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Financial sustainability of the Brazilian Health System and health-related tax expenditures

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Abstract *Using official data from Brazil's Internal Revenue Service, this article estimates health-related federal tax expenditures between 2003 and 2015. The Ministry of Health will thus be able to assess the relevance of these subsidies within a context of gross underfunding of Brazil's public health system. The analysis was built around concepts and theories developed in the fields of political economy and public finance, focusing on policies directed at public funding of the health sector. The results show that tax expenditures associated with health insurance plans was R$12.5 billion in 2015. It is suggested that these resources could be put to better use in public primary care and medium-complexity care services.*

Key words *Health systems, Public health, Budgets, Government funding, Equity*

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Introduction

The 1988 Constitution provides that healthcare is a "duty of the state" and a right of all citizens. According to the letter of the law, this right shall be upheld by the Unified Health System (*Sistema Único de Saúde* - SUS), which shall respond to the social needs of all individuals regardless of their ability to pay, inclusion in the labor market or health status.

It is evident therefore that the government should have concentrated efforts on building and strengthening the public health system over the last 30 years. However, private health plans have benefited from significant government incentives, which have favored and continue to favor the consumption of private health goods and services. Unlike the Beveridge model and similar to the US private model, the Brazilian health system began to work like a duplicated and parallel system in the wake of the privatization of the former health system structured under the National Institute of Medical Care and Social Security (*Instituto Nacional de Assistência Médica da Previdência Social* – INAMPS)[1].

It is not easy for those who defend the SUS to deal with this contradiction. The market aggravates distortions produced by this system as increased private spending and economic power corrode financial sustainability, leading to a vicious circle culminating in a relative fall in public health spending[2]. At the same time, the regulation of the duplicated system is much more complex for the government[3], given that the market also covers services provided by the public sector[4].

It is not surprising therefore that there is a certain degree of consensus among health policy analysts that the greatest challenges facing the SUS - securing funding for the public subsystem, redefining the public-private interface, and reducing income, power and health inequalities - are essentially political[5]. This situation sums up the perverse[6] "Americanization" of the Brazilian health system, suggesting that it would be appropriate to rethink why it has not been possible to break the structural shackles of this historical heritage[7] and move towards increased SUS funding and strengthening regulatory mechanisms defined by the National Supplementary Health Agency (*Agência Nacional de Saúde Suplementar* - ANS) and National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária* - ANVISA).

Tax breaks have played a key role in the economic reproduction of this duplicated and parallel system. This issue deserves far greater attention from the government if the aim is to consolidate the SUS while at the same time reducing family and employee spending on private goods and services.

Given the scale of the funding shortfall[8], the central contradiction of tax breaks for private health insurance plans lies in the fact that they benefit people on higher incomes who can afford insurance cover while at the same time favoring highly profitable private business activities over spending on public health prevention programs and specialized services that are fundamental to the consolidation of the SUS[9].

To assess the pros and cons of health subsidies, this article first presents an inconclusive debate on the theme and then goes on to discuss the magnitude of health-related tax expenditures in Brazil and their evolution between 2003 and 2015, focusing on tax breaks for individual and employer-sponsored health insurance plans. We then go on to discuss the need to regulate the provision of this subsidy. Finally, we emphasize some considerations to help direct future research given that – in addition to the challenges facing the SUS in the sphere of funding, management and public participation – it appears at first sight that tax breaks do not promote the consolidation of the SUS and equity in Brazil's health system.

An inconclusive debate

Several countries – including Australia, Canada and the United States – provide incentives in the form of tax reductions for health insurance plans[10]. These incentives are tax expenditures, given that they are tax that would have been collected in the absence of a particular tax benefit or, in other words, public spending not directly allocated to health[11]. Expressing opposing views, this can either strengthen public sector cost containment policies or enhance the profitability of the private sector, or even compensate the negative effects of the tax burden and abuse of service users[12].

Without going into the merits of supply-oriented subsidies (pharmaceutical industry and philanthropic hospitals), Brazil has followed this global trend, given that other medical spending apart from health insurance plans, such expenses with health professionals, clinics and hospitals, are tax-deductible for both individuals and companies, thus reducing government revenue. Given that private funding mechanisms tend to affect the public health budget[13], it could be sug-

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gested that tax breaks take funding that could be used to improve service quality away from the SUS and help to restrict access to the system, given that they reduce expenditure per capita for certain groups[14].

In the context of a duplicated and parallel public-private health system and given the impacts of this subsidy on the funding of the SUS and equity in the system, it seems plausible that the government should attenuate a distributive conflict[15] that favors people on higher incomes and subsidizes private health insurance companies' profit margins. At the current historical conjuncture, beyond fiscal austerity policies, this conflict does not appear to encourage the adoption of short-term government measures.

(i) From a theoretical standpoint, tax breaks are not viewed as playing a key role in the reproduction of this duplicated and parallel system. After all, it is not just any type of tax exemption. Quite the opposite, it was and is an essential element of the structure and dynamics of the private health insurance market[16];

(ii) From a political standpoint, going against certain entrenched interests in state-society relations could lead to unpredictable realignments in the electoral cycle. Initially, the legitimacy of reducing, eliminating or targeting this subsidy could be questioned by various groups, including: the "middle class", which influence public opinion; employees from the public and private sector and mixed-ownership companies, who would lose all or part of the subsidy; employers, who would suffer from an increase in labor costs, albeit with the possibility of protecting themselves though price adjustment; health insurance plan operators, private clinics and hospitals, and health professionals, who would also lose part of their revenue, given that tax breaks boosts the consumption of private health goods and services[17].

(iii) From an institutional standpoint, it is important to mention that the executive, legislative and judicial branches – that is, the core of the decision-making power of the Brazilian State – is covered by health insurance plans, or hybrid forms such as self-management plans, and benefit from tax breaks. Furthermore, their members receive incentives for the consumption of private goods and services from the federal government in the form of indirect pay[18].

One way of addressing this situation would be to increase funding, improve the quality of services provided by the SUS and enhance government capacity to regulate health care markets. This would attract private sector customer segments, resulting in a reduction in spending by families and employees. While on the one hand this could provide the necessary political support for reducing, eliminating or targeting tax breaks, on the other it would require the government to allocate what otherwise would have been tax expenditure to primary care (prevention) and secondary care (tests, specialist consultations and outpatient surgery) to substantially improve access to and use of the SUS. However, while this appears to be a credible alternative, its scale and depth depend on the growth of the economy and productivity of this system, the countercyclical nature of fiscal policy, and the primacy of the state in the management of the human resources of the Ministry of Health and subnational spheres of government. In any event, given that tax breaks are a result of human actions conditioned by political and economic interests taken within a certain historical period, they should not be taken for granted or go unregulated – detached from values, norms and practices that enable the exercise of government control over the SUS's constitutional framework. After all, concerns about the regressive nature of tax breaks have led several countries to impose thresholds or design policies to reduce or target their impact[19]. In this respect, it seems appropriate to reflect on the regulation of health-related tax expenditures. However, before doing so, the following section examines the magnitude of tax expenditures between 2003 and 2015, focusing on tax breaks associated with private health insurance plans.

The magnitude of health-related tax expenditures in Brazil between 2003 and 2015

This section presents health-related tax expenditures, or revenue forgone by the federal government, associated with family and employee consumption and the production of goods and services by the pharmaceutical industry and philanthropic hospitals between 2003 and 2015. Based on data from Brazil's Internal Revenue Service (*Receita Federal do Brasil* - RFB), special attention is given to revenue forgone associated with individual and employer-sponsored health insurance plans, calculated on an *ad hoc* basis using the comprehensive personal income tax (*Imposto de Renda – Pessoa Física* - IRPF) model and a proxy of medical expenditure by employers based on corporate income tax (*Imposto de Renda Pessoa Jurídica* - IRPJ).

Table 1 shows that the health sector accounted for 22.2% of overall tax expenditure in 2003 (R$32.3 billion). This percentage gradually decreased over the period, standing at 11.7% in 2015. This reduction can be explained largely by a general increase in tax and social security tax exemptions.

In the same vein, Table 2 shows that health-related tax expenditure as a percentage of Ministry of Health expenditure on public health actions and services ranged between 28.2 and 36.6% in the period between 2003 and 2015.

Table 3 shows that, given the scale of funding shortfalls, total health-related tax expenditure in the period was by no means negligible. Based on average prices in 2015, total health-related tax expenditure was R$331.5 billion. It can also be noted that real direct and indirect spending on health increased at a faster pace than the PIB during the period and that in the last year percentage growth in subsidies was greater than that of direct expenditure.

In 2015, the sum of health-related tax expenditure associated with corporation tax (Table 4) and that associated with health insurance plans (Table 5) resulted in a total subsidy for health insurance plans of R$12.5 billion, compared to R$6.1 billion in 2003, showing that this subsidy doubled in real terms during the period under study.

Given the scale of underfunding in the SUS and the large amount of health-related tax expenditures, it is important to review the regulation of these expenditures. In this respect, it is important to stress that the current situation resembles the American private health system, which is recognized as expensive and inefficient and characterized by employee subsidies and benefits[20].

What is the role of the Ministry of Health?

As mentioned above, the amount of money the government would have collected in the absence of a particular tax benefit is effectively a cost, which is why breaks are considered "expenditure" – or spending.

Individuals are able to deduct medical expenses from their taxable income. However, unlike educational expenses, there is no limit (threshold) for such deductions. The same rules apply to employer-sponsored health insurance, which is considered an operating expense and can be deducted from taxable profit[21]. It is worth emphasizing that this type of incentive in Brazil is by no means new to state-market economic relations. It is natural to expect, therefore, that tax ex-

Table 1. Health-related tax expenditure as a percentage of overall tax expenditure between 2003 and 2015.

Year	Health Expenditure (R$ million)		%
	Total	Health	
2003	38,857	8,641	22.2
2004	49,8	10,515	21.1
2005	56,429	11,426	20.2
2006	81,24	14,894	18.3
2007	102,673	15,148	14.8
2008	114,755	17,05	14.9
2009	116,098	17,229	14.8
2010	135,861	18,376	13.5
2011	152,441	20,387	13.4
2012	181,747	23,431	12.9
2013	223,31	25,786	11.5
2014	257,223	29,019	11.3
2015	277,14	32,344	11.7

Source: Internal Revenue Service (RFB)/Centro de Estudos Tributários e Aduaneiro (Cetad).

Elaborated by Department of Studies and Social Policies (Disoc)/Institute of Applied Economic Research (Ipea).

Table 2. Health-related tax expenditure as a percentage of Ministry of Health spending between 2003 and 2015.

Year	Ministry of Health (R$ million)	Health-related Tax Expenditure (R$ million)	%
2003	27,181	8,641	31.8
2004	32,703	10,515	32.2
2005	37,146	11,426	30.8
2006	40,75	14,894	36.6
2007	44,304	15,148	34.2
2008	48,67	17,05	35.0
2009	58,27	17,229	29.6
2010	61,965	18,376	29.7
2011	72,332	20,387	28.2
2012	80,063	23,431	29.3
2013	83,053	25,786	31.0
2014	91,898	29,019	31.6
2015	100,055	32,344	32.3

Source: Ministry of Health (MS) and RFB/Cetad.

Elaborated by Disoc/Ipea.

Table 3. Real growth: Gross Domestic Product, Ministry of Health, health-related tax expenditure and total federal spending on health between 2003 and 2015.

(Values deflated based on National Consumer Price Index average 2015 prices)								(Baseline 100 = 2003)
Year	GDP[1] (R$ million)	Index	Ministry of Health[2] (R$ million)	Index	Health-related Tax Expenditure (R$ million)	Index	Total Federal Spending on Health[3] (R$ million)	Index
2003	4,184,234	100	53,872	100	17,125	100	70,997	100
2004	4,425,245	106	60,805	113	19,551	114	80,355	113
2005	4,566,947	109	64,626	120	19,878	116	84,504	119
2006	4,747,889	113	68,049	126	24,872	145	92,921	131
2007	5,036,079	120	71,385	133	24,408	143	95,792	135
2008	5,292,627	126	74,206	138	25,995	152	100,201	141
2009	5,285,968	126	84,702	157	25,045	146	109,747	155
2010	5,683,908	136	85,753	159	25,431	148	111,183	157
2011	5,909,810	141	93,87	174	26,457	154	120,327	169
2012	6,023,348	144	98,576	183	28,849	168	127,425	179
2013	6,204,339	148	96,284	179	29,894	175	126,178	178
2014	6,235,606	149	100,196	186	31,64	185	131,836	186
2015	6,000,570	143	100,055	186	32,344	189	132,399	186

Sources: IBGE, MH and RFB/Cetad.

Elaborated by Disoc/Ipea.

Notes: 1 GDP deflated using implicit price deflator of the Brazilian Institute of Geography and Statistics (IBGE). For 2015, deflator was calculted using the National Accounts Nacionais Trimestrais, replicando a metodologia utilizada pelo IBGE para os Years de 2010 a 2014. 2 Spending on public health services and actions in accordance with Complementary Law N° 141 that regulates the Constitutional Amendment N° 29/2000, sanctioned by the President of the Republic on January13 2012. 3 Total spending on health: sum of direct spending (Ministry of Health) and indirect spending (health-related tax expenditure).

Table 4. Real growth: Health-related tax expenditure between 2003 and 2015.

(Values deflated based on NCPI average prices 2015)										(Baseline 100 = 2003)
Year	Corporation Tax (R$ million)	Index	Personal Tax (R$ million)	Index	Medications and Chemical Products (R$ million)	Index	Philanthropic Hospitals (R$ million)	Index	TOTAL (R$ million)	Index
2003	7,422	100	2,302	100	2,223	100	5,179	100	17,125	100
2004	8,476	114	2,434	106	2,746	124	5,895	114	19,551	114
2005	8,656	117	2,615	114	3,014	136	5,594	108	19,878	116
2006	9,645	130	2,874	125	6,61	297	5,743	111	24,872	145
2007	10,484	141	3,387	147	4,634	208	5,903	114	24,408	143
2008	11,468	155	3,326	144	4,714	212	6,488	125	25,995	152
2009	9,876	133	3,31	144	5,023	226	6,836	132	25,045	146
2010	9,429	127	3,676	160	5,001	225	7,325	141	25,431	148
2011	10,014	135	3,812	166	4,641	209	7,991	154	26,457	154
2012	10,788	145	4,118	179	5,156	232	8,787	170	28,849	168
2013	11,125	150	4,693	204	5,029	226	9,047	175	29,894	175
2014	11,678	157	4,717	205	5,489	247	9,756	188	31,64	185
2015	11,672	157	4,539	197	6,619	298	9,514	184	32,344	189

Source: RFB/Cetad.
Elaborated by Disoc/Ipea.

Table 5. IRPF: real growth related to type of health-related tax expenditure between 2003 and 2015.

	(Valores deflacionados pelo IPCA a preços médios de 2015)						(Base 100 = 2003)					
Year	Hospitals and Clinics Brazil (R$ million)	Index	Hospitals and Clinics Outside Brazil (R$ million)	Index	Health Plans (R$ million)	Index	Health Professionals Brazil (R$ million)	Index	Health Professionals Outside Brazil (R$ million)	Index	TOTAL (R$ million)	Index
2003	1,417	100	28	100	3,845	100	2,023	100	108	100	7,422	100
2004	1,618	114	32	114	4,392	114	2,31	114	124	114	8,476	114
2005	1,561	110	27	95	4,76	124	2,206	109	102	94	8,656	117
2006	1,761	124	27	96	5,398	140	2,362	117	98	90	9,645	130
2007	2,474	175	40	140	5,778	150	1,89	93	303	280	10,484	141
2008	2,771	196	45	160	6,57	171	1,901	94	180	167	11,468	155
2009	2,197	155	19	65	6,006	156	1,6	79	55	51	9,876	133
2010	1,824	129	14	49	5,976	155	1,601	79	14	13	9,429	127
2011	2,059	145	15	53	6,269	163	1,664	82	8	7	10,014	135
2012	1,988	140	15	53	7,107	185	1,663	82	6	6	10,78	145
2013	1,942	137	16	57	7,488	195	1,582	78	6	6	11,034	149
2014	2,005	142	14	48	8,002	208	1,562	77	6	5	11,589	156
2015	2,125	150	15	54	8,014	208	1,427	71	7	6	11,588	156

Source: RFB/Cetad.
Elaborated by Disoc/Ipea.

penditures associated with health plans should at least be justified in Ministry of Health guidelines.

After all, what is the function of health-related tax expenditure for the federal government? Theoretically, this type of spending could be used to meet the following government objectives, individually or in combination: boost demand for health insurance plans; strengthen regulation of the market price of health insurance plans; reduce waiting lists and waiting times in specialized public services; reduce the tax burden of tax payers who face catastrophic health expenditure; reduce spending on private health goods and services by the work force integrated into the dynamic pole of the economy; and promote tax benefits. In this respect, the government should develop rules to govern the application of this subsidy, assess its impact and make its purpose in relation to health policy more transparent.

On this point, the following hypotheses regarding the *modus operandi* of health-related tax breaks should be considered:

(i) Government health spending is low and management problems arise precisely from SUS funding problems[22]. Tax breaks therefore potentially deny significant resources that could be used to improve access to and quality of services.

(ii) Tax breaks reinforce health system inequalities, reducing direct and indirect per capita public expenditure for low and medium income groups.

(iii) Lobbies tend to maintain or aggravate inequalities, given that the influence of economic elites over the National Congress corrodes the financial and political sustainability of the SUS.

(iv) Subsidies do not remove the burden imposed on SUS medical- hospital services because private patients also use these services (vaccination, urgent and emergency services, blood banks, transplants, hemodialysis, and high-cost and technologically complex services). Paradoxically, therefore, the public system ends up absorbing part of the costs of private healthcare operators – as in the case of the controversial compensatory benefit provided to federal civil servants with health insurance plans.

(v) Unlike the public-private mix, private sector subsidies can boost overall demand for healthcare services in an uncontrolled manner, often duplicating supply. Worse still, service users with health insurance plans favored by tax breaks are able, for example, to do tests and examinations faster, allowing them to "jump the queue" in the SUS, particularly in high-complexity services.

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Although these hypotheses should be empirically tested, they clearly show that tax breaks potentially affect SUS funding and equity in the health system, justifying measures to fill the regulatory gap. This becomes particularly clear when we consider the progressive nature of the SUS and its positive effects on the reduction of income inequalities. In this respect, the poorest 40% of households account for around a half of expenditure on hospital admissions and 45% of expenditure on outpatient procedures, while the richest 20% of families account for 10% of spending. With respect to overall expenditure, the poorest 50% account for 55% of spending, while the richest 30% account for one-fifth[23].

If the government really intends to defend and uphold the principals of universality and comprehensiveness of the SUS laid out in the Constitution, other assumptions should also be considered by the Ministry of Health, bearing in mind the contradictions in the relations between public funding patterns and the health insurance market:

(i) Tax expenditure has played a key role in the reproduction of Brazil's duplicated and parallel health system.

(ii) Tax breaks for health insurance plans do not influence the price adjustments for individual health insurance plans imposed by the ANS – for example, ANVISA monitors drug price reduction resulting from tax breaks for the pharmaceutical industry.

(iii) The total amount of tax expenditure associated with foregone personal and corporation tax is not controlled, either by the Ministry of Health or by the Ministry of Finance – rather, conditional on income, it depends on the amount of money spent on health by taxpayers and employers.

Given the current correlation of forces, there is no single solution for defining the role of the Ministry of Health in this issue. It is therefore essential to bring government and civil society closer together in this debate while avoiding the judicialization of this process. Strictly speaking, the government does not control either the destination or threshold of tax expenditures, which is effectively defined by health insurance companies, contracted network service providers and consumers – that is, these aspects are not necessarily based on federal government priorities.

One alternative, which is similar to educational tax breaks, would be to set thresholds or design measures to eliminate or reduce health-related tax expenditure. Based on the experiences of other countries, targeted tax breaks according to age, income, types of spending (medical, hospital or health insurance plans), or even health status are also an easily applicable measure.

In short, the Ministry of Health should not abdicate its role in the regulation of health-related tax expenditure, the definition of which depends on the development of an institutional project for the sector by the government and its bargaining power to overcome the distributive conflicts in the sector and prevent the sector from being hijacked by the health insurance market.

Final considerations

The historical health bloc should fight to increase funding, improve management and strengthen public participation in the SUS. However, at the same time, in a critique of privatization, it should also propose the creation of institutional structures and regulatory mechanisms that attract private sector customer segments to the SUS and reduce spending of employees, families and the elderly on health insurance plans, medical and hospital services, and drugs.

In an attempt to strengthen the SUS and reorient the model of care, tax expenditure associated with health insurance plans – which reached R$12.5 billion in 2015 – could help to grow Ministry of Health transfers to primary and medium-complexity care.

It is necessary therefore to convince the government and society as to the "positive externalities" of eliminating, reducing or targeting tax breaks and allocating the resulting tax revenue to public primary care (Family Health Program, health promotion and prevention, etc.) and medium-complexity care (urgent care centers, specialized services and technological resources for diagnostic and therapeutic support).

After all, the conversion of indirect public spending on health into direct spending makes more sense from a clinical and epidemiological point of view. This is because it would contribute to overcoming the current treatment-based model and a duplicated and parallel system, which stimulates the overproduction and rampant consumption of health goods and services[24] and responds to chronic conditions by adopting an acute care approach, potentially leading to disastrous long-term health and economic outcomes[25]. However, at the present conjuncture, given the vicissitudes of the electoral cycle, there is a certain level of uncertainty as to the polit-

ical will of the current coalition government to allocate these resources to the SUS with a view to improving access and quality. It would therefore seem appropriate for the Ministry of Health to take on at least a regulatory and monitoring role with respect to health-related tax expenditure.

The fact remains that there is a body of evidence that shows that tax breaks boost health insurance market growth at the expense of the SUS and lead to distributive injustice by favoring higher income groups and profitable private business activities.

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