

Special Editorial

The long battle for SUS funding

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The history of Brazilian National Health System (SUS) is marked by funding problems. Public funds involved were always insufficient to ensure full, universal, and proper healthcare. In 2011, the Brazilian public expenditure on healthcare (federal, state and municipal) was 3.84% of the Gross Domestic Product, while the average of European countries with universal systems was 8.3% of the GDP, which highlights SUS' funding difficulties to perform its tasks and services.

The Popular Initiative Project, known as Movement Health+10, which is being processed in the Congress, signed by 2 million Brazilians, makes an historical defense on the healthcare area and takes position for the increase of public resources, especially of the Federal government, to at least 10% of its Gross Current Revenue (GCP). If approved, the project will guarantee to SUS an increase of R\$40 billion, or 0.8% of the GDP, to the Healthcare Ministry budget in 2013.

This project is important for SUS survival, but we are aware that it doesn't solve completely the historical underfunding of public healthcare in Brazil. It was a problem since the creation of the Social Security budget in the federal constitution of 1988, that reserved 30% of this budget's (taxes and payroll and profit contributions to healthcare, pension and welfare) resources to the federal spending on SUS for 1989, established in the article 198 of the constitution and in its transition ruling. For every other year the definition of this percentage would be decided by the Budget Guideline Law (BGD). In practice, healthcare never had any resources since.

To illustrate this loss of resources, in 2012 the social security budget was R\$ 590.5 billion. If 30% of it was destined to healthcare, considering federal

government spending, the area would receive R\$177.2 billion, well above the spending of the three levels of government, which in 2011 summed up R\$ 154 billion.

In fact, during the 25 years of the SUS, there were several constraints suffered in connection with the financing. In a previous article (Mendes, 2012), we highlight some of the aspects of that situation:

a) From 1993 onwards, the pension ceased to transfer resources to SUS (which were regulated during the social security reform of the government of Fernando Henrique Cardoso);

b) the creation of the Emergency Social Fund in 1994, which was later named Fiscal Stability Fund and, from 2000 on, was renamed as Disconnection of Federal Revenues (DRU) - name which persists -, which defined, among other things, that 20% of the revenue of social contributions would be disconnected from its purpose and would be available for use by the federal government, far from its linking object: the social security. This mechanism has caused loss of resources for social security;

c) the approval of the CPMF in 1997 as a source of funding exclusive for health, which was accompanied by the removal of part of the other funding sources in this sector, thus not contributing to the increase in resources that was expected;

d) the approval of the Constitutional Amendment-29 (EC-29) in 2000, directing resources for health, but with uncertainties about what should be considered as actions and health services and what could not be framed in this context; besides, there were conflicting calculation methods for the application of resources of the Union - that is, the value reported in the previous year, adjusted by the nominal GDP growth - and also, not explaining the origin of the resources concerning social security and ignoring the tense shock over its resources;

e) attempts of the federal government's economic team to introduce expenditure items not considered health expenditure in the Ministry of Health's budget, such as interest payments and retirement of former employees of that organ, among others;

f) The pending on the regulation of EC-29 for eight years in Congress (from 2003 to 2011), causing loss of resources for the SUS and the weakening of the consensus obtained when approved;

g) the continuity of insufficient resources to finance the SUS in the regulation of EC-29 (Supplementary Law No. 141/2012), which maintained the method of calculating the participation of the federal government (the value reported in the previous year, adjusted by the nominal GDP growth) by rejecting a law project that was in the Senate (PLS 127/2007), which defined the use, by the Union, of at least 10% of Gross Current Revenue (RCB).

So, we entered the 2010s without solving financing major conflicts, such as the Law 141/2012 (regulation of EC-29), which should indicate the participation of the three spheres of the government in SUS, maintained the previous calculation of the contribution from the Union (value calculated in the previous year, adjusted by the nominal GDP growth): the introduction of a percentage of 10% on the RCB, as advocated for years by the associated entities to the fighting for universal health care and the Movimento Saúde+10, more recently, was not approved. In 1995, the federal government spent on health activities and services the equivalent to 1.75% of GDP, and 17 years later (2012), this proportion practically remained the same. Federal expenditure on public health services and activities decreased in relation to the Gross Current Revenue of the Union: in 1995 it represented 11.7% of revenues; in 2011, only 7.5% from the same base. The amount of resources lost during the 2000s reported approximately R\$ 180 billion, when compared to the indexation for Gross Current Revenue and the change in nominal GDP.

It is known that the federal government did everything so that the calculation basis of 10% of the RCB was not approved, in order to favor those who do not have a specific source to support such amount, although for years the Social Security Budget (health, social security and welfare) shows surpluses. However, much of it is directed to pay interests on the debt, in order to maintain a primary surplus - a restrictive economic policy in terms of cuts in social expenditure. This direction has a name: Disconnection of Federal Revenues (DRU), in which 20% of all revenue which should be social

security's are directed to other purposes. This mechanism has led to the loss of approximately R\$ 578 billion resources of the social security budget from 1995 to 2012, having its continuity ensured until 2015 (ANFIP 2013).

Despite this evidence of available sources of funding, the federal government comes back with the same arguments for the Movimento Saúde+10. First, it states that it has increased the investment in health from 2003 to 2011, going from an expenditure per capita of R\$244,80 to R\$ 407,00 (representing an increase of 66%). However, it states that in the first year of the Lula government, 2003, health expenditure *per capita* was the lowest between the years 1995 and 2011. Second, the federal government insists to comment its budget rigidity frame. Of its total budget for 2013 (R\$ \$ 2.2 trillion), 46% are committed to financial expenses (amortization payment and debt interest). The interesting point here is that is not explicit that it has been a priority choice for years. The other 54% of the budget are committed to primary expenditure, including mandatory spending and discretionary spending (with protected areas - education, health, "Brasil sem miséria", PAC and innovations - with the other compulsory - servers' benefits - with cuts made and all other areas). Given this scenario, the government says that the 10% corresponding of RCB from the Union for Health in 2013 (R\$ \$ 40 billion) exceed the total of the non-protected areas.

Furthermore, the argument of the federal government is the unfeasibility of Gross Current Revenue as a basis of calculation for application to health. The government says that the Union must discount from the RCB those resources that are already pre-defined, as constitutional transfers to states and municipalities (FPM, FPE), Fundeb, royalties, salary - education, social security contributions and others. However, is not defined in the Popular Initiative Project that 10% should be taken from each of the sources, but the corresponding "amount exceeding 10% of the RCB." The basis of this revenue searches to take distance, more directly, of the cyclic variations of the economy, measured by GDP, which are not growing at the same level of revenue effort as the Union's revenue effort (taxes and contributions). It is about valuing the corresponding health invest-

ment to the federal government collection capacity (RCB), which grew 65.5% from 2000 to 2012, while the GDP only increased 5.9% (values deflated by annual prices average of December 2012, as IGP-DI/FGV). Meanwhile, the Current Net Revenue of the Union - basis for calculation defended by the government - had a lower RCB increase, 56.6% in the same period.

It is known that the Movimento Saúde+10 is aware that the RCB is the calculation basis which contributes to the search of financial sustainability for the SUS, partly recovering the resources lost during its 25 years of existence (ABRASCO et al., 2013). The movement understands too, that the methodology of application of Union should be compatible with the calculation basis for the application of states and municipalities, as these last correspond to total income taxes, included constitutional transfers, which means the self fundraising efforts. Therefore, the use of a percentage of RCB of the Union seeks to ensure the isonomy in the treatment of health financing in the three spheres of government.

It is worth remembering that the defense by the corresponding value to RCB stems from its visibility in the federal public accounts and it is hard to manipulate, as in the case of Current Net Revenue - with different concepts. Besides that, it is a data with the slightest possibility of interpretation, which would help to lower legal questions. After almost ten years of EC-29, it is known the stir about what should or should not be considered expenditure on health programs and services. At last, the defense of RCB has the support of 2 million signatures of Brazilians, which justifies its non-alteration by all who wish to listen to the protests in the streets.

This context of SUS financing is important for understanding the more general background to the discussions presented in this number of *Saúde e Sociedade*. Somehow, the articles presented could not be more up-to-date, as it highlights the commitment of the municipalities with the funding of the public health system and the role of supervision and control of the funds invested in this sector.

Ribeiro e Bezerra, in “O protagonismo dos gestores locais de saúde diante da Emenda Constitucional

no 29: algumas reflexões”, presents reflections on the importance of municipalities commitment in financing SUS. Sobrinho e Espírito Santo, in “Participação dos entes federados no financiamento da saúde bucal de atenção básica: estudo no município da Vitória de Santo Antão, Pernambuco”, measure the percentage of participation of the Union, the State and municipality in the financing of oral health services in primary care in Vitória de Santo Antão, Pernambuco, estimating also the absorption costs of these services per level of government sphere. Gonçalves and collaborators in “Conselhos de Saúde e controle social: um estudo comparativo dos relatórios de prestação de contas das Secretarias Estaduais de Saúde” explicit the monitoring of health accounts made by councils in five States, highlighting the problems in the implementation of this important constitutional task.

We understand that reading these articles contributes to the questioning of the financing and management of SUS resources, fundamental to ensure the right to universal health care in our country.

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