Everything to fear: funding, public-private relations, and the future of SUS

Tudo a temer: financiamento, relação público e privado e o futuro do SUS

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Introduction

Brazil's legal-political organization, typical of capitalist States and established since the Proclamation of the Republic, has allowed capital to guide the logic of health organization, from the campaign model adopted in the beginning of the 20th century, to the Brazilian Unified Health System (SUS).

The end of the 1970s was marked by the collapse of the military dictatorship, the decline of the 'economic miracle', and the severe crisis of the social security medical care model. In this period the Health Reform movement appears, which produced a national mobilization that influenced the inclusion of health as a universal right in the Federal Constitution of 1988 (CF 88).

The 1988 Constitution and the Federal Laws 8.080/90, 8.142/90, and 9.656/98 sustain the organization of the Brazilian health system. Other complementary laws and normative acts of the Ministry of Health (MS) and its regulatory agencies served as the basis for the implementation of SUS, a universal, complete, and equal public health care system. The role of SUS is also to regulate a private, supplementary subsystem based on the rights of consumers and the guarantee of complete patient care and safety, albeit guided by market logic. It is important to note that this subsystem was created in the 1960s and operated without any regulation until 1988.

The advances produced by SUS in almost three decades are unquestionable (PAIM *ET AL.*, 2011). The expansion of basic care coverage to more than 73% of the population through the Estratégia Saúde da Família (Family Health Strategy), reinforced by the Programa Mais Médicos (More Doctors Program); dental health care through Brasil Sorridente (Smile Brazil); the vaccine and medicine program; the Serviço de Atendimento Móvel de Urgência (Mobile Emergency Care Service – Samu-192), the Unidade de Pronto Atendimento (Urgent Care Center – UPA), and beds at Intensive Therapy Units (ITUs) are some examples. SUS offers the largest public system of transplants in the world and an extremely safe public system of blood and hemoderivatives. It is also important to mention psychiatric reform, caring for people with mental disorders and substance-abuse issues in a dignified manner.

The implementation of SUS, in encountering innumerous challenges, problems, and weak points of a political, economic, managerial, and welfare order, has produced an important dissociation between the 'constitutional SUS' and the 'real SUS.' Although it has resulted in more access to health care, and an improvement in Brazilian health and quality of life indicators, especially when compared to the exclusive model in effect before 1988, it has been unable to

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generate confidence and social legitimacy in the Brazilian population, which points to health care as the country's main problem and strives for access to an idealized private health care model.

Such a situation cannot be explained only by the continuing use of media to demonize SUS and sell private health care as a solution. It is determined by challenges and problems that have not yet been overcome, which result in the crisis of SUS, erected in a country with a complex federative structure, which guarantees broad autonomy to federated entities, but which is still marked by a political culture that is strongly centralized, clientelistic, and patrimonialist.

The implementation of SUS, after 1988, was constituted in a markedly anti-hegemonic project (GRAMSCI, 1991). The winning project in the first presidential election held after redemocratization was that led by Fernando Collor, who was against the ideologies of SUS (CEBES, 1992). Neoliberal in character, it advocated the Minimal State and the stratification of clientele. In a certain way, the interests of financial capital were strongly present, albeit in different intensities, in the conformation of the Brazilian State and in its logic of public policy formulation, and also marked the direction of health policy and the strong tension in the implementation of SUS during the Itamar Franco, Fernando Henrique Cardoso, Lula da Silva, and Dilma Rousseff administrations.

In addition, there are the challenges inherent to the production of a universal system in a country with 206 million inhabitants and a continental geographical dimension, great regional differences, a heterogeneous economic-social structure, and that faces transformations in health standards, which are determined by profound demographic, epidemiological, and nutritional changes. Furthermore, one confronts chronic and serious problems that have not yet been solved in relation to the health care model, to labor and health education management, to planning, to health system and services management, and to the judicialization of health care, among others.

To comprehend the SUS development process and the major crisis which it is experiencing, two issues are of special importance: the (chronic) underfunding of health care and public-private relations. These are themes that strongly cut across the conformation of the various challenges faced today, and to analyze them constitutes the main objective of this opinion article that expresses the view of its authors, who are involved in the construction of SUS. This article seeks to reflect on the directions of SUS in the context of the political and economic crisis in Brazil that allowed for Temer's rise to power after the legal-political coup which resulted in the deposition of the Dilma Rousseff administration, and on possible ways to face the strong threat to democracy and social rights.

The (chronic) underfunding of health care in Brazil

To secure an adequate public funding that guarantees the right to health provided in the 1988 Constitution has been one of the greatest challenges for SUS. Total spending on health, in Brazil, reached 9.7% of the Gross Domestic Product (GDP), an amount close to or higher than some developed countries (OECD, 2013). However, the percentage of total public spending on health was only 48.2%, which is less than Latin American countries (such as Argentina, 67.1%; Colombia, 76%; Costa Rica, 75%; Cuba, 93%; and Mexico, 51.7%) and comparable to that of the United States (47.1%). Countries with universal systems invest more than 70% of the total spending on health in their public systems, as demonstrated in *table 1*. International evidence suggest that the universalization of health systems involves public spending equal or superior to 70% of total spending on health, Brazil being more than 20 percentage

points below this level. In 2013, public health spending per capita in Brazil was US$ 525 (OECD, 2013), a small amount if compared to other countries. This means a daily per capita expenditure of less than R$ 3.00 to guarantee complete and universal care.

Table 1. Health spending – international comparison

	Public Health Spending, % of GDP	Total Health Spending per capita (US$)	Public Health Spending per capita (US$)	GDP per capita (US$)
Brazil	4,7	1.083	525	11.208
MERCOSUL				
Argentina	4,9	1.074	721	14.715
Paraguay	3,5	395	154	4.265
Uruguay	6,1	1.431	992	16.351
Venezuela	1,0	497	146	14.415
UNIVERSAL SYSTEM				
Canada	7,6	5.718	3.985	51.964
France	9,0	4.864	3.740	42.560
Switzerland	7,6	9.276	6.131	84.748
United Kingdom	7,6	3.598	3.004	41.781
BRICS				
China	3,1	367	203	6.807
India	1,3	61	20	1.498
Russia	3,1	957	456	14.612
South Africa	4,3	593	286	6.886

Source: (OECD, 2013). World Bank: Public spending on health (% GDP); Total spending on health per capita (current US $); GDP per capita (US $); Public spending on health per capita (current US $).

Most health spending continues to be private. In 2015, 26% of the population had health plans (ANS, 2016), and the sector executed around R$ 132 billion in transactions, as opposed to R$ 236 billion in public spending. Public expenditures on health per capita (R$ 1.17 thousand) represent less than half of the amount spent by health plans (R$ 2.5 thousand) on their users.

The iniquity of SUS, according to Medici (2010), is not only in the degree of usage of the system by rich and poor, but in the nature of the procedures made available by the system to the richest, who use SUS to complement health plans in their search for high cost and high technology care, which are generally not covered by health plans.

Private spending on health in Brazil represented 51.8% of total spending, more than half of which were family out-of-pocket expenses (primarily on medicine), contributing to the iniquity in health funding in the extent to which access to service is conditioned to purchasing power. Another major distortion is the tax deductions of private expenses. In 2013 alone, R$ 13.5 billion were deducted,

which is equivalent to 16% of federal spending on health in that year. Adding together all of the components related to health, the amount is around R$ 21 billion (BRASIL, 2015B).

The indisputable underfunding of SUS results from the fact that its generous constitutional mandate was not accompanied by mechanisms that guaranteed, from the economic point of view, its principles. The implementation of the new social rights coincided with a period of hyperinflation and macroeconomic restrictions. The global movement of State Reform, guided by the objectives of the financial system, is expressed in Brazil with a large growth of the private sector and a strengthening of the market rules in health care and social security, by means of private insurers, and a high growth of public debt, which halted budget increases in social areas, including health (MENDES; MARQUES, 2009; PAIM *ET AL.*, 2011). The minimum percentage of 30% of the Social Security Budget intended for SUS, a constant in the transitional provisions of the 1988 Constitution, was not considered.

In 1989, the lowest percentages of health care spending and the highest degree of health system deterioration and disregard were observed. The Collor administration's 5-Year Health Plan was inspired on the focusing of care on the 'shirtless,' a care model devoted to marginal urban peripheries and to rural poverty by means of an extensive network of low-cost services, harming the basic principles of SUS (CEBES, 1992).

In 1993 the crisis was aggravated, for in addition to not meeting the required 30% of the Social Security Budget for Health, provided by the Budget Guidelines Law (LDO), the Ministry of Social Security suspended the transfer of the amounts collected by the National Social Security Institute (INSS) that were intended, in the budget, for health care. The federal government decreed a State of Public Calamity, and once again used financial loans in the Workers' Support Fund (FAT). In the same year, demonstrating the priority of fiscal adjustment measures, the government created the Emergency Social Fund, today called the Unbinding of Federal Revenue (DRU), which came to withdraw part of the revenues intended for social security and revenues from State and Municipal Participation Funds (UGÁ; PORTO; PIOLA, 2012).

In 1996, in order to overcome the crisis in health funding, the Provisional Contribution on Financial Transactions (CPMF) was created, whose proceeds should go to the National Health Fund (FNS). On average, in the period between 1997 and 2007, when it was extinguished, the CPMF answered for one-third of the resources intended for the Ministry of Health, and its contribution was more effective for funding stability than for the increase of resources, since its impact was softened by the withdrawal of other sources.

The Proposed Constitutional Amendment (PEC) 169, presented in 1993, proposed allocating 10% of federal, state, and city income tax revenue and 30% of the Social Security Budget to health care. In the National Health Council, Resolutions (67 and 68) were approved with the same purpose, proposing the constitutional binding of resources. Other PECs were presented, and various attempts at negotiation were unsuccessful until the year 2000, when Constitutional Amendment 29 (EC-29) was ratified, whose objective was to commit the three spheres of government to health funding, to define what the Public Health Actions and Services (ASPS) would be, and to establish stable sources of funding, preventing crises or situations of insolvency (BRASIL, 2000). Required investments in health care became, for states, at least 12% of gross revenue; for cities, 15% of city tax revenues; and for the Federal Government, the amount invested in the previous year adjusted for changes in the nominal GDP. Regulation by complementary law only happened in 2012, through Complementary Law 141.

EC-29 led to a growth in the resources invested in ASPS from 2.9% in 2000 to 4.7%

of the GDP in 2013 (OECD, 2013). In 2014, ASPS investments totaled R$ 57.4 billion (27%) by states, R$ 65.3 billion (30%) by cities, and R$ 92.6 billion (43%) by the Federal Government. Between 2003 and 2015, federal spending on ASPS evolved from R$ 27.2 billion to R$ 99.2 billion, more than tripling in nominal terms.

In 2012, several civil society entities launched the National Movement for the Defense of Public Health (Movimento Saúde+10), proposing an initiative with the objective of altering the minimum amount to be invested by the Federal Government. Saúde+10 delivered the initiative to Congress with more than 1.9 million signatures asking for the allocation of 10% of the Federal Government's current gross revenues for public health. However, EC 86/2015 was approved, requiring the execution of individual parliamentary amendments and altering the binding rule for federal health resources (BRASIL, 2015A). The minimum stops being calculated based on changes in the nominal GDP and starts being based on the Federal Government's current liquid revenue (RCL), in the following way: 13.2% of the RCL in the first financial fiscal-year subsequent to the enactment of the Constitutional Amendment; 13.7% in the second; 14.1% in the third; 14.5% in the fourth; and 15% in 2020.

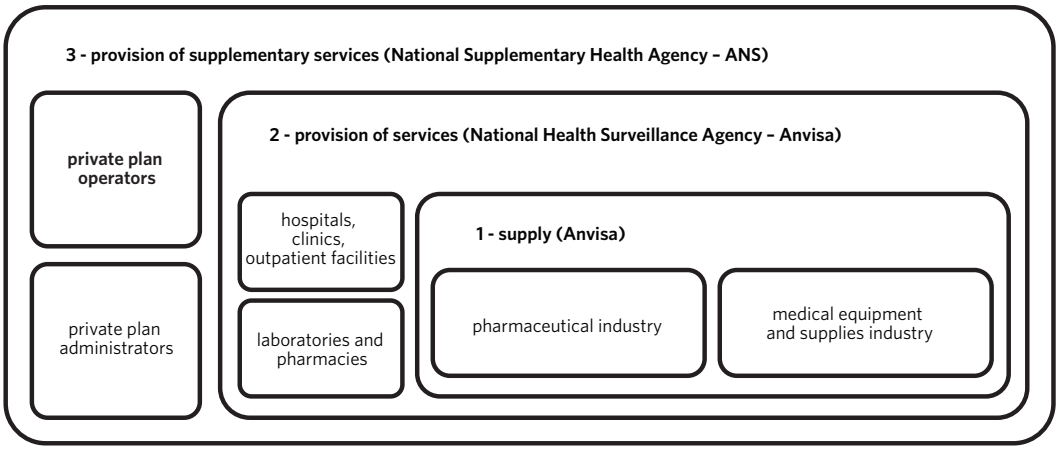
Underfunding guided the XV National Health Conference. The National Health Council launched the SUS Defense Front and supported the approval of PEC 01/2015, which was nevertheless shelved. In August of 2016 the federal government, still in transition, referred PEC 241/2016, which limits federal public spending, an issue that will be addressed later on.

Public-private relations

The development of the private health sector in Brazil is deeply tied to the modernizing option implemented by the military regime. By disintegrating the associative schemes that gave voice to social pleas, it imposed a privatizing policy of rationalization, which, although technically justified, unleashed and exacerbated perverse traits (ALMEIDA, 1998). It was during the dictatorship that the industrial health care complex was built, which was formed to meet a need for health product consumption in our country.

For Gadelha *et al.* (2009), the health care complex can be divided into three subsystems: one that groups chemical and biotechnological industries (pharmaceutics, vaccines, hemoderivatives, and diagnostic reagents); that of mechanical, electronic, and materials industries (medical-hospital and dentistry equipment and materials); and, finally, that of health services (production of hospitals, laboratories, and diagnostic and treatment services). A fourth subsystem should be added to this model, that of supplementary health care. The Ministry of Health's regulation of the private sector occurs in the three sectors described in *figure 1*:

Figure 1. State regulation and private service provision in Brazil



Source: Elaborated by author.

According to Pereira (2009), health regulatory agencies were created so that the modern State could regulate the private sector in a more organized way, bringing homogeneity, stability, and competitiveness to these sectors. The three private segments were instituted and grew in different ways and with distinct objectives. While the supply and service provision sector grew to serve all of the Brazilian population, SUS users or not, that of supplementary service provision became a social security medical care provider, to whom it owes a significant part of its growth.

The supply and service provision sectors were able to organize themselves and they depend, in a way, on SUS. The more resources and access to public purchases, the greater the turnover, leading them to push for prices and an incorporation of their technologies and products, which stimulated competition in the pharmaceutical industry. Thus, the productive health industry was able to produce a common agenda for the sector, with an emphasis on the incorporation, debureaucratization, and increase of financial resources and public purchases, comprehending the power of SUS as a leverage factor and guarantor of a business environment that is favorable to its interests. The provision of supplementary services has grown much in the past few years, going from 30,909,969 beneficiaries in 2000 to 48,487,129 in 2016. The increase in the coverage rate of the Brazilian population with supplementary health care in the period, from 18.2% to 25% (ANS, 2016), can be attributed to the actual performance of the agency with clear rules, bringing more safety to the consumer, and to the improvement of the job market with an increase of formal employment, enabling, through collective contracts, the acquisition of health plans. Members of this sector, nevertheless, were unable to dialogue with each other and produce an agenda centered on common interests. To react against and resist the government regulation imposed as of 1998 was the only agenda that united them, albeit with divergences, since some sectors, such as fast-growing providers in the Northeastern region and benefit managers, were consolidated in virtue of the regulatory rules.

Three issues deserve to be highlighted in public-private relations: judicialization, health care industry lobbies and pressure, and supplementary sector competition with SUS.

The judicialization of health through the incorporation or supply of medicines and procedures not yet made available by the public and supplementary system has become one of the difficult challenges in Brazilian health care, and for the most part, occurs through the conflict that is present among the several actors and interests involved, which is caused by the idea that the realization of the right to health should occur independently of public policy, of contracted coverage in supplementary health care, and of analyses of the available evidence of safety, efficacy, and effectiveness. Between 2010 and 2014, the Ministry of Health spent more than R$ 2.1 billion on lawsuits for the acquisition of medicine, equipment, supplies, surgical operations, and judicial deposits. Citizens cannot be denied the right to use justice to achieve their rights. The balance among individual rights, collective rights, and the responsibility of health organs in avoiding the risk that patients run in using untested medicines and procedures should be discussed rationally and responsibly. Even the legislative branch, in the past few years, has been incorporating medicines and procedures in specific legislation, most of the time without the scientific evidence and processes that prove their safety and efficacy.

Another serious problem is the pressure of industry and of orthoses and prostheses suppliers, who act as true mafias, corrupting professionals and pressuring the public and private system to use their products, through legal means, lobbying, advantages, and illegalities. It is a little-regulated market, that acts in its own interest, jeopardizing citizens and the organization of the public and private health systems, and impacting health spending. There is a need to implement, immediately, use regulations of a sanitary and economic order, penalties and restrictions, actions indicated in the Interinstitutional Working Group's Final Report on orthoses, prostheses, and special materials (BRASIL, 2015B).

Finally, the Organisation for Economic Co-operation and Development (OECD, 2008), in its peer review, indicated that the Brazilian Health System is duplicated in care. Thus, the supplementary system, in general, competes with SUS to have the same users without adequate or due compensation. Since regulation began to be implemented, providers, in general, have reacted to offering complete health care. They pressure the State to authorize the operation of partial health plans, that is, with lesser and differentiated coverage, based on the argument that this will produce an expansion of offerings and alleviate SUS, without obtaining government protection thus far, which has caused, on the part of the providers, innumerous criticisms of the performance of the Ministry of Health and the National Regulatory Agency for Private Health Insurance and Plans (ANS).

What will become of health care as a result of the Temer administration?

In May of 2016, with the removal of Dilma Rousseff by the Chamber of Deputies, the last phase of a coup began that was completed on August 31, with the definitive impeachment of the president by the Federal Senate. Millions of people who were on the streets saying no to the coup continue to be mobilized, in Brazil and abroad, denouncing the coup-like character of the Temer administration and asking for free and democratic elections. With the indecency and haste characteristic of someone who is not committed to the popular vote, Temer throws open the neoliberal project, without an appreciation for the social rights inscribed in the 1988 Constitution.

With the Provisional Measure (MP) 727, he reinstituted the process of economic privatization, aiming to hand over state companies that interest private capital.

Emblematic measures of a government with no social commitment: a minimal State submitted to market interests, using the economic crisis to justify the dismantling of the social State, through austerity programs to solve the crisis, reducing the social rights achieved in the democratic Constitution, as Mazza (2016) points out.

We are surprised by proposals that reduce State responsibility and participation in the direction of social policies and that dismantle rights. Policies of a universal character are targeted as unfeasible and responsible for the crisis. Debates about the focus of several social policies flourish.

In this context, the Temer administration imposes new and serious contours to the dynamic of the chronic crisis experienced by health care and produces the most serious threat to SUS in three decades. The appointment of an engineer and federal deputy from the Progressive Party to the head of the Ministry of Health, in a movement of recomposition of the executive's support base in the National Congress, despite being a practice used by previous administrations, was of fundamental importance for the approval of Dilma Rousseff's impeachment and the support of the liberal and conservative project by the political and business forces that seized the federal government through a juridical-parliamentary coup. It reflects the utilization of the organ responsible for the national command of SUS – and that has the largest budget in the Federal Government – for the production of governability, a practice that is at the root of part of the problems faced in the consolidation of SUS as a State policy.

The composition of the Ministry of Health with staff who have no experience in SUS and in health reform strengthens the intensive use of the public machine in a clientelist manner, the regimentation of political support, and the service of private interests, going beyond the interruption or dismantling of ongoing health policies. Over the first six months of management, controversial declarations were made that only contribute to the anecdotal folklore of national politics. Other, more serious ones, deal SUS a death blow: the explicit defense of reviewing its size; or that the problem with SUS is not the lack of resources and its chronic underfunding, but the 'lack of management'; or that the social rights provided in the 1988 Constitution do not fit into the public budget and that, therefore, they should be revised. These are positions that back theses of liberal economists – who act inside and outside government – and of political and business sectors that bet on the dismantling of the Democratic State of Law, of which SUS is one of the most important expressions.

Nevertheless, for those who have dedicated themselves to the struggle to build SUS in several sites of action, independently of a political-party spectrum, such manifestations violate constitutional principles and cause enormous preoccupation due to the concrete possibility of producing the absolute dismantling of SUS.

The Ministry of Health comes to defend that it is not its task (nor that of its regulatory agency, the ANS) to supervise the quality of health plans, a role that should be performed by the 'consumers' themselves and their defense organs, expressing a view in which health care is no longer a social right to be objectively constituted as a good. The solution for the crisis would be 'accessible' health plans, which would exonerate the State from the need to provide health to a part of the population, expanding the market offering through 'popular health plans.' Such a proposal, though not yet explained, can meet the interests and pleas of market sectors that have proposed, for a long time, the offering of restricted listings of procedures and the utilization, without compensation, of the public or private network contracted by SUS for the offering of higher cost procedures. It is already possible to observe an alliance of important sectors of

the supplementary health market with the project, in the absence of current legislation.

There is an equation, nevertheless, that needs to be considered. Who will pay for the supposed expansion of 'popular plans' without increases in public spending for 20 years? Without government subsidies, there seems to be no viable way to expand the private market to sectors of society that are unable to access it through direct disbursement or through coverage by their employers, even with current strategies of tax waivers and tax benefits (BAHIA, 2005). Countries that increased market coverage, such as the most recent case of the United States (Obamacare), strongly subsidized the operation with public resources.

Individual out-of-pocket spending by Brazilians above total health spending, which was around 50% in 1996, has remained at 30% since 2008, delimiting a possible ceiling that will not tend to increase in a scenario of economic and employment crisis. In addition, spending on private health plans varied around 20.5%, on average, in relation to total spending from 1995 to 2012, which suggests a limit to the expansion of these markets, as already indicated by Ribeiro. There does not seem to be, therefore, a prospect for initiatives of this nature to prosper.

Another serious threat to SUS – and which is also connected to the logic of its privatization – is PEC 451/14, authored by the ex-deputy Eduardo Cunha, that proposes the alteration of Art. 7 of the 1988 Constitution, requiring all Brazilian employers to guarantee (supplementary) health care services, except domestic workers. This represents a deplorable return to the situation that existed before the creation of SUS, when we had so-called 'indigents,' Brazilians who did not have social security coverage and depended solely on philanthropy (ALMEIDA; CHIORO; ZIONI, 2001). Another legislative proposal, ever present in congressional propositions, is that of amnesty for fines and from the compensation liabilities of private health plans to SUS. In addition to waiving the necessary resources, it demonstrates an enormous liberality in relation to private capital.

The most serious threat, and which will have a devastating impact for SUS and for other public policies, is PEC 241/2016, authored by the Executive Branch, which alters the Transitional Constitutional Dispositions Act in order to institute the New Fiscal Regime, limiting public spending – such as health spending – for 20 years. In this manner, the Ministry of Health's budget, for two decades, will be readjusted only for inflation (measured by the Broad Consumer Price Index – IPCA). The PEC does not consider the health needs of the population, the impact of population increases, demographic transitions, and aging populations (in 2030, more than 30% of the population will be more than 65 years old), the necessary expansion of the public network to cover lack of care, the impact of technological incorporation (which is growing and cumulative in the area of health) and the costs associated with changes in health care profiles determined by the prevalence of non-transmitted diseases and external causes, and of sectorial inflation itself, which is higher than that of other sectors of the economy at the international level. Even worse, it detaches social spending from any possible increase in revenues over the next 20 years. Thus, even if federal collection increases, there will not be investments in social areas.

The basic principle of the PEC is to avoid the automatic transfer of real earnings coming from economic growth to primary expenditures, and therefore, to ASPS spending. In relation to minimum investments, the problem is deeper in the extent to which it opts for a starting base that is lowered by the weak performance of the economy and of revenue in 2016. Therefore, if the PEC is approved, the health care minimum would recede, in nominal amounts, in relation to the budget amount available in 2016. In 2018 alone would the minimum reach

the amounts that should be applied in the current fiscal year.

In practice, further reductions in federal health care spending (in relative and absolute terms) would impose a burden on states and cities, which are already in a delicate fiscal situation and have been increasing their percentage interest in total health expenditures since the 2000s, as a result of EC 29.

Federal Government health expenditures fell from 43% to 30% of the total between 2015 and 2022. States and cities, who in 2015 represented 57% of health expenditures, would become responsible for 70% of spending in 2022. The Federal Government, therefore, would answer for less than one-third of total ASPS expenditures in 2022 (SÓTER; MORETTI, 2016). Since the other federative entities will not have the capacity to fund more than 70% of SUS resources, in the face of the proposed rule for the health care minimum, a chaos scenario is very likely for the next few years, pointing toward the risk of a reduction in service offerings and the shrinking or total nonviability of SUS.

A hypothetical exercise supports these affirmations, showing the effects of the federal health care minimum rule, if it had been used between 2003 and 2015 *(table 2)*.

Table 2. ASPS x PEC 241 (R$ thousand) effective expenditures, updated by the IPCA, to 12/2015 prices

Year	ASPS Expenditures*	PEC 241**	Rate of change
2003	59.874.923	61.318.421	2%
2004	65.909.993	61.318.421	-7%
2005	69.574.757	61.318.419	-12%
2006	72.216.875	61.318.417	-15%
2007	76.122.462	61.318.414	-19%
2008	80.056.934	61.318.415	-23%
2009	90.506.007	61.318.412	-32%
2010	92.266.471	61.318.414	-34%
2011	101.693.947	61.318.415	-40%
2012	104.392.049	60.565.463	-42%
2013	103.588.929	61.318.416	-41%
2014	109.036.112	61.318.416	-44%
2015	111.182.971	61.318.420	-45%
TOTAL	1.136.422.429	796.386.464	-30%

Source: Elaborated by author. Public Health Budget Information System (Siops) (2003-2015 nominal amounts).

* Amounts effectively invested in public health actions and services (ASPS).

** Amounts corresponding to that invested in the previous fiscal year, plus the IPCA of the previous year.

The accumulated loss in the period would have been 30% relative to the amounts executed and to the reduction in relation to that which was effectively invested in almost one-third of federal expenditures in ASPS. If only the amounts executed in 2015 are observed, it can be verified that the health care minimum would be almost half of the invested amount. The real reduction of the amounts would make it impossible to maintain the programs created or expanded in the period, such as More Doctors, UPA,

SAMU, Popular Pharmacy, Family Health, and the National Immunization Program, among others.

The funding of a system that serves 206 million people requires an increase in real terms of the amount invested in its actions, above all in the context of growth in demands for health care. If SUS is maintained in its constitutional precepts, the health funding rule cannot be guided only by fiscal prospects, above all if it is observed that the proposal is for the PEC to be in effect for at least ten years. It is necessary to observe health necessities, both in the mid-term and in the long-term, considering that the country should be prepared to meet the growing demands of the population, in the midst of the aforementioned demographic, nutritional, and epidemiological transition.

Conclusion

The conservative changes that point to the end of SUS are supported and produce a symbolic basis in the societal construct as a result of the insidious and permanent destruction of its image produced by mass media, which daily expose, in a dishonest and perverse manner, the system's evils, exploiting its problems without ever analyzing or indicating their determinants and without considering the successes of SUS in the production of access to health care, an improvement in health and quality of life indicators for millions of Brazilians.

We have never been so close to the implosion of SUS. From a State policy, under construction and globally recognized, with its contradictions, challenges, and complexities, we run the risk of seeing it transformed into a government policy, which is disparaged and restrictive for the Brazilians excluded from the formal job market, in detriment to a system that guarantees universal access.

A logic against which we struggled so much in the 1990s, but which, unfortunately, reappears in the proposals of coup supporters and usurpers of power. They do not count on social legitimacy, but take advantage of the political and economic crisis that the country is experiencing in order to impose an agenda that not even the global icons of the 1990s liberal reform – such as Margaret Thatcher or Ronald Reagan – and, in Brazil, Collor and Cardoso, dared to implement, defeating the dream of offering the SUS provided in the Federal Constitution, which is capable of guaranteeing universal, complete, and equal access for the Brazilian population.

In the past few years, SUS has been losing social legitimacy. Surveys demonstrate approval among SUS users (BOLZAN *ET AL.*, 2012; COSEMS-SP, 2012), but paradoxically indicate health plans as the object of desire of workers who ascended economically during the Lula administration (IESS, 2011). Social inclusion through access to consumption, and not through the expansion and strengthening of public policies, lessened worker commitment to social struggles.

The Temer administration, thus far, has not announced or offered a single contribution to the improvement of SUS. Only the prospect of spending restrictions in a system already choked by underfunding and privatization, definitively extending it in view of private health spending provisions and expansion, according to the typologies proposed by Maarse and Scatena (2006) for privatization.

How to react to the retrocessions and threats to democracy, to social and human rights, and defend public policies such as SUS? This question has been feeding debate and will occupy the thoughts of militants who act in defense of SUS and democracy in the near future. It is necessary to face this agenda, to deepen relationships with social movements and with the new collectives that place themselves in the political scene and re-entice them to defend a public, universal, complete, and equal system. We need to overcome a maxim that has been confusing

and depoliticizing the SUS defense movement: we do not all defend the same SUS. At its core, disputes are waged about the way to manage and produce health care.

We are fighting for the SUS that we want when we vigorously face, for example, the cesarean epidemic, when we build a safe and healthy nutrition policy, when we deconstruct the excessive medicalization of life as an adequate therapeutic route, when we invest in the qualification of lightweight technology for the production of quality care (MERHY, 1988), when we build strategies to welcome the transgender, gay, and black populations, women victims of violence, homeless people, and indigenous groups. It is necessary to impregnate our collectives with the dreams that build this SUS project, to explain the disputes, to take a stand, to engage in political debate, to occupy the various spaces. To once again entice the population and workers. Today's struggle calls for reflection, to abandon generic banners and enable debate. However, for this to happen, it will be necessary to advance with a view to strengthening democratic processes and barring an illegitimate State in its wrathful diminishing of rights and of SUS itself.

Collaboration

AACR, APPS, LACF and SSSP contributed in the conception and planning of the study, in the elaboration of the draft, in the editing of the content, and in the approval of the final version of the manuscript. ■

References

AAGÊNCIA NACIONAL DE SAÚDE SUPLEMENTAR (ANS). Dados e Indicadores do Setor. Disponível em: <http://www.ans.gov.br/perfil-do-setor/dados-e-indicadores-do-setor#>. Acesso em: 28 jul. 2016.

ALMEIDA, C. *O Mercado Privado de Serviços de Saúde no Brasil: Panorama Atual e Tendências da Assistência Médica Suplementar*. 1998. (Texto para Discussão no 599). Disponível em: <http://www.ipea.gov.br/agencia/images/stories/PDFs/TDs/td_0599.pdf>. Acesso em: 27 set. 2016.

ALMEIDA, E. S.; CHIORO, A.; ZIONI, F. Políticas Públicas e Organização do Sistema de Saúde: Antecedentes, Reforma Sanitária e o SUS. In: WESTPHAL, M. F.; ALMEIDA, E. S. (Org.). *Gestão de Serviços de Saúde*. São Paulo: Edusp, 2001. p. 13-50.

BAHIA, L. Padrões e mudanças no financiamento e regulação do Sistema de Saúde Brasileiro: impactos sobre as relações entre o público e privado. *Saúde e Sociedade*, v. 14, n. 2, p. 9-30, 2005. Disponível em: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0104-12902005000200003>. Acesso em: 9 nov. 2016.

BOLZAN, L. C. *et al*. Ouvidoria Ativa: A Inovação das Pesquisas de Satisfação na Ouvidoria-Geral do SUS. 2009. Disponível em: <http://www.sgc.goias.gov.br/upload/arquivos/2013-03/ouvidoria-ativa-a-inovacao-das-pesquisas-de-satisfacao-na-ouvidoria-geral-do-sus.pdf>. Acesso em: 28 ago. 2016.

BRASIL. *Constituição da República Federativa do Brasil*. Título VIII, cap. I e II, Secção II. Da Saúde. Brasília, DF: Senado Federal, 1988. p. 133-4.

_____. Emenda Constitucional nº 29, de 13 de setembro de 2000. Altera os arts. 34, 35, 156, 160, 167 e 198 da Constituição Federal e acrescenta artigo ao Ato das Disposições Constitucionais Transitórias, para assegurar os recursos mínimos para o financiamento das ações e serviços públicos de saúde. *Diário Oficial [da] União*. Brasília, DF, 13 set. 2000. Disponível em: <http://www.planalto.gov.br>. Acesso em: 21 jul. 2016.

_____. Presidência da República. Lei nº 8.080, de 19 de setembro de 1990. Dispõem sobre as condições para promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial [da] União*. Brasília, DF, 19 set. 1990. Disponível em: <https://www.planalto.gov.br/ccivil_03/leis/L8080.htm>. Acesso em: 23 dez. 2016.

_____. Presidência da República. Lei nº 8.142, de 28 de dezembro de 1990. Dispõe sobre os mecanismos de participação popular de financiamento para o setor saúde. *Diário Oficial [da] União*. Brasília, DF, 28 dez. 1990. Disponível em: <http://www.planalto.gov.br/ccivil_03/leis/L8142.htm>. Acesso em: 23 dez. 2016.

_____. Presidência da República. Lei nº 9656, de 03 de junho de 1998. Dispõe sobre os planos e seguros privados de assistência à saúde. *Diário Oficial [da] União*. Brasília, DF, 03 jul. 1998. Disponível em: <http://www.planalto.gov.br/Ccivil_03/leis/L9656.htm>. Acesso em: 23 dez. 2016.

_____. Emenda Constitucional nº 86, de 17 de março de 2015. Altera os arts. 165, 166 e 198 da Constituição Federal, para tornar obrigatória a execução da programação orçamentária que especifica. *Diário Oficial [da] União*. Brasília, DF, 17 mar. 2015a. Disponível em: <http://www.planalto.gov.br>. Acesso em: 21 jul. 2016.

_____. Ministério da Saúde. *Relatório Final do Grupo de Trabalho Interinstitucional sobre órteses, próteses e materiais especiais (GTI-OPME)*. 2015b. Disponível em: <https://www.editoraroncarati.com.br/v2/phocadownload/relatorio_final_gti_opme.pdf>. Acesso em: 28 set. 2016.

_____. Ministério da Saúde. *Sistema de Informações sobre Orçamentos Públicos em Saúde*. Disponível em: <http://portalsaude.saude.gov.br/index.php/o-ministerio/principal/siops>. Acesso em: 17 jul. 2016.

CENTRO BRASILEIRO DE ESTUDOS DE SAÚDE (CEBES). Saúde é qualidade de vida. *Saúde em Debate*, Rio de Janeiro, n. 35, p. 7-18, out. 1992.

CONSELHO DE SECRETÁRIOS MUNICIPAIS DE SAÚDE DO ESTADO DE SÃO PAULO (COSEMS-SP). *Ministério da Saúde divulga pesquisa da Ouvidoria sobre grau de satisfação dos usuários do SUS*. São Paulo: COSEMS-SP, 2012. Disponível em: <http://www.cosemssp.org.br/noticias/93/ministerio-da-saude-divulga-pesquisa-da-ouvidoria-sobre-grau-de-satisfacao-dos-usuarios-do-sus.html>. Acesso em: 27 set. 2016.

GADELHA, C. A. G. *et al*. O Complexo Econômico-Industrial da Saúde no Brasil: dinâmica de inovação e implicações para o Sistema Nacional de Inovação em saúde. *Revista Brasileira de Inovação*. Campinas, v. 12, n. 2, p. 251-282, jul./dez. 2013.

GRAMSCI, A. *O Conceito de Hegemonia em Gramsci*. 3. ed. Rio de Janeiro: Graal, 1991.

INSTITUTO DE ESTUDOS DE SAÚDE SUPLEMENTAR (IESS). Pesquisa IESS/Datafolha aponta que o plano de saúde é uma necessidade e desejo do brasileiro. *Saúde Suplementar em Foco,* São Paulo, n. 14, 2 maio 2011. Disponível em: <http://www.iess.org.br/?p=publicacoes&id=672&id_tipo=6>. Acesso em: 28 ago. 2016.

MAARSE, H.; SCATENA, J. H. G. The privatization of health care in Europe: an eight-country analysis. *J Health Polit Policy Law,* Durham, n. 31, p. 981-1014, 2006.

MAZZA, W. P. *O desmonte do Estado Social não é solução para a crise financeira e política*. 2016. Disponível em: <http://www.emporiododireito.com.br/?s=O+desmonte+do+Estado+Social+n%C3%A3o+%C3%A9+solu%C3%A7%C3%A3o+para+a+crise+financeira+e+pol%C3%ADtica>. Acesso em: 26 set. 2016.

MEDICI, A. Breves considerações sobre a relação entre direito sanitário e financiamento à saúde no Brasil. In: SANTOS, L. (Org.). *Direito da saúde no Brasil*. Campinas: Saberes, 2010. p. 243-78.

MENDES, A.; MARQUES, R. M. O financiamento do SUS sob os "ventos" da financeirização. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, n. 3, p. 841-50, 2009.

MERHY, E. E. *et al.* A perda da dimensão cuidadora na produção da saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: REIS, A. T. *et al.* (Org.). *Sistema Único de Saúde em Belo Horizonte*: reescrevendo o público. São Paulo: Xamã, 1998.

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD). *Brasil:* fortalecendo a governança para o crescimento. Relatório sobre a reforma regulatória. OECD, 2008. Disponível em: <http://www.biblioteca.presidencia.gov.br/publicacoes-oficiais/catalogo/lula/oecd-reviews-of-regulatory-reform-brazil-2008/@@download/file/oecd%20reviews%20of%20regulatory%20reform%20brazil%202008.pdf>. Acesso em: 27 set. 2016.

_____. *Health expenditure, public (% of GDP)*. World Bank, 2013. Disponível em: <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>. Acesso em: 12 set. 2016.

PAIM, J. *et al.* O sistema de saúde brasileiro: história, avanços e desafios. 2011. *Lancet*. [Internet]. 2011. p. 11-31. (Série Brasil). Disponível em: <http://actbr.org.br/uploads/conteudo/925_brazil1.pdf>. Acesso em: 21 dez. 2016

PEREIRA, S. S. S. As inovações na regulação: o caso da saúde suplementar no Brasil. In: AGÊNCIA NACIONAL DE SAÚDE SUPLEMENTAR (BRASIL) (Org.). *Atenção à saúde no setor suplementar:* evolução do processo regulatório. Disponível em: <http://www.ans.gov.br/images/stories/Materiais_para_pesquisa/Materiais_por_assunto/Livro_Manual_AtencaoSaude.pdf>. Acesso em: 21 dez. 2016.

RIBEIRO, J. M. UHS development and hospital services rationing. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, p. 771-782, 2009.

SÓTER, A. P.; MORETTI, B. Análise preliminar dos efeitos da vedação do crescimento real das despesas federais e o comprometimento da universalidade do SUS. In: ENCONTRO NACIONAL DE ECONOMIA DA SAÚDE, 12., 2016. *Anais*... Salvador: Associação Brasileira de Economia de Saúde. Disponível em: <http:// abresbrasil.org.br>. Acesso em: 29 set. 2016.

UGÁ, M. A. D.; PORTO, S. M.; PIOLA, S. F. Financiamento e alocação de recursos em saúde no Brasil. In. GIOVANELLA, L. *et al. Políticas e sistema de saúde no Brasil.* 2. ed. Rio de Janeiro: Fiocruz, 2014. p. 395-425.

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