

# **The relationship between political support base, economic policies and prioritized social policies: impacts on Brazilian healthcare system**

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## **Abstract**

This article aims to analyze the relationship between political support base, economic policies implemented and prioritized social policies, especially with regard to healthcare. During the administrations of Collor (1990-1992) and Henrique Cardoso (1995-2002), the neoliberal precepts dominated the economic and social policy decisions. Assistance policies were prioritized, with a very limited scope, without changing the poverty in Brazil although expanding access to the public health system – as a result of the constitutional change after the country's redemocratization.

In the PT governments, Lula da Silva (2003-2010) and Rousseff (2011-2016), electoral support became increasingly dependent on the lower-middle class population and the poor, who projected opportunities for better living conditions in the government. A bigger level of economic growth, driven by the external sector, made it possible to expand real minimum wage real growth and the expansion of social policies. That included the healthcare system, without expanding real resources for the sector. Nevertheless, their macroeconomic policy decisions continued to be subordinated to the neoliberal agenda. After Dilma Rousseff's impeachment process, Michel Temer assumes a reestablishment and deepening of the liberal policies of the 1990s, with possible negative impacts on the Brazilian public health system, especially regarding losses of funding.

The hypothesis of analysis is that the PT governments extended social policies, although constrained by the maintenance of neoliberal macroeconomic policies, because they were important for their support base of the lower income population. With the international economic downturn, Temer' support base (the richest population) does not perceive social policies as an effective priority.

**Key words:** Brazil; health policy; health economics; government priorities; economic constraints on health public care.

## **Introduction**

Brazil's public health expenditure is one of the lowest among countries that have a universal health system and even when compared to neighboring countries in which the right to health is not a State duty. Even more, Brazil is probably the only country in the world that has created a universal public health system and most health spending is private. Just as an illustration, in 2015, the country allocated 9.1% of the GDP in health expenditure, but only 3.9% of GDP were public spending. That means that public sector accounted for only 42.4% and the private sector for 57.6% of health spending (IBGE, 2016).

Even so, it is important to understand the system, especially in a country with more than 200 million inhabitants and so many inequalities, including access to health care, such as Brazil. With all the financing difficulties, and the changes of political priority, the SUS has accumulated several successful initiatives. An important health surveillance system and sanitary control, pharmaceutical assistance, transplants, SAMU nationalization, the control of smoking, HIV/AIDS and blood quality. The National Immunization Program is the largest program of this type worldwide and primary healthcare, through Family Health Program, attend almost 70% of the Brazilian population (Paim, 2018).

Therefore, it is necessary to understand the creation context of SUS (“Sistema Único de Saúde”) and how depending on the support base of the governments in power its policies have changed.

In 1985, after twenty-one years of military dictatorship, Brazil returned to civilian government, although indirectly elected by the Congress (the first direct election for president would only occur in 1989). The José Sarney government determined the drafting of a new Constitution that was developed during 20 months by 558 constituents between deputies and senators. On October 5<sup>th</sup> 1988, the country promulgated the “Citizen Constitution”.

The new Federal Constitution significantly expanded the responsibilities of the State in guaranteeing public policies, especially social ones (Brazil, 1988). The new legislation approved, for the first time, the right to vote of the illiterate, which still corresponded to about 25% of the adult population. In terms of labor rights, it approved a reduction in working hours, an increase in maternity and paternity leave, as well as the right to unemployment benefits. Rights as basic education and housing were made explicit as responsibility of the State. However, perhaps the most profound change has

occurred in relation to the health sector. The new constitution created a universal public health system, which should guarantee free and universal health care for all people: the “Sistema Único de Saúde” (SUS)<sup>1</sup>.

The Federal Constitution of 1988 created the Unified Health System (SUS), with a universal character, integral and equal access to health goods and services: “Article 196. Health is the right of all and the duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other health issues and universal and equal access to actions and services for their promotion, protection and recovery” (Brazil, 1988).

At the same time, in terms of funding, the Constitution did not define specific sources of funds to finance the SUS. In its article 195, it was defined that all Social Security (understood in Brazil as the policies of health, social assistance and the retirement and pension system) should be financed from the budget of the Union, states and municipalities’ governments, considering taxes and social contributions. Nevertheless, there was no specification of which taxes should finance what, the participation of each segment of the Social Security, nor the participation of each federative entity in the financing or how much should be invested in each segment.

Our main objective in this paper is to understand how the SUS has been affected over the 30 years since its inception by economic policies and changes in the bases of support of succeeding governments. Our hypothesis is that the predominance of neoliberal economic policies tended to limit resources to the system, leaving it systematically underfunded. However, despite the primacy of economic liberalism, the changes in the power blocs, and the most important support base of each government, has made the priorities in the health system change.

### **The neoliberalist “wave”: the 1990s policies**

At the same time that the 1990s and the beginning of the 2000s were important for the 1988 Constitution principles implementation, those decades were marked by the

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<sup>1</sup> Before 1988, Brazil did not have a universal public health system. The basis of health system was social security, developed in the 1930s, along with the organization of pension systems by classes of workers. The financing of the Social Security came from workers and employers, and each Retirement and Pension Fund (together with Retirement and Pension Institutes) organized its provision of health services. The State was responsible for health prevention and emergency policies, financed with budgetary resources. However, unlike countries such as France and Germany, the Brazilian health system had very limited coverage, given that the country had a large informal labor market, and informal and rural sector workers did not have a social security system and, thus, health care. Only the urban workers in the formal labor market had health care linked to the social security funds. In the 1960s, this did not reach 15% of the country’s workers.

dominance of neoliberal policies, implemented by Fernando Collor de Mello and Fernando Henrique Cardoso (FHC). This has made it much more difficult to implement effectively the social policies defined in the Constitution.

The Collor government marked the implementation of a series of liberal measures in the Brazilian economy. Those policies were based on a perspective that the previous 50 years of industrialization had created a “closed economy” in which the protectionism and action of State-own enterprises would have generated a productive structure of low productivity, low diversity and expensive productive structure, fueling the inflation high rates. The transformations in various economies in the world also forged this view, such as Reagan’s United States and Thatcher’s United Kingdom, coupled with the inflationary and debt crisis in Latin American countries, which seemed to prove the reading on errors in industrialization of previous decades.

Thus, in the early 1990s, Brazil underwent a series of structural reforms: trade liberalization (removing non-tariff barriers and reducing tariff barriers to trade); financial opening (reducing taxes and limits on the inflow and outflow of external resources); privatizations (initially in sectors whose state participation was high, but not legally protected, as in the mining and fertilizer sectors).

However, in the midst of economic changes that proposed the reduction of the State, the Collor government had an obligation to implement the social policies approved in the 1988 Constitution. Regarding healthcare, the SUS regulation actually came into force under Law 8080, dated September 1990 (Brazil, 1990). Amidst several fiscal austerity policies, the financing of the SUS, made through taxes, was conditioned by the existence of resources.

The Constitution foresaw that health would be financed as part of Social Security through a set of taxes, without defining, within the Social Security, as each branch receive. Although a percentage of transfers of resources to health was defined in 1992, in 1993 the value was already not respected, in view of the pressure to finance retirements. The government decided to withdrew part of the resources to SUS, due to the increase in unemployment rate and the consequent reduction of compulsory contributions, to cover social retirement expenditures. This “clash” in resources allocation within Social Security existed throughout the Collor government and in large part of the Fernando Henrique Cardoso administration. Although this last government has reformed the pension and pension system, in the short term this did not reduce expenses, it only reduced the

possibility of health also being financed with part of the social security contributions of employers and workers (Marques; Mendes, 2012).

Only during the second FHC administration, in 2000, with the approval of the Constitutional amendment 29, was defined a minimum spending on health. In the case of the states, they should allocate at least 12% of their own tax revenue and of the constitutional transfers made by the Union, less the amounts allocated to the respective municipalities. On the other hand, municipalities should apply at least 15% of their own tax revenue and the constitutional transfers made by the Union and states to the municipalities.

For the federal government, the Congress defined the following rule: minimum value in 2000 not less than the amount committed in 1999, corrected by 5%, and for the following years, until 2004, the value committed in the immediately preceding year, corrected by the nominal variation of the Gross Domestic Product (GDP). The Complementary Law 141 of 2012 maintained this rule (Brazil, 2012).

In terms of official political “agenda”, the first FHC term (1995-98) had two main priorities: guarantee of monetary stabilization (after the 1980s it was marked by very high levels of inflation, reaching almost 2,000% per year at the end of the decade and in the early 1990s) and constitutional reforms. With regard to constitutional reforms, they prioritized changes in the newly enacted Constitution of 1988, in order to make the Brazilian economy more “flexible”: deregulation, privatization and economic opening (Couto; Abrucio, 2003). That led to a series of neoliberal macroeconomic policies, with a currency overvaluation, an unprecedented high interest rate, reduction of public spending in the social area, scientific and technological dependence and deepening in “State reform”.

In political terms, the government had broad support from the business class, which hoped that trade liberalization would offer it new business opportunities, and the financial market. When some effects of the stabilization plan (Plano Real) were negative for these groups, as in the case of banks that lost much of their profits, the government adopted policies to guarantee its solvency and allocated public budgetary resources (“Programa de Estímulo à Reestruturação e ao Fortalecimento do Sistema Financeiro Nacional” - PROER ) to protect the financial system.

The neoliberal macroeconomic policies had a double impact on social policies. On one hand, based on greater efficiency in the private sector, they were used to justify not only the reduction of the State as a producer of industrial goods and services (and

legitimize privatizations), but also to increase the presence of the private sector in social areas. In the case of health, this became clear in the greater regulation of private health plans, which grew over those years, and in the hiring of private managers to organize the public health services provision. On the other hand, the liberal pressure to carry out fiscal austerity policies pressured social policies, even within a context in which the country had approved, in previous years, a Constitution that foreseen the expansion of social rights. This last trend was strengthened by the priority given by the government to the political support of large business and financial groups.

Therefore, FHC health policies reflected these contradictions. From one side, it did regulated a minimum resources allocation in the SUS and implemented some of the measures provided by law 8,080: increase in the management and expenditure autonomization and decentralization, focusing the municipalities; greater focus on primary care programs, creating the Family Health Program; reorganization of the State regulatory apparatus (Draibe, 2003). At the same time, the allocation of funds for Social Security was quite limited. A device created at the beginning of the formulation of the Real Plan, the “Fundo Social de Emergência” – FSE, which allowed that 20% of the resources collected in the form of social contributions could be disassociated from its purpose. Although in the early years this was not done, from 1997 the government adopted the appeal, withdrawing resources from retirement and health system.

In turn, from the approval of minimum resources for health in 2000 this problem seemed resolved. Nonetheless, minimum spending has become almost immediately the expenditure ceiling. Federal health expenditures remained fairly stable throughout the FHC government, ranging from 1.66% to 1.95% of GDP, representing, at the end of its second term in 2002, 1.85% of GDP or 12.8% % of total social expenditure (Costa, 2009).

In addition to under-funding, the government prioritized the allocation of federal resources to mid- and high-complexity care, which was widely used by a higher-income population who could not fully cover these care through their health plans (as in AIDS treatments and some types of cancer). Although the government supports a discourse that primary care was the priority, it received fewer resources and was explicitly treated as policies to serve the low-income population – and which had no private health plans.

In this sense, the SUS became a perverse combination of a system that was socially consider “for the poor”, while the greater part of the resources served the needs of the higher income population. This means a universal health system but with a restricted

universalization, due its lack of resources, targeting poverty and prioritizing the richest population.

This prioritization is also clear when considering that since 1991 individuals can deduct from the income tax the totality of their private health expenditures. This means indirect public financing of private health expenditures by the highest income population. Although this benefit is not directly related to SUS, it demonstrates public priorities and highlights the importance of middle class support for these governments.

### **The 13 years of Worker's Party contradictions**

When Lula assumed the presidency in January 2003, he repeated exhaustively three commitments: the contracts would be fulfilled (meeting the “market” expectations), the government would create 10 million jobs and all people would have three meals per day. Although promises of an entirely different nature, they all met with different desires of the Brazilians and those who had elected him.

The commitment in respecting the contracts was a response to the “market fear” that the payment of interest on the public debt would not be realized or that private property could be threatened. Lula defended those conceptions the first time that he competed for the presidential election in 1989, and their opponents, the media and the higher-income population always revived them. Lula kept his promise: he chose a liberal and financial economist for the presidency of the Central Bank (the former president of Bank Boston, Henrique Meirelles) and also kept and even deepened elements of the liberal economic policy of the Fernando Henrique government: he extended the agreed fiscal target with the IMF (the 1998 agreement stipulated for a 3.5% fiscal surplus target, increased to 4.25% for the years 2003, 2004 and 2005) and supported the maintenance of fairly high economic interest rates in order to meet the inflation target.

Those policies helped the government gain the financial market support – or, at least, acceptance. In parallel, two other social groups gained even more space than in the previous government: the industrial bourgeoisie and the agrobusiness. Over the eight years of Lula administration, between 2003 and 2010, those two last fractions of the great capital, especially the national industrial bourgeoisie, gained a “better seat” in the power structure (Machado, 2009).

However, the government's support was not based solely on those elements. The internal bourgeoisie, the urban manual workers and the low middle class were all also important in granting support for the government and were all benefited (although in

different degrees) by its policies. The expansion of subsidies and of credit through the national development bank (BNDES) benefited the large national industry (mainly the portion associated with agrobusiness, such as the meat industry). In its term, the generation of more than 10 million formal jobs and the real minimum wage increase (more than 50% in real terms between 2003 and 2010) (Singer, 2012) favored the urban workers and the low middle income population.

Beyond that, a huge “marginal mass”, systematically excluded from governments’ priorities, was the direct beneficiary of income transfer programs, such as the “Bolsa Família” program, the “Benefício de Prestação Continuada” and the effects of minimal wage rise over pensions. The “Bolsa Família” program alone represented income transfers to ¼ of the Brazilian population, reaching more than 50% of population in poor states in North and Northeast. Although the left wing criticized the program limits, seen on this a neoliberal targeted social policy, and not a real welfare state (Boito Jr., 2003), the program has contributed to poverty alleviation, which reduced about 65%, from 39.4% to 17.0% between 2003 and 2013 (IBGE, 2014). According to a study carried out by the National Treasury, “spending on direct social transfers was responsible for a 47% share of the reduction in income inequality and a 32% improvement in the proportion of poverty” (National Treasury, 2016: 3).

This arrangement was possible because the pace of economic growth was much higher than in previous years. Facing a low annual average growth rate in the 1980s (1.7% p.a.) and 1990 (2.6% p.a.), with the government of Fernando Henrique Cardoso (1995-2002) obtaining an average annual GDP growth of 2.4%, the Brazilian economy grew 4% p.a. between 2003 and 2010, including the 2009 recession caused by the American subprime crisis (IBGE, 2018). This was partially possible due to external factors, with a growth in Brazilian exports from 5.8% p.a. (through Chinese strong demand for soybeans and iron ore and the increase in commodities prices) and an increase in foreign capital flows, the government was able to use economic improvement to expand social policies, credit mechanisms and supported the large national industry.

All the aspects described above show that the government created a social support based, simultaneously, in the working class and in the large national companies, presented by some as “*lulismo*”. This was interpreted in different ways: as a social accommodation to facilitate the full implementation of neoliberalism (Maciel, 2010), or as an attempt to carry out social reforms within the context of neoliberal hegemony (Singer, 2012). The proposal of Singer (2012: 9) seems accurate: “Lulism exists under the sign of



contradiction. Conservation and change, reproduction and overcoming, disappointment and hope in one movement”.

Thus, it is from this specific arrangement between economic growth driven by the external sector and by families’ consumption, associated with liberal economic policies that benefited the financial market, but also met the demands of the large national industry, that we can understand what happened with social policies in PT governments.

The most obvious social policy was social assistance, in view of the role (reduction of poverty and misery) and the size (reach more than 25% of Brazil population) of the Bolsa Família Program. Regarding employment and social security, the system of raising the real minimum wage was important in order to extend the provisions of the lower middle class population and to the retirees who live on a monthly minimum wage. In terms of educational policies, the government created the ProUni (in 2004) and the Fies (created in 1999, but largely amplified in Lula’s government), programs that allow students from poor families to study at private universities for free or subsidized. Besides that, the creation of new federal universities and the adoption of quotas (affirmative policies) for poor and / or black students, allowed the entry of students who were the first in their families to attend a university.

Considering social policies, in fact, health may have been the least prioritized within the PT relationship with its “base of support”. The SUS has no strong and truly symbolic policy of how the low-income population was benefited by the PT government. Although the expansion of the Family Health Program and the access to free or cheap medicines affects mainly the poorest, there has not been a significant increase in health resources, and part of it has been used to provide subsidies for private expenses.

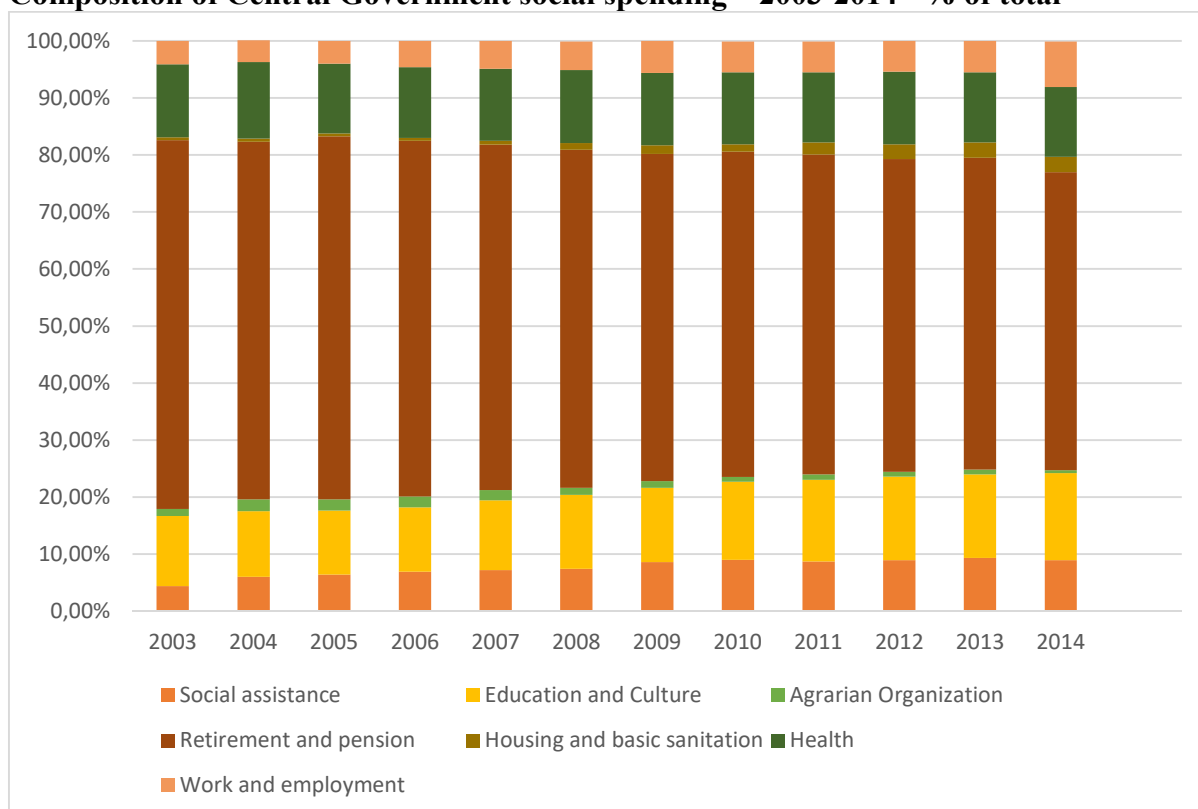
Between 2002 and 2015, considering social expenditures, expenditures with education and culture grew 0.74 pp of GDP and social assistance, mainly because of the Bolsa Família Program, increased by 0.78 pp of GDP. Expenditures with social security (retirement and pensions), which were already high, increased from 0.97 pp of GDP. On the other hand, health expenditures remained almost stable in the period (National Treasure, 2016).

### Composition of Central Government social spending – 2003-2014 - % of total

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Social assistance	4,40%	6,00%	6,40%	6,90%	7,20%	7,40%	8,60%	9,00%	8,70%	8,90%	9,30%	8,90%
Education and Culture	12,30%	11,50%	11,20%	11,30%	12,20%	13,00%	13,00%	13,70%	14,30%	14,70%	14,70%	15,30%
Agrarian Organization	1,20%	2,10%	2,00%	1,90%	1,80%	1,20%	1,20%	0,80%	1,00%	0,80%	0,80%	0,50%
Retirement and pension	64,70%	62,70%	63,70%	62,40%	60,60%	59,30%	57,40%	57,10%	56,10%	54,90%	54,70%	52,30%
Housing and basic sanitation	0,50%	0,60%	0,50%	0,50%	0,70%	1,20%	1,50%	1,30%	2,10%	2,60%	2,70%	2,70%
Health	12,80%	13,40%	12,20%	12,40%	12,60%	12,80%	12,70%	12,60%	12,30%	12,70%	12,30%	12,20%
Work and employment	4,10%	3,80%	4,00%	4,60%	4,90%	5,00%	5,60%	5,40%	5,40%	5,40%	5,50%	8,00%

Source: National Treasure (2016).

### Composition of Central Government social spending – 2003-2014 - % of total



Source: National Treasure (2016).

Regarding the SUS, between 2003 and 2014, the Brazil central government health spending remained between 1.7% and 2.1% of the national GDP. The actual level of expenditure stayed, in fact, almost stable as a proportion of GDP, around 1.6%. The variation that occurred was in fact related to the tax exemptions (subsidies) provided to the private sector, which increased from 0.16% to 0.42% of GDP between 2003 and 2014. The subsidies increased from R\$ 4.4 billion to R\$ 26.2 billion (in real terms, in December 2015). Most of this growth is due to discount in the Income Tax expense on private health spending (from R\$ 2.7 to R\$ 11.9 billion) and medicines (from R\$ 1.8 to R\$ 4.6 billion in the same period) (National Treasure, 2016).

As a result, the relative participation of the federal government in SUS funding decreased from 50.1% to 42.4% between 2003 and 2014. The states (from 24.5% to 26.5%) and mainly municipalities (from 25.4% to 31.1%) eventually increased their relative share in health financing (Vieira; Benevides, 2016).

Considering the total public health spending, in general terms, the item with the biggest participation is ambulatory, hospital and emergency care. In relatively terms, its participation declines from 50.3% to 41.6% between 2003 and 2014. It is worth mention, however, that during those 12 years some important indicatives were created, as SAMU (*Serviço de Atendimento Móvel de Urgência*). By creating SAMU in 2004, Lula's government nationalized and unified the patient transportation policy. The federal government was responsible for funding the program, and many incentives were adopted with the purpose of encouraging co-financing by the other spheres of government (states and municipalities), whose adherence was fundamental since the subnational governments should take care of the program local management (Machado et al, 2011). Ten years later, in 2014, 2,926 municipalities had already received 3,182 ambulances. No less than 74.5% of the Brazilian population was then covered by SAMU.

The item that stands out refers to Family health and community agents that expanded from 6.1% to 9.6% of total health spending (National Treasure, 2016). The most important policy related with this spending is the Family Health Program. The programs was created in 1994 aiming to modify the hospital-centered health model, which was dominant in Brazil. Between its creation and 2003, the government had created 16.682 family health teams, attending around 32% of Brazilian population.

The program grow during Lula and Dilma administrations, with the implementation of the Family Health Strategy, as set out in the National Primary Care Policy (PNAB) in 2006. By 2010, there were 30.782 teams, attending around 54% of the population and by 2016, 41.619 teams, reaching almost 70% of Brazil population (Wartchow et al, 2013; Pinto; Giovanella, 2018).

#### Public Health spending – Brazil central government – 2003-2014 - % of total

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
<b>Total direct spending</b>	<b>92.4%</b>	<b>86.6%</b>	<b>86.4%</b>	<b>86.0%</b>	<b>84.2%</b>	<b>84.1%</b>	<b>80.8%</b>	<b>83.1%</b>	<b>83.3%</b>	<b>79.4%</b>	<b>79.8%</b>	<b>79.9%</b>
Ambulatory, hospital and emergency care	50.3%	46.0%	46.2%	44.7%	44.5%	42.4%	40.7%	40.6%	41.1%	43.7%	42.2%	41.6%
Implement., expansion and modernization of SUS	2.5%	3.2%	2.0%	2.2%	1.7%	2.1%	2.1%	1.9%	1.7%	2.7%	5.1%	5.4%
Family health and community agents	6.1%	6.4%	7.2%	8.0%	8.5%	8.4%	7.7%	8.3%	8.5%	8.9%	8.6%	9.6%
Medications, Vaccines and Laboratorial	5.3%	6.2%	7.2%	7.5%	8.2%	6.9%	6.4%	6.2%	7.6%	8.2%	9.5%	9.8%
Sector workers	11.9%	10.8%	8.9%	9.2%	8.2%	11.1%	11.5%	11.4%	11.4%	10.3%	9.9%	9.6%
Others	16.4%	14.0%	14.9%	14.4%	13.0%	13.1%	12.3%	14.7%	13.0%	5.6%	4.6%	3.9%
<b>Subsidies to the private sector</b>	<b>7.6%</b>	<b>13.4%</b>	<b>13.6%</b>	<b>14.0%</b>	<b>15.8%</b>	<b>15.9%</b>	<b>19.2%</b>	<b>16.9%</b>	<b>16.7%</b>	<b>20.6%</b>	<b>20.2%</b>	<b>20.1%</b>

Source: National Treasure (2016).

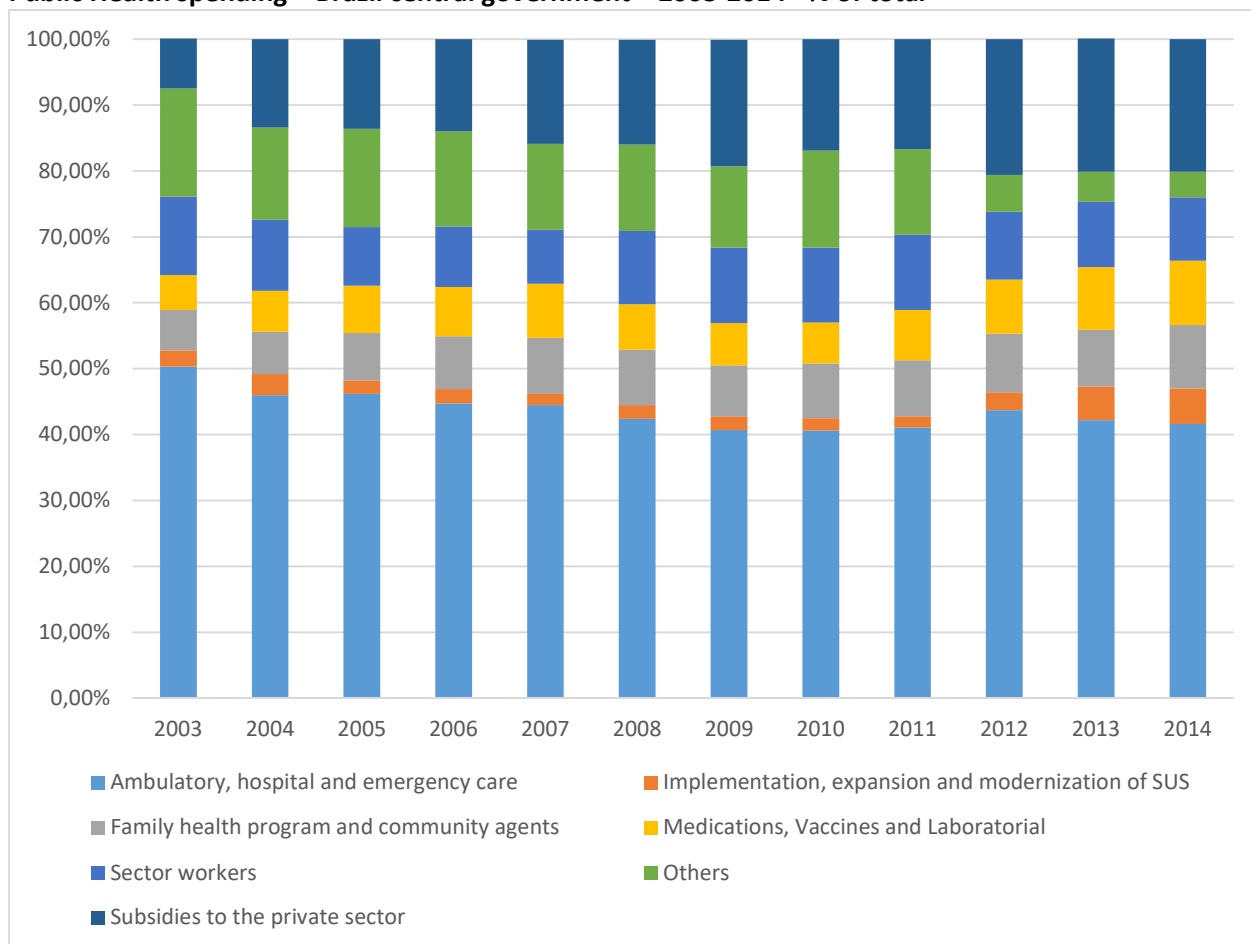
It is also worth mention the increase in spending on medicines, which went from 5.3% to 9.8%. This growth was due to the expansion of the network for access to free or low-priced medicines. In 2004, the government created the “Programa Farmácia Popular”, an own network of pharmacies that offered free medicines or with 90% discount against the price practiced in private pharmacies. In 2006, in order to increase access, the government created the program “Aqui Tem Farmácia Popular”, providing medicines also in accredited private pharmacies. Considering only the “Aqui Tem Farmácia Popular” program, between 2010 and 2015, the amount spent rose from R\$ 423 million to R\$ 3.6 billion (IBGE, 2016 valued updated by the October 2018 price index).

Vaccines also played an important part in this increased. According to data from the Ministry of Health (2016), vaccination coverage would have gone from 73% to 84% of the target public between 2003 and 2014.

A specific health policy of the Rousseff government was the creation of the “Mais Médicos” Program. Pressed by a growing movement of dissatisfaction, the government proposed and passed the law 12.871 in 2013 (Brazil, 2013).

The program aimed to expand and improve the infrastructure of health units; emergency provision of physicians to unattended areas; and training of human resources for the Unified Health System (SUS). It caused a great controversy among doctors, as it allowed an increase in the number of foreign doctors for care in regions devoid of them. In spite of all the contrary pressure, the program spread and allowed the expansion of medical care, mainly in the North and Northeast regions of the country and in previously underserved localities, such as some indigenous communities.

**Public Health spending – Brazil central government – 2003-2014 - % of total**



Source: National Treasure (2016).

### **Temer and the endorsement of conservative neoliberalism**

After the impeachment of Rousseff, Temer became president from May 2016 (first, temporarily, until the end of the procedural rites, which occurred in August of the same year). He sought to base his presidency on fiscal austerity policies, centered on three initiatives: implementing a ceiling on federal spending; approve labor rights reform; approve pension benefits reform.

All of these initiatives meet a same expectation: to reduce the direct action of the State in the economy and, mainly, to reduce costs for the entrepreneurs. The clearest example was the changes in labor legislation. Despite the existence of a large contingent of workers who do not have labor rights in Brazil, the executives have always considered the labor legislation as excessive and costly. The government proposed the reform, using the rhetoric that a reduction of rights would allow an increase in the generation of employment. The reform was easily passed in the National Congress.

Throughout his two and a half year presidency, Temer seems to have reestablished the predominance of the political and social arrangement in Brazil in the 1990s. The interests of the financial elite, with the industrial bourgeoisie and the ideologically coupled upper middle class, returned to predominate explicitly. Although their interests never disappeared, their predominance became much clearer, subordinating the decisions of economic policy and, perhaps the biggest difference with the PT governments, of social policy.

Nevertheless, even the comparison with the 1990s might be unfair. With all its limitations, the governments of Collor (1990-92), Itamar (1993-94) and, especially, Cardoso (1995-2002) minimally implemented the policies established in the 1988 Constitution and expanded social policies in the country. However, “since President Dilma Rousseff impeachment in 2016, important signs of inflection have emerged in the set of public policies established by the New Republic political cycle” (Pochmann, 2017: 318).

In terms of federal government spending in healthcare, the Temer government maintained the same level of federal health spending. In 2016 and 2017, federal spending on SUS was 1.9% and 1.8% of GDP, respectively.

However, the government Temer own health minister went on to state that the country would not have a “degree of development” or budgetary conditions to maintain a universal public system. The government has set up a working group, together with institutions of private health plans, to discuss the creation of popular plans. Subsequently, a measure was adopted, based on the assumption of efficiency rather than on sanitary priorities, which deprives the Union of its attribution of shared planning and coordination of SUS to redefine criteria for the transfer of resources to states and municipalities. The regressive character of the non-elected government has also affected actions regarding identity demands and minority population segments (Bahia, 2018).

Besides that, it is to be expected that some of the more general changes made by this government will have a huge impact on SUS funding. Proposed by the government of President Michel Temer in July 2016, only two months after he took office, and approved by the National Congress, the Constitutional Amendment (EC) nº 95/2016 established a “New Fiscal Regime” in the scope of the Union Fiscal and Social Security Budgets (Brazil, 2016). The justification for approving the text would be to contain the evolution of the debt-to-GDP ratio and reduce the instability of the economy attributed to the deterioration of public accounts.

This new regime can be summarized by the imposition of a ceiling to federal government spending for twenty years, started 2016 and that can only be reviewed after 10 years. During 20 years, federal government expenditures can only grow the equivalent of last year's inflation – the inflation observed in the last twelve months until the month of June of the previous year. This means that, in real terms, federal government freezes for twenty years, regardless of population and GDP growth.

This ceiling is valid for total expenses, without considering a ceiling per area of activity. In the case of health, Constitutional Amendment 86/2015 provides that the federal government must allocate a minimum of 15% of its net current revenue (total revenue discounted from transfers to states and municipalities, in addition to some social security contributions) in the sector (Brazil, 2015).

This means that it tends to be an inconsistency between constitutional amendments. To preserve the allocation of at least 15% of the federal government's health resources, its participation will have to grow compared to other expenditures, which will have to be reduced in order to meet the expenditure ceiling. If the ceiling is prioritized, and all expenditures maintain their existing relative participation in 2016 when it was implemented, health expenditures would tend to decrease.

A study by Vieira and Benevides (2016) shows that if the ceiling was in place between 2003 and 2015, federal health spending would have been 42% lower. Instead of 1.7% of GDP (including state and municipal governments, public health spending in Brazil is about 3.5% of GDP), the federal government would have allocated only 1% of GDP in health.

Different simulations have been done to try to project what would be the loss of resources in the SUS with this new fiscal regime. This evolution would depend on the growth rate of the economy and the growth of other expenses. Different calculations project health expenditure of 12% of net current revenue in 2026 and only 9.4% in 2036 (Rossi; Dweck, 2016) or a value that can vary between 10.2% and 13.4% in 2026 and between 7.6% and 13.4% by 2036 (Vieira; Benevides, 2016). The loss of resources for the SUS, accumulated over twenty years, would be from at least R\$ 200 billion to more than R\$ 750 billion.

In all scenarios, what we would have is a loss of resources for the SUS, a failure to comply with Constitutional Amendment 86 and greater pressure on states and municipalities to finance health. The limit also does not consider that the Brazilian population is in a deep process of transformation, with a rapid population aging. It is

estimated that, between 2017 and 2036, the population over 60 will almost double, going from 24.9 to 48.9 million (from 12.1% to 21.5% of the total population) and, as a consequence, we will have an increase in diseases that require long care and greater pressure on SUS financing.

Besides that, the absorption of technology and new medicines makes inflation in the sector much higher than the average price increase in the economy. The National Treasure (2018) made an evolution of what could be expect in terms of the evolution of the demand for public health services. They consider two scenarios.

The Baseline Scenario considers the evolution of health care supply costs, population growth, and changes in the age structure of the population. This scenario represents an estimate of the 'vegetative' growth of demand to be verified over the projection period. The Expansion Scenario, in addition to the factors previously mentioned, also considers the expansion in the coverage of some services. When possible, this scenario was based on the expansion targets included in the National Health Plan 2016-2019. In the Base Scenario, projections indicate real growth of 25.9% (about 2.6% per annum) in the demand for primary health expenditure over the next 10 years. In the Expansion Scenario, such growth would be higher, resulting in a real expansion of 37.0% (around 3.6% per year) in the period (National Treasure, 2018: 9).

In both scenarios, growth above inflation would result in strong pressure on the spending ceiling and also a much higher expending than the minimum application of resources in health, according to rule established by EC nº 95/2016. The primary health expenditure of the Union, which reached 8.7% of the ceiling in 2017, would represent 11.5% in the Base Scenario and 12.6% in the Expansion Scenario in 2027 (National Treasure, 2018).

## **Conclusions**

Considering that during the 25 years between 1990 and 2015 the macroeconomic policy was predominantly neoliberal, focusing on the use of the interest rate to control inflation and the pressure to adopt fiscal austerity policies, the SUS was over all those years pressed in terms of financial resources. This means that, from the financial point of view, fiscal austerity predominated over health policy, regardless of the government in question and its political support base.

However, this last issue generates changes: not in the total resources allocated in the system, but in the allocation priority of the existing resources. Thus, in the Fernando Henrique Cardoso administration, federal resources in the SUS were allocated mainly in the medium and high complexity, which proportionally benefits more the high-income population. In this turn, in the Lula and Dilma Rousseff governments, part of the resources were directed to the expansion of policies of primary health care, such as the expansion



of the Family Health Program and the policy of free or discounted drug distribution. These policies mainly benefited the low-income population. In turn, during the Temer administration, the SUS lost even more priority, being at risk of losing a larger share of the public budget.

This means that the support of the low - income population to PT governments have not been able to redirect macroeconomic policy, subjugated to the interests of another part of its support base. What the base of support of low income was able to modify the proportion of resources directed within the health policy, without generating greater resources to the SUS.

In this case, we can say that health policy works as well as a metonymy of PT governments. Its macroeconomic policy remained subject to the same interest groups as the previous liberal governments, while social policies achieved a little more resources in some specific sectors (such as social assistance, with the Bolsa Família program), but in general they did not receive greater contribution within the budget of the Union. On the other hand, the support base of the low-income population was relevant, at least, to allocate more of the low resource to health policies that benefited them.

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