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Expenditures in the health care system in Brazil: the participation of states and the Federal District in financing the health care system from 2002 to 2013

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OBJECTIVE: To analyze the public expenditures of states on health care and the participation of states and the Federal District in financing the Unified Health System, better known by the acronym SUS. To develop the research, two targets were used: ''to rescue expenses per government source (federal, state and municipal) during the period from 2002 to 2013'' and ''to rescue resource transfers from the federal SUS to the states and also to municipalities''.

METHODS: This research is bibliographic, documentary and descriptive and used a quantitative approach. Data were extracted from the Information System Public Health Budget, and additional data were collected from the public managers of states, municipalities and the Federal District during the period from 2002 to 2013. Federal data from the Undersecretary of Planning and Budget (originally extracted from the Integrated System of Financial Administration of the Federal Government and available on the Budget Public Health System webpage) were also collected.

RESULTS: The data revealed that during the same researched period, the Federal District has maintained the health care system budget, whereas states and municipalities have increased their budgets for the same spending.

CONCLUSIONS: By analyzing the results, there is clearly a disparity regarding the investment expended by the entities of the Federation. Although municipalities and states have gradually increased their application of resources to health care, the federal state has maintained the same budget. These results reveal a bit of concern about public health funding.

KEYWORDS: Public expenses; Health service; Federal entities.

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INTRODUCTION

With the advent of the Constitution of Brazil in 1988, the guarantee of the right to health for all citizens has been defended. To assure access to this right, some guidelines, such as universalized service based on health as a right of citizenship, community participation and placing priority on preventative services, have been recommended. In the same context, the Constitution led to the creation of a funding chain for the Unified Health System, SUS.

From Constitutional Amendment no 29, created on September 13, 2000, public health financing became a common responsibility for the federal government, states and municipalities.

This research has been based on how the union states are spending on health funding and transfers to SUS compared with the municipalities within the period from 2002 to 2013.

Given the importance of further studies of public health funding, it is important to focus efforts on developing knowledge to support the activities of managers to allocate financial resources to the health-care system.

The current constitution established the SUS as a model of universal and equal health to ensure assistance to all of those in need of health care.

Historically, before the creation of the SUS, the agency responsible for the implementation of public health policies, the Ministry of Health, which is supported by members of states and municipalities, had developed actions to promote health and prevent diseases; these actions included

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vaccination campaigns and endemic disease control, all of which were performed in universal manner. Regarding health care, only a few hospitals took action. This action was termed hospital care and was provided only to people defined as indigent, who had no right to health care access; this access was only provided by charity institutions in some states and municipalities, (1).

The National Institute of Social Security (INPS) was responsible for offering health care; later, the institute was named the National Institute of Medical Care and Social Security (INAMPS) and was responsible for providing health care to its members (2), including formal workers and their dependents, highlighting the lack of universal coverage.

At the end of the 1980s, the INAMPS promoted a health-care expansion to provide universalized coverage. In that period, there was no requirement to prove that the person was insured. That action created the Unified and Decentralized Health System (SUDS), which was instituted by contracts between state governments (3).

The Constitution of 1988 included the text ''health is a right of all and a duty of the government…,'' which universalized the right to health care. Article 198 of the Constitution established that ''actions and public health services integrate a regionalized and hierarchical network as a unified system.''

Regarding funding, the Constitution assured that the SUS would be funded by ''social security budget resources from federal, state, Federal District and municipality sources, as well as from other sources.''

To enact the new constitutional provisions, Law 8.080 (4), created on September 19, 1990, ''creates conditions to promote and to protect health recovery, organization and functioning of relevant services…'' In article 2, this law states that ''health is a fundamental human right, obligating the State to provide indispensable conditions to fully exercise this right.''

In the same year, Law 8.142 (5) was amended on September 28, 1990, to ''orders community participation in SUS management and intergovernmental transfers of funding resources to the health field…'' and states in article 1° that SUS will include two collegiate institutions, the Health Conference and the Health Council, to provide management of all of the different entities in SUS administration.

Although Law 8.080 and Law 8.142 led to the creation of the new SUS model, the old health system, the INAMPS, still exists and serves as a foundation for the SUS. The old health system, the National Institute of Medical Care and Social Security, was only formed in 1993, with the formation of Law 8.689 (6) on July 27th.

The new constitutional paradigms brought the common responsibility of funding to the three levels of government, and constitutional amendment 29 (7), added on September 13, 2000, obliges each level of government to apply a minimum amount of its own funding resources to health. Thus, the following discussion about public expenses on health care is presented.

According to Rani (8), public expenses are ''the representative cost of quantity and quality in services and goods offered by the government''. According to the author, the concept of spending is being used because there are two main sides: governmental expenses and public expenses. For the first, the costs are divided into units from direct and indirect public administration. For the second, the costs come from economic activities, including state-owned enterprises.

In regard to government expenditure, we can rate two different budget types: budgetary and extra-budgetary. According to Bezerra Filho (9), the extra-budgetary expenditures are not described in the Budget Law, which includes deposit, bail, transfer payment and anticipated budget revenues. However, according to Andrade (10), budget expenditures come from budgetary law and additional credits to support programs and government actions.

According to Oliveira (11), state expenditures are classified as follows: departmental, functional and economic. From other perspectives, Rani (12) classifies government expenditures into: aggregate expenditures, expenditures by categories and expenditures by functions.

Regarding functional classification, Oliveira (13), and regarding expenditures by function, Rani (14) report that health expenditures come from federal and state transfers as well as from municipality expenditures.

Funding can be divided into six different pillars: primary care; medium- and high-complexity outpatient and inpatient care; health surveillance; pharmaceutical assistance; SUS management; and health service network investment (15).

The health agreement, regulated by ordinance MS/GM 399 (16) since February 22, 2006, has defined the transfer of resources to each funding pillar, establishing a new management system between the three levels of government to reach better effort and quality for expenditures and for public health services.

METHODS

Methodological framework

This is a documentary and descriptive study that involves the collection of data from an official database within the time period from 2002 to 2013 and that is based on Constitutional amendment 29, which has introduced the possibility of monitoring the funding percentage applied to the health sector.

The approach is quantitative, allowing for the processes of data collection and analysis and using statistical tools to meet the research goals (17).

Procedures for collecting and analyzing data

The study data were collected from the Information System Public Health Budget database, which stores financial health budget information from the union, states, Federal District and municipalities. The data originate from the accounting department of each responsible civic entity. The department stores information from reports and budgetary and financial execution statements of the federal, state and local governments. All of the data are electronically reported to the DATASUS/MS database (18); with this tool, reports and indicators can be extracted.

In summary, the data collection has been taken from consultants' reports that are available on the Information System Public Health Budget webpage, which is supplied with data from state and local managers. The data collection process has demonstrated that all expenditures come from funding and that spending on governmental actions for health services by states, the Federal District and municipalities came from the town budgets (19).

Regarding the federal state, during the period under review, publications from the Secretariat of Planning and Budget of the Executive Secretariat of the Ministry of Health (using data from the Integrated System of Financial

Administration of the Federal Government) until 2012 were used. Data for the year 2013 was included in the Information System Public Health Budget. The period of this research is from 2002 to 2013.

To analyze the evolution of public spending in stocks and public health services by states and the Federal District, a sequence of activities was performed. The methodological sequence is described below.

Initially, the predefined annual data for expenditures (financed by tax source and constitutional transfers) made by states and the Federal District were collected.

Then, data were extracted as the percentages of personal resources, stock expenditures and public health services, transiently established by Constitutional Amendment 29 and maintained by Complementary Law 141/12. For comparative analysis, technical notes available on the Information System on Public Health Budget website related to the balanced budget of the States from 2002 to 2013 were used as the data source to assess the consistency of the data in the system to support the self-control of health managers.

With the data, it was possible to analyze the evolution of the public expenditures of the states and the Federal District.

Regarding union spending data, which was obtained from the Secretariat of Planning Budget of the Ministry of Health for the period from 2002 to 2012, data that were accessible on the Information System on Public Health Budgets website were used. The period of 2013 was used for entering data into the system.

The data were collected and analyzed; the results are presented in the following section.

RESULTS

Data from the Information System on Public Health Budgets and from the Secretariat of Planning Budget of the Ministry of Health revealed the evolution of government expenditures on actions and public health services in the three levels of government from 2002 to 2013, as shown in Table 1.

The total expenditure by the government in Brazil in 2002 was approximately R$ 47.55 billion (R$ 47,551,531) and in 2013 was R$ 194.27 billion (R$ 194,806,681), reflecting an increase of 13.73% per year (an increase of 151.03% accumulated over the time period).

On the government level, we observed the following behavior.

1. UNION

In 2002, there was an expenditure of R$ 24.736 million (R$ 24,736,843), and in 2013, the expenditure reached R$ 83.053 million (R$ 83,053,255), representing a cumulative increase of 129.28% in the time period or an increase of 11.75% per annum.

The expenses of the union represented a share of the gross domestic product equivalent to 1.67% in 2002 and to 1.71% in 2013, remaining steady over time due to the attempt to fulfill the constitutional rule of nominal change in the gross domestic product. The share of total federal spending on public administration was 52.02% in 2002 and 42.63% in 2013; thus, the stake was decreased, whereas other federal entities showed an increase in this aspect.

2. STATES AND THE FEDERAL DISTRICT

In 2002, there was an expenditure of R$ 10.757 million (R$ 10,757,458); in 2013, the expenditure reached R$ 52.003 million (R$ 52,003,322), representing a cumulative increase of 171.59% over the period or an increase of 15.60% per annum.

State spending represented an equivalent share in the gross domestic product of 0.73% in 2002 and of 1.07% in 2013, showing considerable growth (47.46%). Involvement in the total spending on public administration in 2002 on the state level was 22.62%, which increased to 26.69% in 2013; thus, the state increased its stake, in contrast with the union.

3. MUNICIPALITIES

In 2002, there was an expenditure of R$ 12.057 million (R$ 12,057,231), and in 2013, the expenditure reached R$ 59.750 million (R$ 59,750,103), representing a cumulative increase of 173.32% in the time period or an increase of 15.76% per annum.

Table 1 - Cost of federal, state, Federal District and municipalities with actions of public health services, by level of government, in current values and percentage share, during the period from 2002 to 2013. Amounts in thousands of Real (R$).

Year	Federal		State		Municipalities		Total	
	(A) Expenditures (current $ thousand)	(B) Proportion of Gross Domestic Product (%)	(C) Expenditures (current $ thousand)	(D) Proportion of Gross Domestic Product (%)	(E) Expenditures (current $ thousand)	(F) Proportion of Gross Domestic Product (%)	(A+C+E) Expenditures (current $ thousand)	(B+D+F) Proportion of Gross Domestic Product (%)
2002	24,736,843	1.67%	10,757,458	0.73%	12,057,231	0.82%	47,551,531	3.21%
2003	27,181,155	1.60%	13,317,828	0.78%	13,771,212	0.81%	54,270,195	3.19%
2004	32,703,495	1.68%	17,318,612	0.89%	16,414,513	0.85%	66,436,621	3.42%
2005	37,145,779	1.73%	19,664,416	0.92%	20,289,504	0.94%	77,099,698	3.59%
2006	40,750,155	1.72%	22,978,253	0.97%	23,564,590	0.99%	87,292,998	3.68%
2007	44,303,496	1.66%	25,969,634	0.98%	26,431,209	0.99%	96,704,339	3.63%
2008	48,670,190	1.61%	30,976,460	1.02%	32,459,759	1.07%	112,106,408	3.70%
2009	58,270,259	1.80%	32,258,750	1.00%	34,538,059	1.07%	125,067,068	3.86%
2010	61,965,198	1.64%	37,264,003	0.99%	39,271,732	1.04%	138,500,933	3.67%
2011	72,332,284	1.75%	41,487,250	1.00%	45,995,180	1.11%	159,814,714	3.86%
2012	80,063,148	1.82%	44,819,206	1.02%	51,924,709	1.18%	176,807,062	4.02%
2013	83,053,255	1.71%	52,003,322	1.07%	59,750,103	1.23%	194,806,681	4.02%

Source: The Information System on Public Health Budgets (SIOPS; for state, local and federal data; in the latter case, only from 2013) and the Secretariat of Planning and Budget, Ministry of Health (SPO/MS; for federal data from 2002 to 2012).

Table 2 - Share of total transfers for health care spending by municipalities, states and the Federal District (excluding spending financed with funds from loans and other sources) by region of the country during the period from 2002 to 2013.

Year	Midwest	Northeast	North	Southeast	South	Brazil
2002	52.27%	56.40%	54.55%	37.63%	45.94%	44.86%
2003	53.31%	55.50%	52.62%	38.38%	42.93%	44.55%
2004	52.38%	57.59%	52.17%	39.71%	42.96%	45.61%
2005	49.99%	55.69%	49.87%	35.74%	41.19%	42.96%
2006	50.11%	54.72%	48.40%	36.46%	41.02%	43.17%
2007	50.07%	55.17%	48.23%	36.05%	40.87%	43.00%
2008	48.68%	54.92%	47.37%	34.18%	39.60%	41.71%
2009	51.16%	55.39%	48.89%	35.28%	42.41%	43.05%
2010	49.37%	54.06%	48.09%	34.74%	41.56%	42.13%
2011	48.18%	54.60%	50.97%	33.32%	40.88%	41.51%
2012	49.25%	55.54%	48.44%	34.62%	41.26%	42.21%
2013	47.84%	51.82%	49.57%	33.58%	42.78%	41.62%
Average	50.22%	55.12%	49.93%	35.81%	41.95%	43.03%

Source: SIOPS

Municipal expenditures represented a share of the gross domestic product equivalent to 0.82% in 2002 and to 1.23% in 2013, showing considerable growth (51.16%). The share of total spending in the municipal sphere of government, which was 25.36% in 2002, was 30.67% in 2013, indicating an increase in the stake, in contrast with the union.

In general, it was found that the union maintained its share of expenditures regarding the gross domestic product, while the states and municipalities increased their spending over the same period.

Table 2 shows the share of total transfers for health care spending in the municipalities, states and Federal District by region in Brazil. It was expected that the Northern and Northeastern regions were the most dependent on transfer payments from the system and that the Southern and Southeastern regions were less dependent. However, it was found that the Northeastern region (55.12%) was more dependent on transfers, followed by the Midwest (50.22%), North (49.93%), South (41.95%) and, lastly, Southeast (35.81%). In some years, the Northern region had a higher percentage than the Midwestern region. However, this dependence remains.

Additionally, within the same time period (2002 to 2013), we recorded transfers for health care expenditures undertaken by states, the Federal District and municipalities per region in Brazil according to data from the Information System on Public Health Budgets.

DISCUSSION

It was possible to verify the continued participation of the union in relation to the gross domestic product and to verify that states and municipalities have increased their participation in relation to the same gross domestic product and thus also to the union.

Regarding the participation in transfers from the health care system in terms of total health expenditure by the states and Federal District, it was found that the Northeastern region (55.12%) was more dependent on transfers, followed by the Midwestern (50.22%), Northern (49.93%), Southern (41.95%) and Southeastern (35.81%) regions.

This situation was motivated and explained by the transfer resource of the SUS to the states (in those regions), which was capable of increasing transferred resources to municipalities.

We must highlight two different situations that interfered with establishing the federal public health funding in Brazil within the period from 2002 to 2013: 1) the extinction of the provisional Contribution on Financial Transactions on December 2007; and 2) the regulation of Constitutional Amendment 29 in 2012 with Complementary Law 141.

Therefore, it is expected that a new, permanent tax be created to replace the old one (such an amendment was created; however, no further resource was created to fund public health).

In relation to state public funding, creation of the Basic Care State is anticipated to transfer funds to municipalities and to increase fiscal incentives to medium- and high-complexity outpatient and inpatient facilities. Recently, the state of São Paulo established a minimum wage, which was agreed upon in March 2012 by the Bipartite Commission (CIB) 34[40], representing an advance in the progressive planning of funding, which is a breakthrough from the State Health Secretary of São Paulo, for funding equipment and renewing basic health units. Regarding municipalities, a minimum percentage of applications is expected to be established to define actions and health public services according to Complementary Law 141 of 2012.

The advancement of health care will be possible only if there is a strengthening in the level of primary care. It is necessary to prioritize investments, efforts and resources to fund primary care and health surveillance. Focusing on health promotion and disease prevention to avoid spending more on recovery and rehabilitation is also required.

Along with strengthening primary care and health surveillance processes, investments in training and new technologies must be continuous to complete a model for the population and for health professionals to improve the health status across the country.

Moreover, Brazil cannot let the discussion halt regarding financing of the public health system, which must be contextualized on the basis of economic and political guidelines, resulting in strengthening or weakening of the health system. Constitutional Amendment 29 and its regulation by Complementary Law 141 of 2012 represent extraordinary achievements for funding of the SUS; however, their implementation remains challenging.

AUTHOR CONTRIBUTIONS

Zucchi P conceived and coordinated the study, participated in the analysis of the sample, performed the statistical analyses. Costa RM collected the data, participated in the analysis of the samples, and performed the statistical analysis. Barbosa RS participated in the analysis and interpretation of the samples.

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