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

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.
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 & Funcia1. 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).

Arretche2 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), Arretche3 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.4, Mendes & Funcia5 and Piola & Barros6.

As a complement, Marques7 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 21st century.

Santos Neto et al.8 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-Reis9: 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.10: “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://bvsms.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 Funcia11, 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\textsuperscript{13}, 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\textsuperscript{11}, 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](chart1.png)

**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.
The selection of FNS expenses above R$ 500 million of the selected expenses (over R$ 500 million) of this unit, as shown in Table 2, reveals a negative nominal variation of 3.90%. Of these 8, below the projection of resources for 2019, there are significant nominal and actual 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 change below inflation). Among the selected one, 5.23% is for Indigenous Health, 7.48% for Exceptional Medications, 11.71% for the Family Health Program, 14.90% for the Federal Incentive-Health Surveillance, and 16.70% for Basic Pharmacy Program-PAB. These are the sub-functions highlighted as follows: Primary Care (AB), Hospital and Outpatient Care (AHA), Prophylactic and Therapeutic Support (SPT), Preventive and Diagnostic Support (SPT), Hospital and Outpatient Care (AHA), Prophylactic and Therapeutic Support (SPT), and Others (OSF).

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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Population (^1) (in millions of inhabitants)</th>
<th>Net Current Revenue (^2) (R$ million at current prices)</th>
<th>GDP (^3) (R$ billion at current prices)</th>
<th>Update Factor (^4) (at 2019 prices)</th>
<th>Ações e Serviços Públicos de Saúde (ASPS)</th>
<th>Despesas Empenhadas (^5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R$ million (at current prices)</td>
<td>R$ per capita (at current prices)</td>
<td>R$ million (at 2019 prices)</td>
<td>R$ per capita (at 2019 prices)</td>
<td>R$ per capita (at 2019 prices)</td>
<td>Proportion of GDP</td>
</tr>
<tr>
<td>2014</td>
<td>202.8</td>
<td>641.578</td>
<td>5.779</td>
<td>132410</td>
<td>91.899</td>
<td>453.15</td>
</tr>
<tr>
<td>2015</td>
<td>204.5</td>
<td>674.523</td>
<td>5.996</td>
<td>121594</td>
<td>100.055</td>
<td>489.27</td>
</tr>
<tr>
<td>2016</td>
<td>206.1</td>
<td>709.930</td>
<td>6.267</td>
<td>111715</td>
<td>106.236</td>
<td>515.46</td>
</tr>
<tr>
<td>2017</td>
<td>207.7</td>
<td>727.254</td>
<td>6.554</td>
<td>108462</td>
<td>114.701</td>
<td>552.24</td>
</tr>
<tr>
<td>2018</td>
<td>208.5</td>
<td>805.348</td>
<td>6.828</td>
<td>103900</td>
<td>116.821</td>
<td>560.29</td>
</tr>
<tr>
<td>2019</td>
<td>209.3</td>
<td>845.489</td>
<td>7.113</td>
<td>100000</td>
<td>117.293</td>
<td>560.41</td>
</tr>
</tbody>
</table>

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 Statistics17.
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 Statistics17. (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 Statistics17. (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 Brazil16. (5) For 2019, the PHAS federal spending floor was considered, calculated by the author based on the CA 95 rule.
According to Funcia\textsuperscript{11}, 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 – around R$ 20.0 billion, above the R$ 14.0 billion recorded in 2016. **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\textsuperscript{11}.

The National Health Council\textsuperscript{18} 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
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 esti-
mates follow:

If the “Health +10” Project (Complementary
Law 321/2013) had been approved by the Na-
tional 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\(^1\), 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\(^9\),
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\(^6\) 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 Na-
tional 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\(^9\), this amount in 2015 was R$ 32.3 bil-
ion (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 resourc-
es 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-

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

<table>
<thead>
<tr>
<th>Denomination</th>
<th>2016-1st q</th>
<th>2016-1st s</th>
<th>2016-2nd q</th>
<th>2016-3rd q</th>
<th>2017-1st q</th>
<th>2017-1st s</th>
<th>2017-2nd q</th>
<th>2017-3rd q</th>
<th>2018-1st q</th>
<th>2018-1st s</th>
<th>2018-2nd q</th>
<th>2018-3rd q</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Other Programs</td>
<td>10.10</td>
<td>21.86</td>
<td>29.07</td>
<td>50.17</td>
<td>11.08</td>
<td>14.76</td>
<td>32.73</td>
<td>52.12</td>
<td>LM</td>
<td>LM</td>
<td>69.48</td>
<td></td>
</tr>
<tr>
<td>Fighting Nutritional Needs</td>
<td>0.00</td>
<td>5.08</td>
<td>12.39</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>65.89</td>
<td>0.00</td>
<td>0.00</td>
<td>32.94</td>
<td>65.87</td>
<td></td>
</tr>
<tr>
<td>Exceptional Medications</td>
<td>21.33</td>
<td>LM</td>
<td>LM</td>
<td>LM</td>
<td>21.05</td>
<td>LM</td>
<td>LM</td>
<td>LM</td>
<td>7.68</td>
<td>18.46</td>
<td>33.27</td>
<td>65.02</td>
</tr>
<tr>
<td>Vaccines and Vaccination</td>
<td>12.64</td>
<td>27.92</td>
<td>LM</td>
<td>73.12</td>
<td>17.54</td>
<td>LM</td>
<td>LM</td>
<td>68.88</td>
<td>3.97</td>
<td>30.08</td>
<td>45.55</td>
<td>59.74</td>
</tr>
<tr>
<td>Restructuring of Federal University Hospitals – Rehuf</td>
<td>1.13</td>
<td>22.67</td>
<td>41.35</td>
<td>LM</td>
<td>0.00</td>
<td>18.13</td>
<td>27.83</td>
<td>72.84</td>
<td>0.10</td>
<td>8.78</td>
<td>20.45</td>
<td>54.75</td>
</tr>
<tr>
<td>Promoting Science and Technology Research</td>
<td>0.00</td>
<td>7.73</td>
<td>8.32</td>
<td>39.97</td>
<td>0.24</td>
<td>10.04</td>
<td>11.13</td>
<td>39.04</td>
<td>0.40</td>
<td>1.98</td>
<td>13.17</td>
<td>47.27</td>
</tr>
<tr>
<td>Family Health Programming and Structuring – Proesf</td>
<td>0.00</td>
<td>20.94</td>
<td>34.81</td>
<td>LM</td>
<td>na</td>
<td>na</td>
<td>28.76</td>
<td>52.21</td>
<td>0.22</td>
<td>14.61</td>
<td>18.42</td>
<td>43.16</td>
</tr>
<tr>
<td>Acquisition and Distribution of Strategic Medicaments</td>
<td>1.35</td>
<td>30.47</td>
<td>40.48</td>
<td>62.71</td>
<td>14.35</td>
<td>17.65</td>
<td>25.71</td>
<td>47.59</td>
<td>4.32</td>
<td>22.07</td>
<td>26.73</td>
<td>42.00</td>
</tr>
<tr>
<td>Epidemiological Surveillance Actions</td>
<td>9.49</td>
<td>16.14</td>
<td>23.26</td>
<td>42.02</td>
<td>4.96</td>
<td>10.46</td>
<td>26.69</td>
<td>57.17</td>
<td>5.30</td>
<td>10.19</td>
<td>18.83</td>
<td>29.68</td>
</tr>
<tr>
<td>Modernization of SUS Units/MS</td>
<td>14.88</td>
<td>19.12</td>
<td>23.40</td>
<td>41.89</td>
<td>2.60</td>
<td>6.56</td>
<td>11.91</td>
<td>10.53</td>
<td>1.48</td>
<td>4.46</td>
<td>6.29</td>
<td>23.37</td>
</tr>
<tr>
<td>Women, Child, Adolescent and Young Adult Health Care Attention</td>
<td>2.14</td>
<td>24.39</td>
<td>25.10</td>
<td>39.96</td>
<td>1.71</td>
<td>7.25</td>
<td>9.51</td>
<td>26.37</td>
<td>0.00</td>
<td>0.01</td>
<td>3.42</td>
<td>17.99</td>
</tr>
</tbody>
</table>

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.
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\(^2\).

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\(^4\), 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\(^4\), 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\(^4\), 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\(^4\), 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 stimulate 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


---

Article submitted 15/04/2019
Approved 12/07/2019
Final version submitted 03/09/2019