to a decreasing in tax revenues. According to CNS, the health budget for 2014 represented

14.38% of the same year RCL, i.e., it was greater than anticipated (13.2%) for the first year of EC n° 86/2015 scheduling (CNS, 2015).

Between 2002 and 2014, the allocation of resources to ASPS by the three levels of Government raised from 94.6 to 216.6 billion reais, in constant values of 2014, a 129%

increase. However, the Union percentage in SUS funding decreased from 52% to 42% in the same period (*graphic 1*). States and municipalities, mainly, have worked to broadening the system funding. States contributions have increased from 23% to 26% as well as the municipalities' ones, from 25% to 31%.

Graphic 1. The performance of the three governments' levels in SUS financing



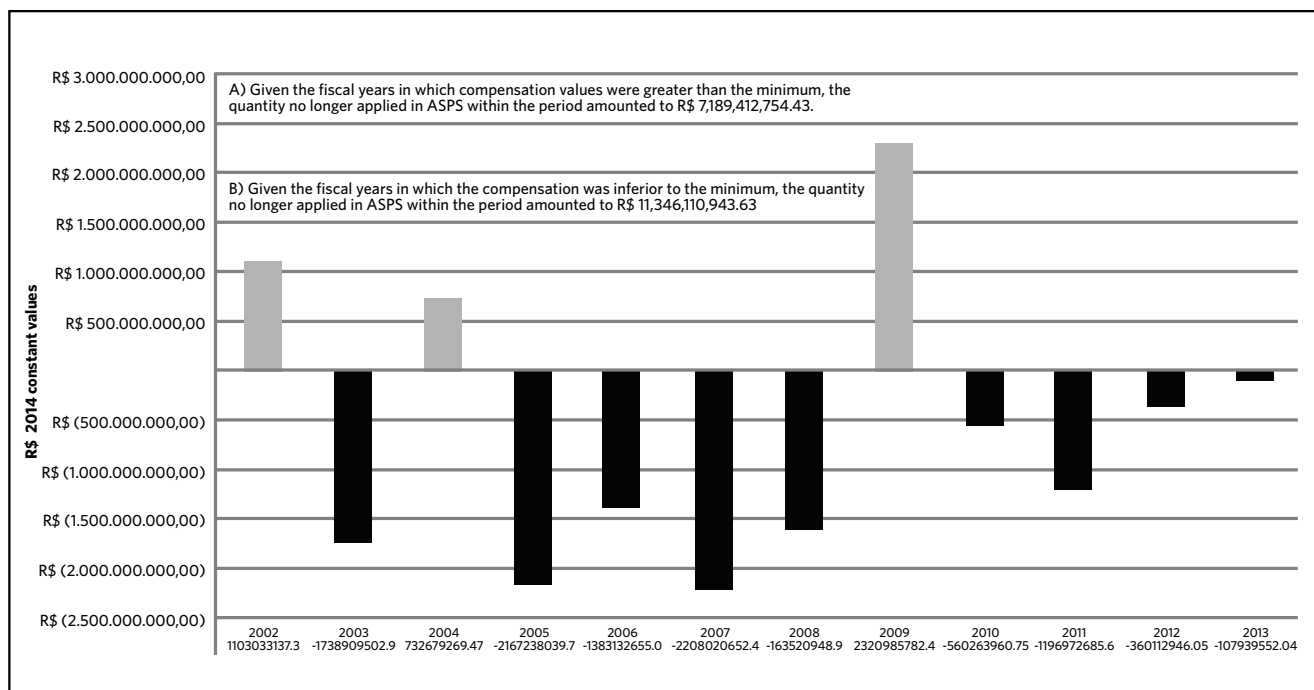
Source: Ministry of Health. Information System on Health Public Budgets (Siops) and Department of Planning and Budget.

Despite the decreasing participation of federal Government's in SUS financing, Machado, Lima and Andrade (2014) claim that efforts have been made regarding a better sharing of resources towards needy regions within the period 2002-2011, although these resources have not yet been sufficient to overcome regional inequalities. The authors highlight that the redistributive efforts were greater in primary care and in epidemiological surveillance, but call the attention to a low spent in epidemiological surveillance. They reinforce, in their assessment, that it cannot be said that health, as a whole, has been a priority for the Governments of that period.

Another issue under debate in CNS regards the unpaid commitments (RP in

Portuguese) related to the Ministry of Health's ASPS expenditure. The expenditure phase applied to the monitoring of the minimum compliance is the expenditure already committed. A high RP entry is noted at the end of the fiscal year as well as cancellations in subsequent fiscal years, although only after LC n° 141/2012 a determination to restore canceled values was provided. So, the debate about that subject lasts over ten years now, because the values were accounted aiming its minimum application in ASPS, but actually did not result in effective actions and services. *Graphic 2* shows the difference between the minimum to be applied and the expenditure committed, deducted from the cancelled RP.

Graphic 2. Difference between expenditures allocated, net of cancelled unpaid commitment, and the minimum value to be applied on ASPS by the Ministry of Health, in R\$ 2014 constant values



Source: The authors.

Note: To obtain the updated accounted expenditures, one deducted from the committed expenditure in each fiscal year the values of processed and non processed unpaid commitment, canceled throughout the period until December 2014. The minimum amount to be applied in ASPS was obtained from the Statement of Health Expenditures of the Budget Summary Report, published by the National Treasury. Values were deflated by the National Index of Price to the Ample Consumer (IPCA).

ASPS expenditure as a percentage of the Gross Domestic Product (PIB) raised from 3.2% to 3.9% from 2002 to 2014, and the expenditure *per capita* in dollars (Purchasing Power Parity – PPC) experienced a significant increase in the same period, from 82.06 to 747.79 dollars. This increase was due also to the resources allocation broadening as to the national currency purchasing power increase, reality that will change in 2015 because of the current political and economic crisis, which leads to the reduction of tax collection with consequent reduction of resources allocated in ASPS, in addition to increasing inflation.

Table 1 shows some health expenditure indicators concerning selected countries. Germany *per capita* expenditure in dollars is five times the Brazilian one, the United Kingdom, four times, and even neighboring

countries not carrying a universal health care system surpass the national expenditure, as are the cases of Argentina and Chile. It is important to note that data contained in table 1 was retrieved from the World Health Organization (WHO), according to which the Brazilian *per capita* government expenditure amounted to 701 dollars. Recently, the Census Bureau (IBGE, 2015) published the Health Satellite Account, updating data expenditure on health in Brazil until 2013. In that document, *per capita* government expenditure in 2013 equaled R\$ 946.21, equivalent to 662.35 dollars (3.6% of GDP), i.e., a value lower than the one presented by WHO. Health total expenditure in Brazil amounted to 8% of GDP and not 9.7%, as shown in table 1. Yet, it was decided to keep WHO data in the table so to compare countries following the same methodology adopted by WHO.

Table 1. Data of health expenditure in selected countries, 2013

Countries	Per capita government expenditure on health (PPP, dollars)	Total expenditure on health as a percentage of GDP (%)	Total government expenditure on health care as a percentage of total government expenditure (%)	Government health expenditure as a percentage of total expenditure on health (%)
Argentina	1167	7,3	31,8	67,7
Australia	2792	9,4	18,7	66,6
Brazil	701	9,7	6,9	48,2
Canada	3322	10,9	18,5	69,8
Chile	795	7,7	15,3	47,4
France	3360	11,7	15,8	77,5
Germany	3696	11,3	19,4	76,8
Spain	2004	8,9	13,9	70,4
United Kingdom	2766	9,1	16,2	83,5
United States	4307	17,1	20,7	47,1

Source: World Health Organization. Countries. Available in: <<http://www.who.int/countries/en/>>. Access in: oct. 2015.

It is also worth mentioning about *table 1* that, among the selected countries, Brazil shows the lowest percentage of Government health expenditure in relation to total Government expenditure (6.9%) and is among the governments with the lowest health expenditure in relation to total expenditure on health (48.2%), equating up to Chile' and USA' indicators, but further from the countries carrying universal health system. Without approaching a discussion on the efficiency of health systems, these indicators reveal how SUS financing falls short of those made by countries choosing to ensure universal access to health services to their citizens and that are recognized worldwide for the quality of those services.

The discussion on SUS underfunding is not a new issue in the national context. As stated earlier, the debate lasts since the system creation and has increased in recent years. But, instead of preserving social

security funding sources, it opts for waiving a series of social contributions, which are their funding sources. According to the National Association of Tax Auditors of Brazil's Federal Internal Revenue Service (ANFIP, 2014), interests on debts and tax expenses showed the greatest increasing over the past two years, favoring the richest, in the first case, and not even being accounted by the government, in the second, so not bringing benefits to society.

In addition to the diminishing of social security revenues by the waivers, the Executive sent to the National Congress, on 8 July 2015, the proposal of Constitutional Amendment n° 87/2015, aiming, in particular, to extend the Union Revenues Untying (DRU) period for eight years, and to increase the untying rate from 20% to 30%. The decision would even more diminish the volume of resources available in the exclusive sources of social security funding, created to preserve social

policies of various political interests.

Concomitantly, given the difficulty to create a new tax under the current context of political and economic crisis with the purpose of reducing the fiscal deficit worsened by public debt increasing, the responsibility of negotiating a new source of SUS funding for the health sector is apparently delegated. For this reason, the former Minister of Health, Arthur Chioro, officially stood for the Provisional Taxing on Financial Transactions (CPMF), but was strongly contested by deputies and senators, who rejected the proposal in less than 24 hours.

Soares and Santos (2014), in a work that discusses SUS financing and resource allocation, claim that a political alignment among Governments under the federal scope was conducted as for health expenditures behavior within the period 1995-2012. The authors highlighted the stagnation of these expenditures in relation to GDP, pleading the commitment of the federal government with the primary surplus targets as a partial explanation.

In a discussion on public funds and social policies funding in Brazil, Salvador (2015) draws the attention to the fact that both play a relevant role in the maintenance of capitalism and in the social contract assurance. The author points out that public funds ensure the expansion of the consumer market and finance countercyclical policies during economic activity slowdowns. Considering these two applications of public resources, he questions whether, in the dispute for public fund resources, the Country will continue to prioritize the financial market and its players or the construction of a social protection system. He states that, as of 2009, the federal government broadened tax waivers as a measure of fighting against the effects of the global economic crisis, worsening even more the Social Security Budget funding. It impaired the shares of states and municipalities in the financing of health and education

policies to the extent that tax waivers also reduced the amount transferred from both the Municipalities Participation Fund and the States Participation Fund.

Incentives to the health private sector

Another important issue concerns incentives to the health private sector. According to Lígia Bahia, quoted by Guimarães (2013, p. 1),

the origin and continuity of health privatization in Brazil are due, above all, to entrepreneurial initiatives and to the state intervention, not to an individual choice. Neither the individuals nor the society (often seen as a bunch of people simply inside anywhere) are the ones to decide about health privatization (free translation).

The 2011 federal tax expenditure was 16 billion reais, equivalent to 22.5% of approximately 70 billion destined to SUS by the Ministry of Health in that year. The deductions with health plans reached R\$ 7.7 billion, covering 24.8 million of individuals – holders and their dependents in the income tax – that accounted for 9.18% of the private health plans revenue, whose net profit grew more than two-and-a-half times in real terms between 2003 and 2011 (OCKÉ-REIS, 2014).

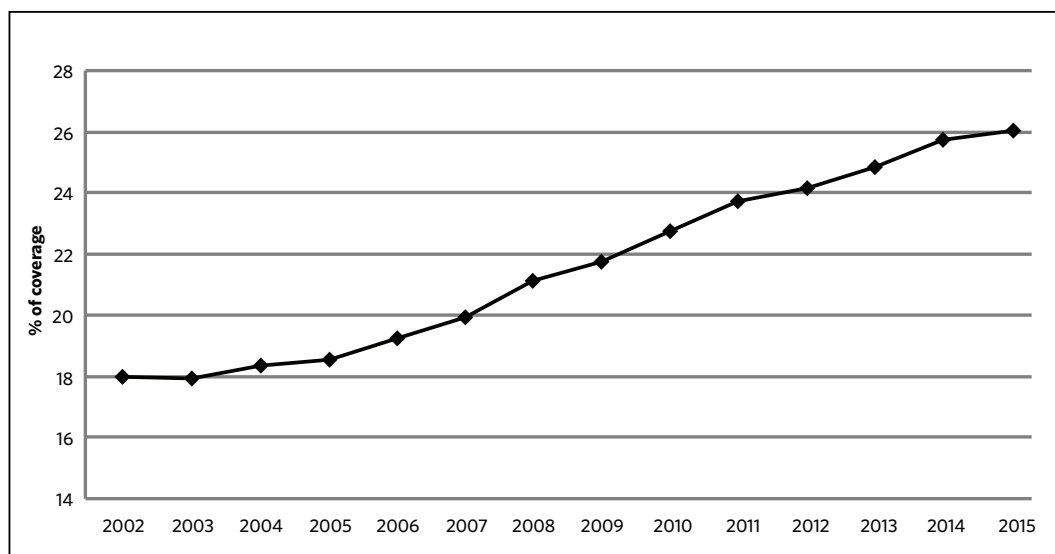
Private health plans financing is not provided exclusively by means of tax waivers. The public administration, in its three levels of government, in many cases, pays benefits to public employees so them to acquire their health plans or provides its own health service. These expenses are not accounted as ASPS, but this gives an idea of the choices being made in terms of health care and its contradiction within the State scope. For instance, the federal budget, by means of the system Siga Brasil (Follow Brazil), showed that the Ministry of Health expenditure with health plans

to their employees achieved 384.4 million reais in 2014.

The various incentives introduced by the Government have contributed to increasing the acquisition of health plans between 2002 and 2015 (*graphic 3*), also raising the coverage

rate from 18% to 26% over the period. Although these data are not related to the beneficiaries, because each beneficiary may carry more than one health plan, the data provide an approximation of the percentage of people covered.

Graphic 3. Coverage rate of health plans contracted for health care in Brazil



Source: National Regulatory Agency for Private Health Insurance and Plans. Coverage rate. (ANS, 2016).

Note: Data refer to the month June each year and the number of contracted plans. A same beneficiary may carry more than one health plan.

Another way of income waiver concerns specific programmes in which the value waived should revert to SUS in the form of projects accomplished by the participating institutions. The projects are approved and monitored by the Ministry of Health, namely, the National Program of Cancer Care Support (Pronon) and the National Programme of Support to Disabled People Health (Pronas/PCD). Both programmes are funded by the income tax deduction to donors, individuals and legal entities, in accordance to Law nº 12,715/2012, and to Support Programme to SUS Institutional Development (Proadi-SUS), currently regulated under the Law nº 12,101/2009.

Proadi is composed of only six very well-known philanthropic private hospitals. Albert Einstein Hospital, Oswaldo Cruz German Hospital, Hospital do Coração, Hospital Samaritano and Syrian-Lebanese Hospital are located in the city of São Paulo; and Hospital Moinhos de Vento is located in the city of Porto Alegre. Institutions wishing to participate in Pronon and Pronas must accredit previously so to pass projects before the Ministry of Health. In 2013, Pronon's waiver amounted to approximately 74.7 million reais, while Pronas' added to 70.8 million and Proadi's totaled 325.4 million reais (BRASIL, 2015A).

Mendes and Weiller (2015) criticize, in an

article that examines the impact of health tax waiver on SUS financing, the transformation of the right to health into a guarantee of products and services consuming, and highlight the process of health policy commodification. The authors argue that, to face SUS lack of resources, one should be concerned with the persistence of fiscal incentives to the private health sector. This is an issue that deserves a broader debate.

Recent threats to health as a social right

In addition to the issues already identified against the guarantee of right to universal and egalitarian health, it is important to note the approval of another incentive measure to the health private sector taken by the Brazilian Government, once again strengthened by the approval of Law nº 13,097, of 1/19/2015. This law allows for the direct or indirect participation of companies and the control by companies or foreign capital over health care to establish, operationalize or explore general hospitals, including the philanthropist ones, specialized hospitals, polyclinics, general clinics and specialized clinics, among others. Previously to its approval, this measure was highly criticized by public health entities and even deserved a disclosure note of rejection by the National Board of Health (CNS, 2014).

According to Sá *et al.* (2015), among the risks brought by foreign capital, one can mention: pressure on the labor market, resulting in migration of professionals from the public to the private sector, mainly physicians; strengthening of the health sector segmentation; worsening of inequality and increasing in the volume of resources used to subsidize private health care consuming.

These decisions clearly aimed to stimulate the private offer of health plans and services, and they seem to be coordinated. Note the case of PEC nº 451/2014, which proposes

to include health care plan in the package offered by the employer as a fundamental guarantee to the employee. In case the proposal is approved, the logic of health as a social right would be greatly affected, and SUS would supply services solely in a residual basis for those not formally inserted in the labor market, therefore unable to afford a health insurance. The focus is addressed to the health services consuming and the market dynamics, forcing, once again, public health entities, in this case, eight of them, to publish a joint note accusing PEC nº 451/2014 of

leading to the resuscitation of a reality worse than that lived during Inamps former times, because it now assures insurance companies and private health companies to have a captive market guaranteed by the Constitution. (CEBES *ET AL.*, 2015; FREE TRANSLATION).

Shortly after the submission of PEC nº 451/2014, the President of the Senate announced on the House behalf a series of proposals for tackling the economic crisis, which was named Agenda Brazil, among which the assessment of a differentiated charging for SUS procedures stratified by income range (BRASIL, 2015B). Once again, the principle of health universality was threatened, generating strong reaction of movements in defense of the right to health and causing the Senator to withdraw the proposal from the Agenda (BORGES, 2015).

Comments

Concerning the difficult path of SUS financing, Mendes (2014) comments some constraints experienced over the years 2000: (a) the Union Revenue Untying (DRU), which deducts 20% on the amount collected from social contributions; (b) the creation of the CPMF, initially addressed to funding health, but that ended as a replacement of sources in

SUS financing; (c) the tension caused by the approval of EC n° 29/2000, which carried a lack of definition about ASPS concept and a different rule for the Union in relation to states and municipalities; (d) the advances of the government economic team against health financing ties; (e) the postponement of EC n° 29 regulation in Congress, delayed until 2012; (f) the threat of the Tax Reform proposed by Lula administration, imposing losses to social security; and (g) the insufficient resources for SUS financing after the EC n° 29 regulation.

The various decisions and discussions taken place within the scope of the Executive and Legislative Powers in recent years lead to a reflection about the future of the well-being in Brazil, especially as for health as right. Although many politicians are elected with a speech pro SUS and bound to its consolidation, their decisions and defenses actually contradict the pre-election speech.

The system funding inadequacy is a chronic problem that was aggravated over the last two years and shows a negative perspective for 2016. The federal Government's effort to allocate resources beyond the minimum determined by the Constitution has not been noted, on the contrary, part of the resources allocated remains as unpaid commitments, part of which is procrastinated over the years only to be later cancelled, leading, in many fiscal years, to an ASPS provision inferior to the minimum determined.

Obviously, such situation impacts the access to and quality of services, something that was not explored in this text. But it is worth to at least mention that the need for investment in health is huge. However, despite all these difficulties, it is possible to affirm that progresses can be noted, although it is quite a challenge to measure health participation in the improvement of the people quality of life since there are many variables of confusion due to the

fact that health situation is strongly determined by the socio-economic conditions of individuals.

While public health financing is not prioritized, tax waivers to incentivize the private sector health plans have increased. This reality, coupled with PEC n° 451/2014 proposal and the SUS charging provided for in the original version of Agenda Brazil, reinforces the understanding of health as a commodity rather than as a social good. As a consumer, every individual has access to health services he/she can afford, since the private sector can offer a great range of different health plans for different income strata. Because health plans are considered a commodity and whereas part of the population is prevented from consuming even the cheapest ones, the State takes on a residual role with the purpose to intervene in market flaws. Similar example recently occurred in the United States with the programme ObamaCare, in which the State, in addition to implementing health care programs for the elderly and poor, created a subsidy for those who neither pertained to these two groups nor could afford a health plan.

That was not the option in the 1988 Constitution, which set out health as right of all and duty of the State. Health as right has as basis the promotion of equality between citizens, the solidarity and the social cohesion. Brazil should not regress. Europe has shown that, despite the economic crisis, it is possible to adopt measures to prepare individuals for the new realities of the labor market without significantly changing the universal access services, including health.

In this context, Santos (2015) ponders that there is a breakdown of scenarios, hopes of dispute and power exercises based on the promise to use power for the common good, in a way that increases the search of means for the exercise of power to be restructured, democratized and

compelled to be controlled by society. In this sense, the author warns that: the resumption of SUS initial course is linked to the reversal of the current State policy and the national and global macroeconomic context as well; for such reversal, SUS supporters are indispensable, but not sufficient; social participation and sense of belonging in the debate about allocation of public resources are essential for the decisions on system financing and private plans subsidize to become scrutinized by the actual funder of

such policies, the citizen.

The recent political and economic crisis in Brazil cannot serve as a motto for dismantling an important social policy as health, on the grounds of its financial non sustainability. As affirmed in this text, it has been a long time now since decisions have been taken to favor the private health sector rather than SUS. The population needs to be more vigilant and aware of what is at stake to clearly fight for the State we want. ■

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