

## Underfunding and federal budget of SUS: preliminary references for additional resource allocation

Francisco Rózsa Funcia (<https://orcid.org/0000-0002-5410-6367>)<sup>1</sup>

**Abstract** *This paper aims to identify new sources of revenue for the additional allocation of resources to meet the population's health needs fixed in the federal budget expenses, in the context of the Unified Health System (SUS) underfunding process and the negative effects of Constitutional Amendment 95/2016 for this process – verified decrease in the proportion of federal net current revenue destined to SUS. From this perspective, it is necessary to address the problem of underfunding by linking the search for additional resources with new sources of funding with actions and public health services that will be improved, expanded and created, of which criteria are: regarding sources, exclusivity for SUS, non regressive taxing and review of revenue waiver; and, regarding uses, prioritization of primary care as reference of the health care network and appreciation of civil servants in the health area. The result calculated for the sources ranged from R\$ 92 billion to R\$ 100 billion, higher than the R\$ 30.5 billion calculated for uses under the described terms. A documentary research was conducted to collect data from secondary sources, especially in the reports sent to the National Health Council by the Ministry of Health.*

**Key words** *Public Health, Health System Funding, Healthcare Funding, Health Economics.*

<sup>1</sup> Universidade Municipal de São Caetano do Sul. R. Santo Antonio 50, Centro. 09521-160 São Caetano do Sul SP Brasil. francisco.r.funcia@gmail.com

## Introduction

The processes of planning, monitoring and evaluation of public policies in Brazil are based on the actions and goals established in the Brazilian public sector legal instruments – Multiyear Plan (PPA, *Plano Plurianual*), Budgetary Guidelines Law (LDO, *Lei de Diretrizes Orçamentárias*) and Annual Budgetary Law (LOA, *Lei Orçamentária Anual*), which express the Brazilian budgetary cycle: according to Vignoli & Funcia<sup>1</sup>. Based on the PPA (quadrennial), the guidelines and priorities are established annually through the LDO, which, in turn, is the reference for detailing the budgetary actions in the LOA of each government entity (Federal Government, states, Federal District and municipalities).

These instruments, in turn, should express the health programs that were detailed as objectives and respective goals in the Health Plans (which are directly related to PPAs) and the Annual Health Programs (which are directly related to the LDOs and LOAs).

Arretche<sup>2</sup> warns that unpredicted political and economic situations of budgetary and financial constraints may result in the partial revision of both planned programming and public policy objectives. Regarding this issue, in the case of the Brazilian Universal Public Health System (SUS), Arretche<sup>3</sup> emphasizes the dependent feature of local governments regarding the transfer of resources from the Federal Government for the implementation of health policies.

Therefore, the implementation of the health policy in Brazil based on the Federal Constitution of 1988 was partially conditioned by the chronic SUS underfunding process – which may be characterized by the insufficient allocation of budgetary and financial resources, both to fully comply with the constitutional principles of universal access, integrality and equity, and to make an equitable comparison with other countries that adopt a public health system similar to Brazil, according to studies by Marques et al.<sup>4</sup>, Mendes & Funcia<sup>5</sup> and Piola & Barros<sup>6</sup>.

As a complement, Marques<sup>7</sup> defines this chronic feature of SUS underfunding process as being structural in nature, since there was no “massive and class support” to this public health system in the presence of neoliberalism, of the dependent dynamics of the Brazilian economy in relation to developed countries and the fragility “of the economy in the presence of foreign capital flows and the importance assumed by the generation of primary surpluses to honor the debt

service (...)”. These factors adversely affected the federal budget and, particularly, the health budget, which was approximately 1.6% and 1.7% of the Gross Domestic Product (GDP) throughout the 21<sup>st</sup> century.

Santos Neto et al.<sup>8</sup> considers that one of the negative consequences of this underfunding process of SUS is related to the limitation to the implementation of primary (or basic) care priority as the reference for the population’s health care network.

This loss was also mentioned by Ocke-Reis<sup>9</sup>: considering SUS underfunding, the fiscal waiver resulting from the hiring of private health plans promotes the reduction of “financial resources that could be allocated to expand prevention programs and improve the quality of specialized health services, essential for the consolidation of SUS”.

The structural issue of the previously addressed chronic SUS underfunding process is also present in the reflection proposed by Noronha et al.<sup>10</sup>: “A structured, functional and not underfunded Unified Health System creates many difficulties, if not makes it unfeasible, for the capital to operate both in the health insurance market and in the provision of private health services”.

As expenses in the LOA will only be programmed when corresponding to the funding capacity (or estimated revenue) for this purpose, the chronic underfunding process of the Unified Health System (SUS) is one of the conditioning factors of the population’s health needs that will be met by each year.

In this context, the aim of this introductory article is to identify new sources of revenue for the additional allocation of resources to meet the population’s health needs through the federal budget expenditure programming.

For that purpose, the article is structured in two sections, in addition to this introduction and the final considerations: the first deals with the adopted methodology; in the second, the results are divided into four subsections that address (i) the negative effects of Constitutional Amendments 86/2015 (CA 86) and 95/2016 (CA 95) for SUS funding; (ii) the spending floor for the funding of health actions and services in the federal budget of SUS of 2019; (iii) the aspects of budget and financial execution of the Ministry of Health (MoH) in 2017 and 2018; and (iv) the criteria raised to subsidize the debate regarding the identification of sources of revenue and the allocation of additional resources to SUS.

## Methodology

From the methodological point of view, a documentary research was carried out based on studies and, mainly, documents sent to the National Health Council (CNS, *Conselho Nacional de Saúde*) by the MoH, specifically the Annual Management Reports (2014 to 2017 – the last year available at the time when this report was written) and the Quarterly Accountability Reports (2016 to 2018), both available for consultation at <http://bvsmis.saude.gov.br/>, as well as the monthly budget and financial execution worksheets of federal health expenditure (committed, settled and paid, including the remains to be paid), prepared by the Planning and Budget Subsecretariat/MoH as approved by the CNS and that are part of these reports, which allow assessing the level of expense settlement.

These spreadsheets contain the identification of expenses classified as public health actions and services (PHAS) for the calculation of compliance with the spending floor under Complementary Law No. 141 (CL 141), which also defined the content of the aforementioned reports and the basic procedures of the planning and accountability process that the SUS manager must follow.

Finally, the effects of alterations in the rules for federal funding of SUS established by the CA 86 and CA 95 for resource allocation were considered, as well as data from the Public Health Budget Information System (SIOPS, *Sistema de Informações sobre Orçamentos Públicos em Saúde*), to assess the evolution of state and municipal investments with their own resources, and from the websites of the Central Bank, National Treasury Secretariat, Internal Revenue Service Secretariat and the Brazilian Institute of Geography and Statistics (IBGE, *Instituto Brasileiro de Geografia e Estatística*), to complement the analysis performed. The international comparison of health investments was based on data from the World Health Organization.

## Discussion and Results

### Constitutional Amendments 86/2015 and 95/2016 and the underfunding process of SUS

The CA 86 and CA 95 introduced provisions that had negative effects on the budget and financial planning and execution of the Ministry of

Health, aggravating SUS underfunding process: the first established the mandatory budget execution of individual parliamentary amendments at 0.6% of the Net Current Revenue as part of expenses that are computed for the federal spending floor; and the second withdraws budgetary resources as of 2018 (based on the federal spending floor related to the figure verified in 2017) and SUS funding as of 2017 (based on the overall “ceiling” of primary expenses paid in 2016), both updated according to the annual IPCA (Broad Consumer Price Index)/IBGE variation until 2036, even if there is revenue growth – which will reduce these expenses in *per capita* terms as a result of population growth during the same period.

The main motivation for the promulgation of CA 95 was the need to reduce the primary deficit (negative difference between primary revenues and expenses) through a fiscal adjustment focused on reducing these expenses to generate primary surplus to fund financial expenses (mainly interests and the amortization of public debt) which, unlike primary expenses, will not be limited until 2036 and will not be audited, either.

This type of recessive fiscal adjustment, effective for twenty years starting at the end of 2016, made the process of resuming economic growth unfeasible, jeopardizing the living and health conditions of most of the population, especially due to unemployment and the falling income levels, still present in 2019. In this context of the financial “ceiling” of federal expenses until 2036, the pressure for additional allocation of state and municipal resources for SUS funding increases.

However, according to Funcia<sup>11</sup>, the Federal Government’s participation in the SUS funding process was reduced from 73% to 43% in the period of 1991-2017, counterbalanced by the increased allocation of resources at state (from 15% to 26%) and, mainly municipal level (which grew 2.5-fold in that period – from 12% to 31%).

Chart 1 illustrates the growth in the percentage of investments in public health actions and services (PHAS) with their own resources in the period 2004-2017 by the state and municipal levels of government. While the states have been applying percentages close to the minimum parameter of 12% of the state public revenue baseline, the municipalities have increasingly applied percentages that are far above the minimum parameter of 15% of the municipal public revenue baseline – these parameters were established by CA 29 and by CL 141.

Considering this scenario, the capacity to expand the percentages of PHAS investment with

their own resources by these levels of government, especially the municipal government, is also restricted when analyzed together with the constitutional competencies of taxation and the available revenue of each entity of the Federation, respectively: according to Afonso<sup>13</sup>, the Federal Government (69% and 57%); states (25% and 25%); and municipalities (6% and 18%).

In other words, even after intergovernmental transfers (according to the concept of available revenue), the Federal Government still holds most of the resources, which has made the constitutional decentralization of the health policy excessively dependent on federal transfers, in the case of SUS, almost a fund-to-fund modality – nearly 2/3 of the Ministry of Health budget is spent on these transfers to state and municipal health funds.

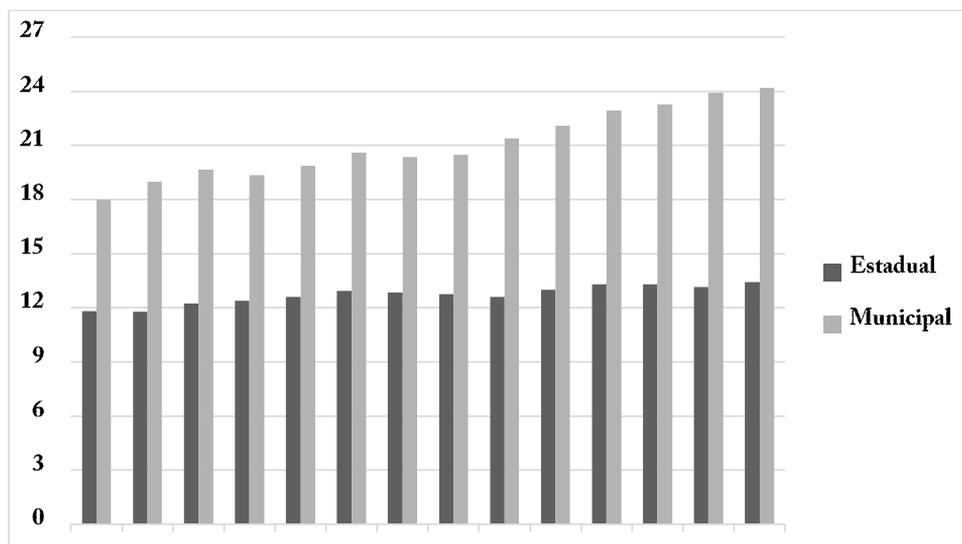
#### PHAS spending floor in the Federal Budget for SUS in 2019

The values of the PHAS spending floor in the Federal Union Budget in 2019 is R\$ 117.293 billion and R\$ 560.41 *per capita*, below the respective committed values from 2014 to 2018

(considering 2019 prices). These values represent 13.87% of the federal net current revenue (RCL, *Receita Corrente Líquida*) and 1.65% of the Brazilian GDP, which is below the amounts observed in 2017 and 2018, as shown in Table 1.

The SUS federal budget also shows a strong component of parliamentary participation regarding the decision-making of the actions that will be undertaken: according to Funcia<sup>11</sup>, in 2018, the committed PHAS expenses related to parliamentary amendments was R\$ 8.841 billion – which represented 7.6% of total PHAS expenses and 83.0% over R\$ 4.832 billion (calculated according to the rule established by CA 86, i.e., 0.6% of the Federal Net Current Revenue for the mandatory execution of individual amendments).

Considering other data analyzed for the 2019 budgetary programming, the PHAS expenditure of the National Health Fund (R\$ 106.363 billion) – the Ministry of Health's budgetary unit that has the biggest allocation of resources when compared to the others – is only 0.63% (in nominal terms) higher than the amount executed in 2018 (R\$ 105.692 billion), that is, below the 3.90% inflation projected for 2019, which represents a real decrease in resources, also observed for most



**Chart 1.** States and municipalities: investments with their own resources in public health actions and services (in % of the respective public revenue baseline).

Source: The author. Adapted from Brazil, Ministry of Health /SIOPS12.

of the selected expenses (over R\$ 500 million) of this unit, as shown in Table 2.

The selection of FNS expenses above R\$ 500 million represents approximately 96% of the total expenses of this unit: of the 18 selected ones, 12 showed a nominal variation of resources for 2019 below the projected inflation of 3.90%. Of these, 8 show a negative nominal variation and 4 show a variation between zero and 3.90%.

Among the ones with negative variations, are amendments associated with the National Health Fund (-5.23%), Indigenous Health (-7.48%), Exceptional Medications (-23.31%) and Modernization of SUS/MoH Units (-36.47%). The negative variation in Vaccines and Vaccinations (-19.90%) results from changes in budget reallocation and expense execution procedures – from the National Health Fund to Oswaldo Cruz Foundation (the item value in this unit shows significant nominal and actual growth).

In the case of positive variations, the highlights are Basic Pharmacy Program-PAB (20.67%), SUS Professional Training (16.7%), Financial Incentive-Health Surveillance (13.55%) the Family Health Program (11.71%). However, as the consolidated variations in FNS expenses and FNS selected expenses are similar (0.63% and 0.40%, respectively), it can be inferred that there was an internal reallocation in the expense scheduling process, of which result shows a nominal change below inflation.

### Aspects of Budgetary Execution of the Ministry of Health in 2017 and 2018

Expenses committed to the Health Function (PHAS and non-PHAS) in 2017 were analyzed according to the main sub-functions of government that are part of the Ministry of Health's budget allocations, highlighted as follows: Primary Care (AB), Hospital and Outpatient Care (AHA), Prophylactic and Therapeutic Support (SPT), Epidemiological Surveillance (VE), Health Surveillance (VS) and Other Subfunctions (OSF).

Chart 2 shows the percentage share of expenses by government subfunction from 2009 to 2017, with a strong predominance of resource allocation to AHA. During this period, the expense ratio between the "AB/AHA" subfunctions increased from 2009 to 2014 and then stopped growing, considering the average of the period from 2014 to 2017, which may have been the result of a change in health policy orientation, combined with the effects of CA 95.

**Table 1.** Ministry of Health: Assessment of Expenses Committed to Public Actions and Health Services from 2014 to 2018 and the Federal Spending Floor for the year 2019.

Year	Population <sup>1</sup> (in millions of inhabitants)	Net Current Revenue (RCL) <sup>2</sup> in R\$ million (at current prices)	GDP <sup>3</sup> in R\$ billion (at current prices)	Update Factor 4 (at 2019 prices)	Ações e Serviços Públicos de Saúde (ASPS)			Despesas Empenhadas <sup>5</sup>		
					R\$ million (at current prices)	R\$ per capita (at current prices)	R\$ million (at 2019 prices)	R\$ per capita (at 2019 prices)	Proportion of RCL	Proportion of GDP
(A)	(B)	(C)	(D)	(E)	(F)	(G=ExD)	(H=FxD)	(I=E/B)	(J=E/C)	
2014	202.8	641.578	5.779	1.32410	91.899	453.15	121.683	600.02	14.32%	1.59%
2015	204.5	674.523	5.996	1.21594	100.055	489.27	121.661	594.92	14.83%	1.67%
2016	206.1	709.930	6.267	1.11715	106.236	515.46	118.681	575.84	14.96%	1.70%
2017	207.7	727.254	6.554	1.08462	114.701	552.24	124.407	598.98	15.77%	1.75%
2018	208.5	805.348	6.828	1.03900	116.821	560.29	121.377	582.14	14.51%	1.71%
2019	209.3	845.489	7.113	1.00000	117.293	560.41	117.293	560.41	13.87%	1.65%

Source: The author. Adapted from Brazil, Ministry of Health/SPO14, Brazil; Ministry of Finance/STN15, Central Bank of Brazil/16 and Brazilian Institute of Geography and Statistics/17.  
Notes: (1) For 2019, the author's projection is based on the population growth rate in 2018 calculated based on the Brazilian Institute of Geography and Statistics/17. (2) For 2019, we adopted the updated predicted value in Brazil, Ministry of Finance/STN15. (3) For 2019, the author's projection is based on the nominal variation in the Gross Domestic Product in 2018 available from the Brazilian Institute of Geography and Statistics/17. (4) Calculated based on the Broad Consumer Price Index accumulated in 12 months from June 2014 to 2018; for 2019, the author's projection of 3.9% is based on the Central Bank of Brazil/16. (5) For 2019, the PHAS federal spending floor value was considered, calculated by the author based on the CA 95 rule.

**Table 2.** Ministry of Health – National Health Fund: main expenses committed in 2018 and programmed in the 2019 budget (in R\$ 1,00 at current prices).

Denomination	Committed in 2018	2019 Budget – Law No. 15.808, of January 15, 2019	
		Updated allocation	Nominal Variation
Medium and High Complexity - MAC (AIH/SIA/SUS)	45,969,387.567	47,654,958.293	3.67%
Family Health Program - PACS/PSF	14,621,624.798	16,333,096.000	11.71%
National Health Fund Amendments	8,742,641.033	8,285,251.901	-5.23%
Exceptional Medications	7,217,097.546	5,535,000.000	-23.31%
Primary Care Floor - Fixed PAB	5,150,326.716	5,150,250.000	0.00%
Vaccines and Vaccination - FNS	4,833,287.751	3,871,616.889	-19.90%
Financial Incentive - Health Surveillance	2,025,618.443	2,300,000.000	13.55%
Popular Pharmacy Program - FNS	2,092,605.081	2,040,000.000	-2.51%
Basic Pharmacy Program - PAB	1,499,930.865	1,810,000.000	20.67%
Indigenous Health	1,519,665.569	1,406,000.000	-7.48%
Blood and Blood Products Program	1,380,956.000	1,378,538.497	-0.18%
Drug Acquisition and Distribution / STD / AIDS	1,260,799.999	1,316,000.000	4.38%
SUS Professional Training	1,015,522.259	1,185,115.000	16.70%
Emergency mobile care service - SAMU	1,078,357.951	1,100,000.000	2.01%
Social Pioneers	1,065,000.000	1,065,000.000	0.00%
Modernization of SUS / MoH units	1,475,799.206	937,570.102	-36.47%
SUS Hospitals	711,219.181	701,404.787	-1.38%
Total Selection	101,659,839.965	102,069,801.469	0.40%
National Health Fund - FNS	105,691,749.926	106,362,473.422	0.63%
Proportion–FNS Selection/Total	96.2%	96.0%	

Source: The author. Adapted from Brazil, Ministry of Health/SPO<sup>14</sup>.

According to Funcia<sup>11</sup>, in 2017, there was also a growth in both year-end commitments (above 81%) as well as the enrolled and re-enrolled remains to be paid for execution in that year (above 50%). Both situations can be explained by the financial ceiling of CA 95/2016, which conditioned the settlement and payment of expenses committed in 2017 and the remains to be paid. Although to a lesser extent, this fact occurred again in 2018, showing a new level of enrollment and re-enrollment of remains to be paid – around R\$ 20.0 billion, above the R\$ 14.0 billion recorded in 2016.

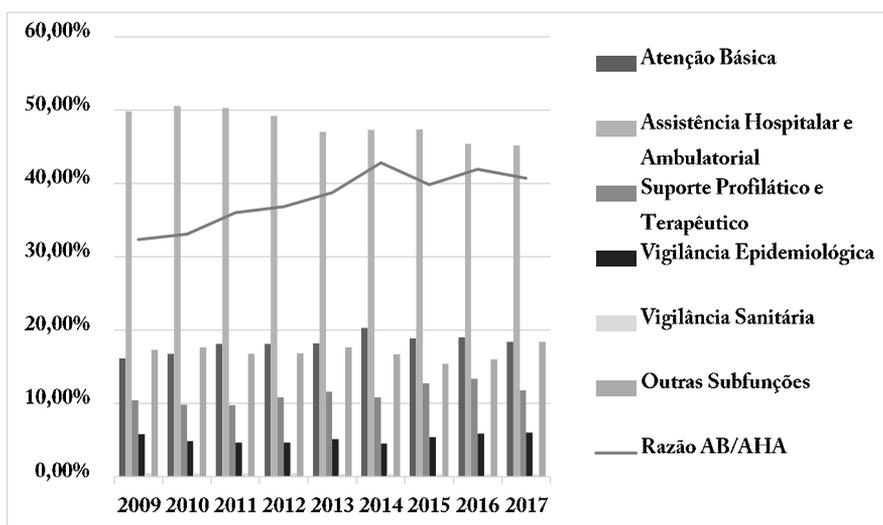
Regarding the budgetary and financial execution of the Ministry of Health in 2018, there is an indicator of the level of expense settlement, taking as reference the parameters adopted by the Budget and Finance Committee of the National Health Council (Cofin/CNS) to analyze the implementation of the expenses executed by the Ministry of Health. Table 3 shows the expense items of the National Health Fund with low execution, demonstrating a recurring behavior during the analyzed periods. This low level of liquidation may be related to both the dynamics of budgetary execution, where the speed of expense

execution influences the allocation of resources (which are scarce and of alternative uses) during the year, as well as the effects of CA 95.

#### Criteria for the Identification of Sources and Additional Resource Allocation

The debate about the need for additional resources for SUS funding has shown that there is no contradiction between those who advocate such need and those who want to prioritize the management. It is even possible to affirm that it is necessary to allocate more budgetary and financial resources to SUS in order to allow management improvement – after all, considering the three spheres of government, SUS spent approximately R\$ 3.60 *per capita* per day, according to Funcia<sup>11</sup>.

The National Health Council<sup>18</sup> approved a document containing references to new sources of funding: “to be destined exclusively to SUS and primarily for public actions and services, without increasing the current regressive taxation characteristic in Brazil” and “to have previously defined the allocation of these resources to



**Chart 2.** Ministry of Health - Percentage share of the main sub-functions in terms of committed values and ratio between “Primary Care/Hospital Outpatient Care” subfunctions in the period 2009-2017.

Legend: AB = Primary Care; AHA = Hospital Outpatient Care.

Source: The author. Adapted from Brazil, Ministry of Health/SPO14.

change the care model, so that primary care is the reference of care, and for the and appreciation of civil servants in the health area”.

Considering these references, what would be the estimates of these additional resources and what expenses could the expanded budgetary and financial resources have?

In response to the first question, three estimates follow:

If the “Health +10” Project (Complementary Law 321/2013) had been approved by the National Congress, the SUS would have a minimum investment of 10% of the Federal Government’s Gross Current Revenues (RCB) – according to Brazil National Treasury Secretariat<sup>15</sup>, the RCB was R\$ 1,535,662,595,325.00 in 2018 -which would correspond to R\$ 153.566 billion, that is, an additional annual allocation of resources to the SUS federal budget of approximately R\$ 36.0 billion, compared to what was committed in PHAS in 2018 (R\$ 117.293 billion, according to Table 1 of this article);

If, as a result of a public debt audit process, it was possible to reduce R\$ 200.0 billion of interest and amortization expenses of public debt from an estimated total of R\$ 1,065,725,301,673 in

2018, according to *Auditoria Cidadã da Dívida*<sup>19</sup>, half of this amount (R \$ 100.0 billion), when the country once again had a primary surplus, could be allocated annually to SUS; and

If the federal revenue waiver, estimated by Brazil, the Internal Revenue Secretariat<sup>20</sup> at R\$ 306.4 billion for 2019, were audited, revised and reduced by 30%, there would be approximately R\$ 92 billion of additional revenue for the National Treasury, which could be allocated for SUS funding. Part of this amount could be obtained from the auditing, reviewing and reduction of health-related revenue waivers – according to Ocke-Reis<sup>9</sup>, this amount in 2015 was R\$ 32.3 billion (equivalent to 11.7% of the total), with R\$ 12.5 billion related to “subsidies that sponsor the consumption in the health insurance market”.

In brief: the estimates of additional resources for SUS previously presented in “b” and “c” (respectively, R\$ 100 billion and R\$ 92 billion per year) are far above those required by the “Health+10” Project, in addition to allow federal funding to increase consolidated health expenses (sum of the three government spheres) to figures between R\$ 300 and R\$ 365 billion (or between 4.3% and 5.4% of GDP) – still below the inter-

**Table 3.** Ministry of Health – National Health Fund – Groups of expense items with low execution according to the liquidation levels<sup>1</sup> classified as intolerable and unacceptable in the 3rd quarter of 2018 (and the classification in the previous quarters and semesters as of 2016).

Denomination	2016-1 <sup>st</sup> q		2016-2 <sup>nd</sup> q		2016-3 <sup>rd</sup> q		2017-1 <sup>st</sup> q		2017-1 <sup>st</sup> s		2017-2 <sup>nd</sup> q		2017-3 <sup>rd</sup> q		2018-1 <sup>st</sup> q		2018-1 <sup>st</sup> s		2018-2 <sup>nd</sup> q		2018-3 <sup>rd</sup> q		
	%	Liq																					
Other Programs	10.10	21.86	29.07	50.17	6.35	11.08	14.76	32.73	52.12	LM	69.48												
Fighting Nutritional Needs	0.00	5.08	5.08	12.39	0.00	0.00	0.00	65.89	0.00	0.00	0.00	0.00	65.89	0.00	0.00	0.00	0.00	0.00	0.00	32.94	0.00	32.94	65.87
Data Processing Service – Datasus	LM	LM	LM	LM	4.43	13.14	21.65	56.34	5.74	19.42	5.74	19.42	5.74	19.42	5.74	19.42	5.74	19.42	5.74	19.42	5.74	19.42	65.73
Exceptional Medications	21.33	LM	LM	LM	21.05	LM	LM	LM	7.68	18.46	7.68	18.46	7.68	18.46	7.68	18.46	7.68	18.46	7.68	18.46	7.68	18.46	65.02
Vaccines and Vaccination	12.64	27.92	LM	73.12	17.54	LM	LM	68.88	3.97	30.08	3.97	30.08	3.97	30.08	3.97	30.08	3.97	30.08	3.97	30.08	3.97	30.08	59.74
Restructuring of Federal University Hospitals – Rehuf	1.13	22.67	41.35	LM	0.00	18.13	27.83	72.84	0.10	8.78	0.10	8.78	0.10	8.78	0.10	8.78	0.10	8.78	0.10	8.78	0.10	8.78	54.75
Promoting Science and Technology Research	0.00	7.73	8.32	39.97	0.24	10.04	11.13	39.04	0.40	1.98	0.40	1.98	0.40	1.98	0.40	1.98	0.40	1.98	0.40	1.98	0.40	1.98	47.27
Family Health Programming and Structuring – Proesf	0.00	20.94	34.81	LM	na	na	28.76	52.21	0.22	14.61	0.22	14.61	0.22	14.61	0.22	14.61	0.22	14.61	0.22	14.61	0.22	14.61	43.16
Acquisition and Distribution of Strategic Medicaments	1.35	30.47	40.48	62.71	14.35	17.65	25.71	47.59	4.32	22.07	4.32	22.07	4.32	22.07	4.32	22.07	4.32	22.07	4.32	22.07	4.32	22.07	42.00
Epidemiological Surveillance Actions	9.49	16.14	23.26	42.02	4.96	10.46	26.69	57.17	5.30	10.19	5.30	10.19	5.30	10.19	5.30	10.19	5.30	10.19	5.30	10.19	5.30	10.19	29.68
Modernization of SUS Units/MS	14.88	19.12	23.40	41.89	2.60	6.56	11.91	10.53	1.48	4.46	1.48	4.46	1.48	4.46	1.48	4.46	1.48	4.46	1.48	4.46	1.48	4.46	23.37
Women, Child, Adolescent and Young Adult Health Care Attention	2.14	24.39	25.10	39.96	1.71	7.25	9.51	26.37	0.00	0.01	0.00	0.01	0.00	0.01	0.00	0.01	0.00	0.01	0.00	0.01	0.00	0.01	17.99

Note: (1) The liquidation level is obtained by dividing the amounts of the liquidated expenses and the updated allocation; indices expressing a classification of liquidation levels better than “unacceptable” and “intolerable”, not dealt with in this article, were not depicted in this table. Legend: q = quarter; s = semester; Liq = Liquidation level; LM = Liquidation level with a better classification than “unacceptable” and “intolerable”; na = information is not available.

Source: The author. Adapted from Brazil, Ministry of Health/SPO<sup>14</sup>.

national minimum parameter of 7.9% of GDP found for universal health access systems, such as that of the United Kingdom, according to the World Health Organization<sup>21</sup>.

As for the answer to the second question (“what expenses could the expanded budgetary and financial resources have?”), if there was a political decision aimed at:

Reviewing the health care model to strongly prioritize primary care and, among the initiatives for this purpose, a proposal to quadruple the amount of expenditures committed to Primary Care Floor-Fixed PAB in 2018 (R\$ 5,150 billion), according to Brazil, Ministry of Health/SPO<sup>14</sup>, would require R\$ 15.500 billion/year of additional resources;

Strengthening pharmaceutical assistance and, among the initiatives for this purpose, a proposal to quadruple the budgetary resources for Basic Pharmacy-PAB compared to the amount committed in 2018 (R\$ 1,500 billion), according to Brazil, Ministry of Health/SPO<sup>14</sup>, would require approximately R\$ 4.5 billion/year of additional resources;

Increasing by 50% the amount of expenses committed with the Community Health Agents Program and the Family Health Program (PACS/PSF) by the Ministry of Health in 2018 (R\$ 14.622 billion), according to Brazil, Ministry of Health/SPO<sup>14</sup>, to be transferred from the fund-to-fund modality to the municipalities, would require R\$ 7,300 billion/year of additional resources.

Quadruplicating the amount of expenses committed with the Emergency Mobile Care Service (SAMU) by the Ministry of Health in 2018 (R\$ 1.078 billion), according to Brazil, Ministry of Health/SPO<sup>14</sup>, to be transferred from the fund-to-fund modality to the municipalities, would require R\$ 3,200 billion/year of additional resources.

The sum of the amounts of additional resources to strengthen public health actions and services as described in items I to IV is R\$ 30.5 billion, much lower than the values suggested in “b” and “c” (whose sum results in a total of R\$ 192 billion) from new sources of funding. It can be inferred that there is fiscal space to pursue a political equation that will result in additional resources for SUS federal funding in the short term without the need for tax reforms (of which conflicts of interest and effects on the level of economic activity require time to find a consensus proposal) and without compromising the goal of balancing public accounts. This scenario, if effectively implemented, would contribute to stimu-

late economic growth with employment and income generation, considering the importance of the health sector in the Brazilian economy, with positive effects on the population’s quality of life and health.

## Final Considerations

SUS needs new permanent, stable and exclusive sources of revenue (with legal provisions to prohibit untying and respect the principle of contributory capacity or progressivity), considering the limited possibility of increasing the participation of states and municipalities in SUS funding (together they represent 57%) and the decrease in federal participation observed since the early 1990s, which should continue due to the reduction in the federal spending floor due to CA 95, as previously shown.

On the one hand, it would be indispensable to tax large fortunes, inheritances (reviewing the current Tax on Inheritance and Donation of Any Property or Right – ITCMD), large financial transactions, dividends, as well as creating higher rates of income tax for both high income, and for products such as tobacco, alcohol, sugary drinks, etc. This is a debate that gives rise to a conflict of interests in society, which requires time to build a political consensus to make it possible to approve this tax reform.

But, on the other hand, this search for new sources could be started with the citizen public debt audit and the revenue waiver audit, which would allow an additional inflow of resources to the National Treasury of R\$ 292.0 billion, of which up to R\$ 192.0 billion would be destined to SUS, according to previous calculations, far above what is necessary to change the health care model in order to prioritize primary care. In this case, there would be no attrition due to a tax reform, nor it would hinder the goal of restoring the public account balance.

The defense of the SUS and its adequate funding must be integrated with the guarantee of social security and citizenship rights included in the Federal Constitution, as opposed to the withdrawal taking place with the support of the National Congress through the approval of Proposed Amendments to the Constitution under the patronage of the governments of President Temer (2016-2018) and Bolsonaro (as of January 2019), which increase the negative effects of CA 95 on the socioeconomic development and, especially, on SUS funding.

## References

- Vignoli F, Funcia FR. *Planejamento e Orçamento Público*. Rio de Janeiro: Editora FGV; 2014.
- Arretche M. Uma contribuição para fazermos avaliações menos ingênuas. In: Barreira MCRN, Carvalho MCB, organizadores. *Tendências e Perspectivas na Avaliação de Políticas e Programas Sociais*. São Paulo: IEE/PUC; 2001. p. 43-56.
- Arretche M. *Democracia, federalismo e centralização no Brasil*. Rio de Janeiro: Editora FGV; 2012.
- Marques RM, Piola SF, Ocke-Reis CO. O financiamento do SUS numa perspectiva futura. In: Marques RM, Piola SF, Roa AC, organizadores. *Sistema de Saúde no Brasil: organização e financiamento*. Brasília: MS, Departamento de Economia da Saúde, Investimento e Desenvolvimento, OPAS/OMS no Brasil; 2016. p. 247-258.
- Mendes A, Funcia FR. O SUS e seu financiamento. In: Marques RM, Piola SF, Roa AC, organizadores. *Sistema de Saúde no Brasil: organização e financiamento*. Brasília: MS, Departamento de Economia da Saúde, Investimento e Desenvolvimento, OPAS/OMS no Brasil; 2016. p. 139-168.
- Piola SF, Barros E. O financiamento dos serviços de saúde no Brasil. In: Marques RM, Piola SF, Roa AC, organizadores. *Sistema de Saúde no Brasil: organização e financiamento*. Brasília: MS, Departamento de Economia da Saúde, Investimento e Desenvolvimento, OPAS/OMS no Brasil; 2016. p. 101-138.
- Marques RM. Notas exploratórias sobre as razões do subfinanciamento estrutural do SUS. *Planejamento e Políticas Públicas* 2017; 49:35-53.
- Santos Neto JA, Mendes AN, Pereira AP, Paranhos LR. Análise do financiamento e gasto do Sistema Único de Saúde dos municípios da região de saúde Rota dos Bandeirantes do estado de São Paulo, Brasil. *Ciênc Saude Colet* 2017; 22(4):1269-1280.
- Ocke-Reis CO. Sustentabilidade do SUS e renúncia de arrecadação fiscal em saúde. *Ciênc Saude Colet* 2018; 23(6):2035-2042.
- Noronha JC, Noronha GS, Pereira TT, Costa AM. Notas sobre o futuro do SUS: breve exame de caminhos e descaminhos trilhados em um horizonte de incertezas e desalentos. *Ciênc Saude Colet* 2018; 23(6):2051-2060.
- Funcia FR. Financiamento: perspectivas para os próximos 4 anos. In: *33º Congresso de Secretários Municipais de Saúde do Estado de São Paulo* [apresentação na Internet]. 2019 Mar 27-29; São Paulo, Brasil. [acessado 2019 Ago 11]. Disponível em: <http://www.cosemssp.org.br/congresso/congresso-2019/programacao/apresentacoes/>
- Afonso JR. Federalismo Fiscal Brasileiro: uma visão atualizada. *Caderno Virtual* [periódico na Internet] 2016 [acessado 2019 Ago 11]; 1(34):[cerca de 24 p.]. Disponível em: [https://webcache.googleusercontent.com/search?q=cache:f8a6IaN0E\\_cJ:https://www.portaldeperiodicos.idp.edu.br/cadernovirtual/issue/download/157/4+&cd=17&hl=pt--BR&ct=clnk&gl-br](https://webcache.googleusercontent.com/search?q=cache:f8a6IaN0E_cJ:https://www.portaldeperiodicos.idp.edu.br/cadernovirtual/issue/download/157/4+&cd=17&hl=pt--BR&ct=clnk&gl-br)
- Brasil. Ministério da Saúde (MS)/Sistema de Informações sobre Orçamentos Públicos em Saúde (SIOPS) [página na Internet]. Brasília: MS, Departamento de Economia da Saúde e Investimentos e Desenvolvimento; 2019. [acessado 2019 Abr 04]. Disponível em: <http://siops.datasus.gov.br/evolpercEC29.php>
- Brasil. Ministério da Saúde (MS)/Subsecretaria de Planejamento e Orçamento (SPO). *Relatórios Anuais de Gestão 2014 a 2017, Relatório de Prestação de Contas Quadrimestrais 2016 a 2018 e planilhas de execução orçamentária disponibilizadas ao Conselho Nacional de Saúde até março de 2019*. Brasília: MS/SPO; 2015 a 2019.
- Brasil. Ministério da Fazenda (MF)/Secretaria do Tesouro Nacional (STN). *Demonstrativo da Receita Corrente Líquida*. Brasília: MF/STN; 2014 a 2019.
- Banco Central do Brasil. *Relatório FOCUS*. Brasília: BCB; 2019.
- Instituto Brasileiro de Geografia e Estatística (IBGE). *Séries do Produto Interno Bruto (PIB), Índice de Preços ao Consumidor Amplo (IPCA) e População* [página na Internet]. Brasília: IBGE; 2014 a 2018. [acessado 2019 Abr 14]. Disponível em: <http://www.ibge.gov.br>
- Conselho Nacional de Saúde (CNS). *Seminário CNS/COFIN no 11º Congresso da Associação Brasileira de Saúde Coletiva – Documento Final – 28 de Julho de 2015* [documento na Internet]. Brasília: CNS; 2015. [acessado 2019 Ago 11]. Disponível em: [http://conselho.saude.gov.br/ultimas\\_noticias/2015/docs/documento\\_final\\_seminario\\_cns\\_Cofin\\_abrasco.pdf](http://conselho.saude.gov.br/ultimas_noticias/2015/docs/documento_final_seminario_cns_Cofin_abrasco.pdf)
- Auditoria Cidadã da Dívida. *Dividômetro* [página na Internet]. Brasília: Auditoria Cidadã da Dívida; 2019. [acessado 2019 Abr 15]. Disponível em: <https://auditoriacidada.org.br>
- Brasil. Ministério da Fazenda (MF), Secretaria da Receita Federal do Brasil. *Demonstrativo dos Gastos Tributários PLOA 2019*. Brasília: MF; 2018.
- Organização Mundial da Saúde (OMS). *Domestic general government health expenditure (GGHE-D) as percentage of gross domestic product (GDP) (%)* [página na Internet]. Geneva: WHO; 2017. [acessado 2018 Mar 24]. Disponível em: <http://apps.who.int/gho/data/node.main.GHEDGGHEDGDPHA2011?lang=en>

Article submitted 15/04/2019

Approved 12/07/2019

Final version submitted 03/09/2019