

The future of the Brazilian Health System: a short review of its pathways towards an uncertain and discouraging horizon

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Abstract *This article reflects on the future of the Brazilian Unified Health System (SUS, acronym in Portuguese), based on the foresight exercises conducted by the Brasil Saúde Amanhã initiative of the Oswaldo Cruz Foundation. The text briefly reviews some paths followed by the SUS as referred to in the Federal Constitution of 1988. It highlights the movement towards the decentralization of care and the constraint of health financial resources that reduced policies of increasing public expenditures. It examines the public and private arrangements for financing and provision of services that have resulted in sectoral privatization, mainly from economic policies articulated with concession of fiscal benefits. It analyzes the changes in the public sector financing through successive constitutional amendments that resulted in the weakening of established social protection policies, particularly of the health sector. For the future, the text considers population aging and analyzes trends in the epidemiological profile, with consequent changes in the health care paradigm. The article concludes by pointing out the consequences of fiscal strangling in the organization of the healthcare system and the need to reverse legal provisions that hamper the fulfillment of the constitutional mandate for equity and universality.*

Key words *Health policy, Healthcare funding, Forecasts, Public policy*

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Introduction

Making prophecies about the future of human societies does not belong to the realm of scientific culture, whichever our understanding of what science is. Camouflaged and named as projections, prophecies gains prominence in the erudite media and can seek admission into the academic sphere. Depending on the amount of intervening variables in a process, the capacity to predict can vary from a very reasonable estimate of what might happen in a given period of time to a mere speculation about what could or, to put it another way, what we would like to see happen.

On this subject, the journalist Adam Shawn¹ mentions the works of two researchers. First, the physicist Michael Berry attempted to forecast the path of a snooker ball after it was hit. Guessing where the first ball would go was easy; the second impact became more complicated, but still possible. The problem arose when to forecast the ninth impact it would be necessary to take account of the gravitational pull of someone standing nearby. To predict the 56th, it would be necessary to include the effect of every single particle in the universe.

From another angle, the economist Prakash Loungani, Advisor at the International Monetary Fund, analyzed the accuracy of economic forecasters. His findings revealed that economists had failed to predict 148 of the last 150 recessions that occurred around the world over the last three decades. Loungani also alleged that forecasts from both private and public sector economists were little different, and had a strong bias towards optimism. Or, to put it another way, wishful thinking.

Along these lines of thought, the foresight exercises developed by the Oswaldo Cruz Foundation in its initiative *Brasil Saúde Amanhã* (Brazil Health Tomorrow)^{2,3} follow the ideas of Gramsci who stated:

It is certain that to foresee means only to see well the present and the past as movement, i.e. to identify with exactness the fundamental and permanent elements of the process. But it is absurd to think of a purely 'objective' foresight. The person who has foresight in reality has a 'programme' that he wants to see triumph, and foresight is precisely an element of the triumph. [...] only to the extent that the objective aspect of foresight is connected with a programme does this aspect acquire objectivity⁴.

To compare future scenarios, the initiative adopted a set of basic principles that, according to Celso Furtado in his book *Capitalismo Global* (global capitalism), should underlie any

long term national development plan for Brazil, where:

the main goal of social action would cease to be the reproduction of the consumption patterns of the wealthy minority to be the meeting the needs of the whole population, and education be conceived as the development of human potential in the ethical, aesthetic and solidary action dimensions⁵.

This framework provides the basis for the ideas outlined in this paper.

Background

The 1988 Constitution was designed against a backdrop of intense dispute between popular forces and the ruling elite, simultaneously and contradictorily marking the dawn and twilight of a new social order. The former were mobilized in support of democratic freedom, social rights and bringing down the dictatorship, while the latter were anxious to resume their “project” in which the country serves the interests of the privileged few and without any commitment to a project of building and strengthening a nation.

Despite the time elapsed, we are not yet able to fully grasp the potentiality and vigor of the various forces that led to the overthrow of the military regime of 1964 and the possibility of drawing up a constitutional pact. Souza suggests that in the wake of the collapse of “a nationalist alliance to dynamize the country and boost people’s purchasing power and entrepreneurial profit”, the coup was able to “[build] the modern Brazilian middle class, a country that serves the interests of the 20%, and [forge] an overpriced market for the predatory elite”. According to Souza,

the courtship between the military and economic elites came up against problems when, during the Geisel administration, there was an ambitious attempt to create a strong industrial infrastructure base, often based on – although private capital was always welcome – the capital of state-controlled companies. [...] And it was precisely at this point that the sudden love of the Brazilian monied elite for democracy began, as a reaction to the Geisel administration’s plan to strengthen national capitalism⁶.

Fiori suggests that three projects for Brazil were present throughout the history of the twentieth century, and persist at the beginning of the new century. The first one, a liberal approach, based on orthodox economic policy and subaltern integration into international division of labor, which was hegemonic until the 1930

revolution and resurfaced at other moments. A second project, of conservative traits, grounded in an industrializing developmental program that surfaced in various forms during the Vargas and Kubitschek administrations and in the military regime. The third and last project, although tangentially related to the ideas and alliances of conservative developmentalism, only appeared in the 1988 Constitution when certain civil, social, political, economic, and citizenship rights were instituted⁷.

The latter project manifested itself in the conception and design of social protection provisions laid out in the chapter of the constitution that deals with social security, defining it as a “set of actions under the initiative of public authorities and society directed at ensuring rights related to health, pensions and other benefits, and social assistance”. The chapter also provides that “Health is a right of all persons and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at (providing) universal and equal access to health promotion, protection and recovery actions and services”⁸.

Beginnings of the deconstruction of the “Social Order”

By the end of the 1980s, healthcare policies in Brazil seemed to be taking two divergent paths. While decentralization and public participation were enshrined in the Constitution, the nation’s public health system was facing a deepening funding crisis due to the failure of government funding arrangements, culminating in the repeal of the constitutional provision stating that 25% of the revenue from social security contributions should be allocated for healthcare actions and services.

The 9th National Health Conference, with the theme “municipalization is the way forward”, legitimized the intensification of the decentralization process, weakening the power of the states and federal governments. Furthermore, the National Institute of Medical Care for Social Security (INAMPS, acronym in Portuguese) – one of the few government bureaucracies inspired in protecting workers’ health with national coordination capacity – was disestablished and Law 8080, the so-called “*Lei Orgânica da Saúde*” (basic health law)⁹ was passed.

The Constitution (Article 199)⁸ and Law 8080/90 (Article 4, paragraph 2)¹⁰ ensured the private initiative freedom to participate in

healthcare provision alongside the SUS as a complementary service provider, opening the way for the proliferation of private, and incentivized, healthcare services. Despite this, space was reserved for the preservation of the declaratory principles of the right to health and decentralization through the municipalization of service provision, maintained by political leaders in response to increased demands for health services made by the public not covered by private health plans associated with the expansion of universal suffrage^{9,11}.

At the beginning of the 2000s, the Brazilian healthcare system was effectively split into two: one system for the rich and well-off, with a reduction or break in coverage for chronic diseases and old age, subject to a certain degree of regulation under Law 9656/1998¹²; and Brazil’s universal public health system, the so-called Unified Health System (*Sistema Único de Saúde* - SUS), used by 75% of the population. The public system remained fragmented and decentralized. It was poorly coordinated, integrated and underfunded. It was emphasizing treatment over health promotion and prevention without priority setting, and service-oriented.

The growth of the private health sector was boosted through the provision of concessions and tax benefits that facilitated the adhesion of workers to private collective health plans and, perversely, led to the provision of public funding and incentives to the private sector, leading to a fragmented and stratified healthcare system both in the society at large as among those covered by the private arrangements¹³.

Despite health being part of social security and a universal social right, Brazil was out of tune with other countries that established universal healthcare systems as the public and private funding arrangements and service provision are concerned. This is particularly evident when government expenditure on health as a proportion of total expenditure on health in the country is considered. While total health expenditure as a percentage of Gross Domestic Product is similar between countries (between 9 and 11%), public health expenditure as a percentage of total health expenditure in other countries in 2015 was around 80% (81% in the United Kingdom, 82.3% in Sweden, and 82.4% in France)¹⁴, compared to only 42.9%¹⁵ in Brazil, which is even less than that of the United States (49.2%)¹⁴. The situation is even worse when we consider health expenditure per capita based on purchasing power parity, revealing the huge gap between Brazil

and developed countries: Brazil, 611; the United Kingdom 3,288; Sweden 4,408; France, 3,574; and the United States 4,696^{14,15}.

The path towards social protection

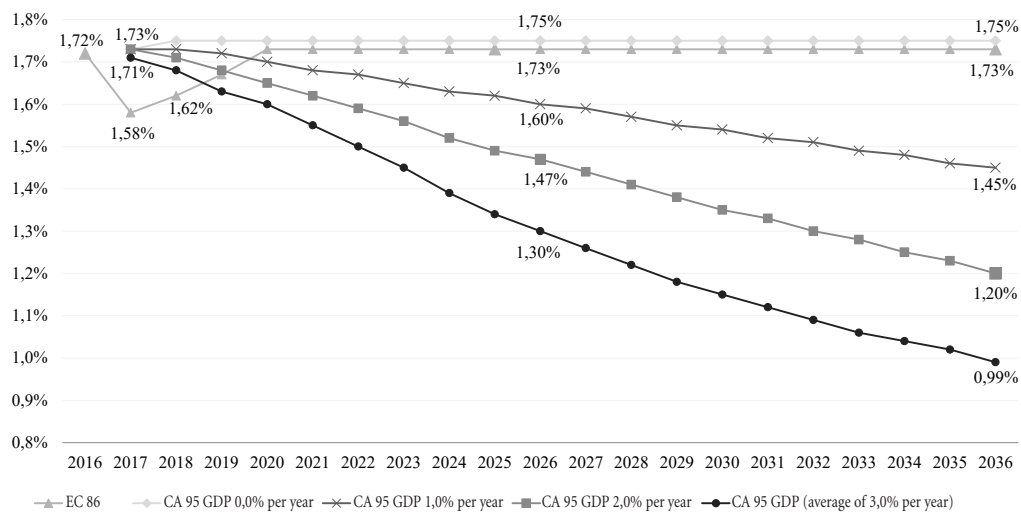
The 1988 Constitution provided that 25% of the revenue from social security contributions should be allocated for healthcare actions and services. This provision was not very successful and ended up being modified in 2000 by Constitutional Amendment 29, regulated by Complementary Law 141/2012¹⁶. The amendment determined that state and local governments should allocate a minimum of 12% and 15% of their total revenue to health, breaking that federal fixed revenue commitment, stating that funding should be tied to the variation in nominal GDP.

While the 1990s brought reduced federal government flexibility, with the introduction of the Fiscal Responsibility Law and the federal government revenue decoupling mechanism (*Desvinculação das Receitas da União*), the approval

of the Constitutional Amendment N° 95/2016¹⁷ imposed even stronger constraints. As a matter of fact, the new fiscal regime would not have needed a constitutional amendment if the government had not needed to remove funds from health and education, whose funding arrangements were governed by rules set out in the constitution¹⁸.

Vieira and Benevides¹⁹ simulated the impact of the new fiscal regime on health sector funding, estimated both in terms of net revenue and percentage of GDP, by comparing different funding scenarios based on Constitutional Amendment N° 95 and Constitutional Amendment N° 86. Graph 1 shows the projections for health expenditure as a proportion of GDP under different growth scenarios.

It is important to highlight that there is essentially no practical limit on the amount of government spending in a country that issues its own currency, with sufficient labor supply and without external restrictions. Public sector deficits are private sector surpluses and, therefore, public sector surpluses mean a deficit for busi-



Hypotheses: 1) GDP: four real GDP growth scenarios were considered: three based on a real GDP growth rate of 1.0% for 2017 (Focus / Bacen of 11/18/2016) and 0.0%, 1.0% and 2.0% per year between 2018 and 2036 and a fourth scenario, where GDP and inflation estimates were based on projections for the General Social Security Regime (RGPS, acronym in Portuguese) annexed to the 2016 Project of Budgetary Guidelines Law (PLDO, acronym in Portuguese), which presents an average annual rate of 3.0%; 2) Consumer Price Index: the first three scenarios based on 4.93% in 2017 (Focus / Bacen of 18/11) and 4.5% between 2018 and 2036; the fourth scenario based on projections for the RGPS annexed to the 2016 PLDO (2017: 6.0%; 2018: 5.4%; 2019: 5.0%; 2020 to 2036: 3.5%); 3) CNR/GDP hypothesis – public health at 11.45% of GDP (forecast 2017); 4) CNR 2017 = R \$ 729.8 billion, according to 2017 PLOA; 5) Nominal GDP of 2016 estimated at R\$ 6,220.5 billion, and RCL for 2016 estimated at R\$ 729.8 billion, according to the SOF / MPOG Primary Revenue and Expenses Evaluation Report – 5th Bimester, 2016; 6) Base for minimum application in actions and public health services according to CA 95 of 15.0% of the CNR of 2017.

Graph 1. Health expenditure projections under the constitutional amendments 95 and 86 (% of GDP) showing the impact of Constitutional Amendment 95.

Source: Vieira and Benevides¹⁹.

nesses and families. In other words, fiscal responsibility is ultimately detrimental to society. Public policy decision-makers should be guided by the economic and social responsibility synthesized in the variables of inflation and employment, as well as in the building of a welfare state.

The mainstream economics depart from the *Adam Smith*'s concept of money as a commodity. However, Innes²⁰ demonstrated that money is in fact a credit-debt relation. The acceptance of a debt by one particular agent to another is the act through which money is created. In simple terms, given that there is an obligation to pay tax, it can be understood that money is ultimately the creation of the state²¹. From this perspective, public expenditure is always funded by monetary issuance, while taxation and state indebtedness are simply ways of reducing the quantity of money held by the public.

This gives rise to the idea of functional finance²², a counterpoint to the idea of "sound finance", that underlies all the ideas about austerity and holds governments hostage to budget balances. This perspective rejects the idea of balancing the government budget in a particular year or any other arbitrary period so that public spending may be guided by employment and inflation rates.

Accordingly, expenditure on health, social security or any other government spending should be guided by its economic and social impacts. From an economic standpoint, health expenditure produces a more positive impact on the GDP:

The multiplier effect of the country's health spending was calculated to be 1.7. In other words, for each R\$ 1 increase in health spending, there is an expected \$1.7 increase in GDP (Abrahão, Mostafa e Herculano, 2011). According to Stuckler and Basu (2013), in a study analyzing 25 European countries, the United States and Japan, health and education had the largest fiscal multipliers, typically greater than 3¹⁹.

However, the defense of restrictive fiscal policies is underpinned by political reasons. As early as the 1940s, Kalecki²³, when talking about full employment, suggested that there were three types of reasons. The first is to maintain control over the government by blackmailing it by confirming that anything that may shake the state of confidence can cause economic crisis. The second questions the direction of public spending for fear of competition from public investment or that subsidizing mass consumption will dismantle one of the basic moral principles of the

capitalist system, "You shall earn your bread in sweat". Finally, the third reason stems from the natural empowerment of workers whereby dismissal ceases to be a disciplinary measure.

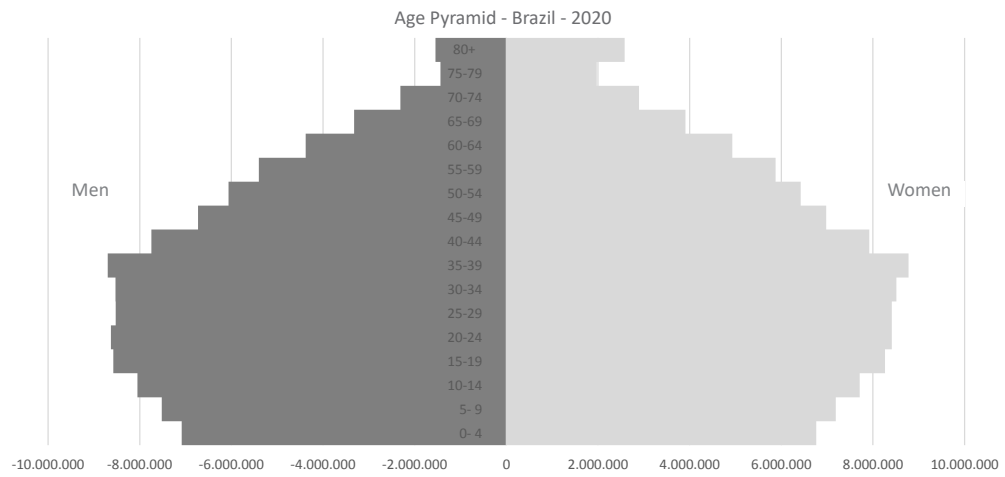
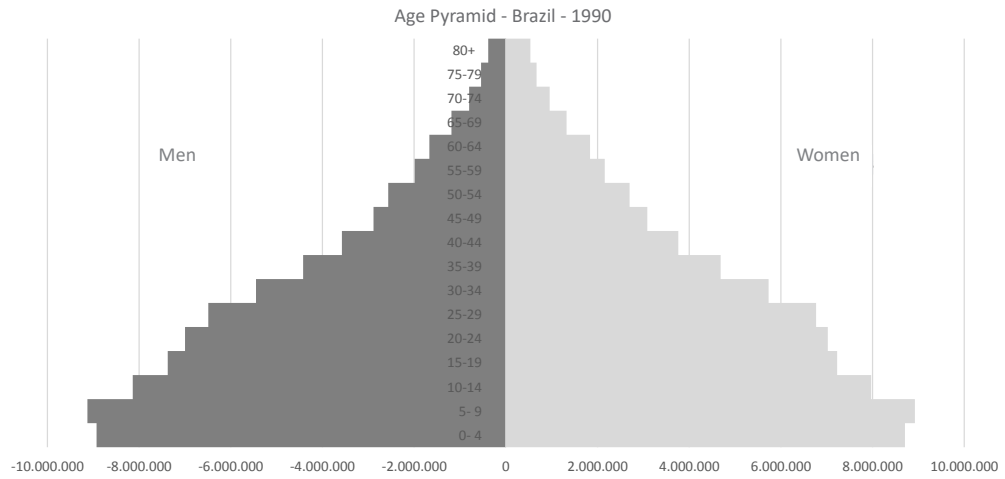
It is important, within the scope of this reflection, to stress the opposition to the direction of public spending. Not only welfare policies that subsidize mass consumption such as the *Programa Bolsa Família* (family assistance program), but mainly the competition between public investment and private capital. A well-structured, operational and adequately funded SUS poses a threat to private investment in both the private health insurance market and provision of private healthcare services. Public spending cuts therefore bear no relation to modernizing the state and making it more efficient.

As such, fiscal responsibility has nothing to do with government budget constraint, but rather with political reasons. Plainly, we cannot ignore the existence of various legal directives that impose the sound finance doctrine and the ideology of austerity. However, budget deficits are not the problem. Social spending (health, social security, or education for example) should not be looked at from the standpoint of arbitrary budget balances for a particular year or any other period, but rather based on an assessment of economic and social outcomes.

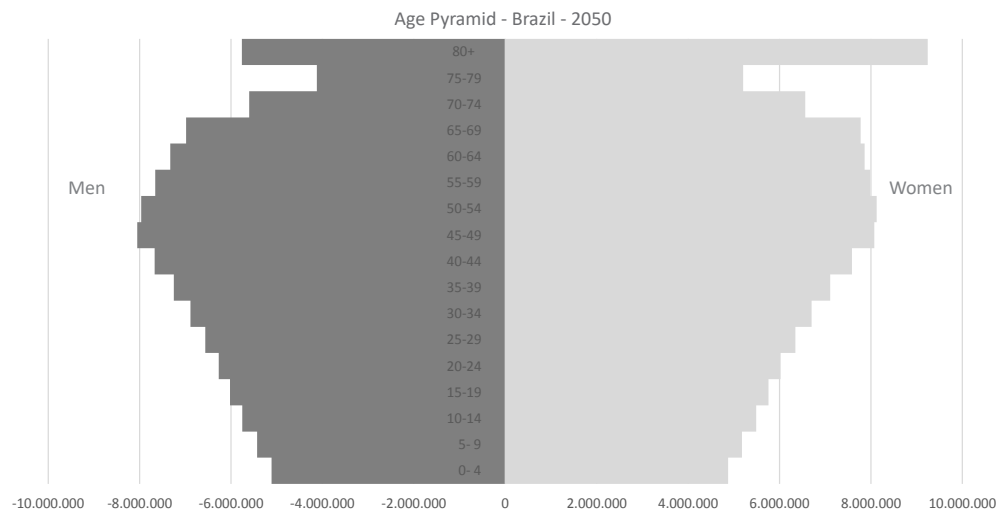
The outlook for Brazil's health system

Brazil has witnessed major changes in its demographic and epidemiological profiles in the thirty years since the promulgation of the Constitution. Generally speaking, the trends that have been observed (Graph 2) are unlikely to undergo any major changes in the next 30 years. According to forecasts made by the Brazilian Institute of Geography and Statistics (IBGE, acronym in Portuguese), the population aged over 65 years tripled between 1988 and 2018, reaching 18.3 million and is projected to reach 49 million in 2048, 14 million of which aged over 80 years²⁴.

These trends reflect morbidity and mortality patterns characterized by the coexistence of problems directly related to poverty associated with a pattern of predominance of chronic degenerative diseases, aggravated by a high prevalence of events caused by external causes. This implies changes in the healthcare paradigm in the wake of a process in which curable acute diseases are replaced by others that require continuing care on a permanent basis (from cure to care *apud* Cochrane²⁶), following the trends of the developed



Source: IBGE, Projection of the Brazilian Population and Federation Units, 2013.



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Graph 2. Population composition in absolute terms by age and sex - Brazil – 1990, 2020, 2050.

Source: População 1990: IBGE. Projeção da População do Brasil por Sexo e Idade para o Período 1980-2050 - Revisão 2008²⁷.
 Source: População 2020 – 2050: IBGE. Projeção da população por sexo e idade: Brasil 2000-2060²⁴.

countries where the process started in the middle of the twentieth century. This profile requires the involvement of various types of health professionals, as well community and social services, home care, palliative health care, and long-term care facilities. As a result, referral and counter-referral processes require alternatives to traditional political and administrative measures in order to facilitate the flow of demand²⁷. Furthermore, based on our calculations and assuming current technological options, it is estimated that the change in demographic profile forecast over the next decades will mean that health spending will have to increase by 38% in 20 years.

Striving for effective integration and coordination of healthcare provision may seem like a fanciful goal in a highly segmented system with public and private third party payers. In a country of continental proportions, with 27 states and 5,570 municipalities, which vary significantly in size, population, biome, land use, and socio-economic situation, it is impossible to think of an equitable health system that addresses these differences without a strong coordination and integration of federal, state, and local services. In 2011, a mere 95 municipalities had sufficient capacity to deliver adequate appropriate medium complexity care²⁸. Inequalities in access to health services across Brazil and exclusive and advantageous contracts between private service providers and payers constitute additional barriers to achieving universal and equitable access to healthcare²⁹.

The contraction in government spending, aggravated by the review of federal to local government transfer mechanisms adopted by the Ministry of Health at the end of 2017 that led to a relaxation of programmatic conditions, has ended up accentuating the fragmentation of the public system and indirectly stimulating private arrangements, similar to what happened in the 1990s¹¹. The gross revenue of health insurance companies in 2016 was almost one and a half times greater than the Ministry of Health's budget. Moreover, while SUS expenditure across the three levels of government increased in real terms by only 0.5% between 2012 and 2016, the gross revenue of health insurance companies increased by 27% in the same period. In 2016, revenue per capita of health insurance companies was 2.55 times that of the SUS, while spending per capita on the 6.5 million of Brazilians with health insurance (3.5% of the population) was four times greater (based on data from SIOPS³⁰ and the ANS³¹).

The siphoning of resources towards higher income groups with health insurance is the result of a combination of the transfer of untaxed indirect salaries to the end consumer of goods and services through collective health insurance plans, income tax deductions for both individual and collective health plans, coupled with greater control over the workforce³². From a total of federal tax expenditures of around R\$39 billion in 2018, healthcare accounted for R\$18 billion³³.

Fiscal strangulation has a number of consequences from a healthcare system organization point of view: a tendency toward fierce competition between state and local governments and among care providers; undermining of the organization of the healthcare networks, with further fragmentation and segmentation of care; a reduction in investing in new capacities; and a reduction in the quality and safety of services. In the private sector, new care arrangements are constantly emerging, such as neighborhood clinics and *clínicas populares*, together with the development and strengthening of new types of prepaid health insurance schemes, such as *planos populares*, *VGBL Saúde* and franchise systems. An increase in inequality in access to health care across regions and income groups is also likely, together with the stratification of care and a concentration of investment and cutting edge innovation in the wealthier private sector.

This picture corresponds to what Viana et al.³⁴ call "private profit-making commercial pluralism". This pessimistic outlook distances itself even further from the desirable and feasible scenario termed "integrative state pluralism under the auspices of public law", which is closer to the constitutional compliance.

In spite of compensatory measures that helped remove 28 million from poverty between 2000 and 2015, the concentration of income among the wealthiest 1% of Brazilians continued to deepen, with Brazil's six richest people holding the same wealth as the poorest 50 percent of the population. Taxation and public spending have not been efficient in reducing inequalities in Brazil³⁵. Any path without the reversion of Constitutional Amendment N° 95 (and in fact a wide set of measures that have negatively impacted the health sector taken since the promulgation of Constitutional Amendment N° 86/2015³⁶) represents a Brazil which, as Souza⁶ puts it, serves the interests of the 20% (of the population). Or, even worse, a country that supposedly serves the interests of the 20%, but actually belongs to the 1%. The latter is committed to one of the proj-

ects elucidated by Fiori⁷, anchored in a supposedly balanced budget, the paradigms of orthodox economics and subaltern integration into international division of labor. Indeed, the reversion of these measures seems indispensable for any national project that does not incorporate “final solutions” into its strategies.

Collaborations

JC Noronha participated in the conception, analysis, write-up and final approval of the article. GS Nortonha and TR Pereira participated in the conception, analysis, critical revision of relevant intellectual content and final approval of the article. AM Costa participated in the conception, analysis, relevant critical revision of intellectual content and final approval.

References

- Shawn A. Why economic forecasting has always been a flawed science. *The Guardian*; 2017 Set 2. [acessado 2018 Jan 3]. Disponível em: <https://www.theguardian.com/money/2017/sep/02/economic-forecasting-flawed-science-data>.
- Fundação Oswaldo Cruz (Fiocruz). *Saúde Amanhã: prospecção estratégica do sistema de saúde brasileiro*. [acessado 2018 Jan 3]. Disponível em: www.saudeamanha.fiocruz.br.
- Gadelha P, Noronha J. Pensar e construir o futuro: Saúde Amanhã. *Boletim de Análise Político-Institucional* 2016; 9:11-16.
- Gramsci A. *Cadernos do cárcere*. Vol. 3. 3ª ed. Rio de Janeiro: Civilização Brasileira; 2007. p. 342-343.
- Furtado C. *Capitalismo Global*. 26ª ed. São Paulo: Paz e Terra; 1998.
- Souza J. *A radiografia do golpe: entenda como e porque você foi enganado*. Rio de Janeiro: LeYa; 2016.
- Fiori JL. *O voo da coruja: para ler o desenvolvimentismo brasileiro*. Rio de Janeiro: Record; 2003.
- Brasil. *Constituição da República Federativa do Brasil*. Brasília: Senado Federal; [página da Internet] 1988. [2018 Jan 3]. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/constituicaocompilado.htm.
- Costa AM, Noronha JC, Noronha GS. Barreiras ao universalismo do sistema de saúde brasileiro. In: Tetelboin C, Laurell AC, coordenadores. *Por el derecho universal a la salud: una agenda latinoamericana de análisis y lucha*. Buenos Aires: CLACSO; 2015. p. 17-39.
- Brasil. Lei Nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União* 1990; 20 set.
- Noronha JC, Soares LT. A política de saúde no Brasil nos anos 90. *Cien Saude Colet* 2001; 6(2):445-450.
- Brasil. Lei nº 9.656, de 3 de junho de 1998. Dispõe sobre os planos e seguros privados de assistência à saúde. *Diário Oficial da União* [página da Internet] 1998; 4 jun. [acessado 2018 Jan 3]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/L9656compilado.htm.
- Sestelo JAF, Souza LEPP, Bahia L. Saúde suplementar no Brasil: abordagens sobre a articulação público/privada na assistência à saúde. *Cad Saude Publica* [periódico na Internet]. 2013 May [acessado 14 Jan 2018]; 29(5):851-866. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2013000500004&lng=en
- Organisation for Economic Co-operation and Development (OECD). *OECD Health Statistics 2017* [página na internet] [acessado 2018 Jan 5]. Disponível em: <http://www.oecd.org/els/health-systems/health-data.htm>
- Instituto Brasileiro de Geografia e Estatística (IBGE). *Conta-Satélite de Saúde Brasil 2010-2015*. [monografia na Internet]. Rio de Janeiro: IBGE; 2017 [acessado 2018 Jan 10]. Disponível em: <https://biblioteca.ibge.gov.br/visualizacao/livros/liv101437.pdf>
- Brasil. Lei Complementar Nº 141, de 13 de janeiro de 2012. Regulamenta o § 3º do art. 198 da Constituição Federal para dispor sobre os valores mínimos a serem aplicados anualmente pela União, Estados, Distrito Federal e Municípios em ações e serviços públicos de saúde; estabelece os critérios de rateio dos recursos de transferências para a saúde e as normas de fiscalização, avaliação e controle das despesas com saúde nas 3 (três) esferas de governo; revoga dispositivos das Leis nºs 8.080, de 19 de setembro de 1990, e 8.689, de 27 de julho de 1993; e dá outras providências. *Diário Oficial da União* 2012; jan 16.
- Brasil. Emenda Constitucional Nº 95, de 15 de dezembro de 2016. Altera o Ato das Disposições Constitucionais Transitórias, para instituir o Novo Regime Fiscal, e dá outras providências. *Diário Oficial da União* 2016; 16 dez.
- Rossi P, Dweck E. Impactos do Novo Regime Fiscal na saúde e educação. *Cad Saude Publica* [periódicos na Internet]. 2016 [acessado 2018 Jan 14]; 32(12). Disponível em: <http://www.scielo.br/pdf/csp/v32n12/1678-4464-csp-32-12-e00194316.pdf>
- Vieira FS, Benevides RPS. O Direito à Saúde no Brasil em Tempos de Crise Econômica, Ajuste Fiscal e Reforma Implícita do Estado. *Revista de Estudos e Pesquisas sobre as Américas* [periódicos na Internet]. 2016. [acessado 2018 Jan 8]; 10(3):32-59. Disponível em: <http://periodicos.unb.br/index.php/repam/article/view/21860>
- Innes AM. What is Money? *The Banking Law Journal* [periódico na Internet]. Maio 1913. [acessado 2016 Jul 01]. Disponível em: <https://www.community-exchange.org/docs/what%20is%20money.htm>.
- Knapp GF. *The State Theory of Money*. [monografia na Internet]. Londres: Mcmillan & Company Ltd.; 1924. [acessado 2017 Set 20]. Disponível em: <https://socialsciences.mcmaster.ca/econ/ugcm/3ll3/knapp/StateTheoryMoney.pdf>
- Lerner AP. Functional finance and the federal debt. *Social research* [periódico na Internet]. 1943 [acessado 2018 Jan 4]; p. 38-51. Disponível em: <http://cas2.umkc.edu/economics/people/facultyPages/wray/courses/Econ%20601/readings/lerner%20functional%20finance.pdf>
- Kalecki M. Aspectos políticos do pleno emprego. *Jornal GGN* [periódico na Internet]. 1942 [acessado 2018 Jan 4]. Disponível em: <https://jornalggm.com.br/noticia/aspectos-politicos-do-pleno-emprego-por-michal-kalecki>
- Instituto Brasileiro de Geografia e Estatística (IBGE). [homepage na internet]. *Projeção da população por sexo e idade: Brasil 2000-2060*. [acessado 2018 Jan 12]. Disponível em: https://ww2.ibge.gov.br/home/estatistica/populacao/projecao_da_populacao/2013/default_tab.shtm

25. Cochrane AL. *Effectiveness and efficiency. Random reflections on health services*. [monografia na Internet]. London: Nuffield Provincial Hospitals Trust; 1972. (Reprinted in 1999 for Nuffield Trust by the Royal Society of Medicine Press, London. [acessado 2018 Jan 04]. Disponível em: <https://www.nuffieldtrust.org.uk/files/2017-01/effectiveness-and-efficiency-web-final.pdf>
26. Ouverney AM, Noronha JC. Modelos de organização e gestão da atenção à saúde: redes locais, regionais e nacionais. In: Fundação Oswaldo Cruz. *A saúde no Brasil em 2030 - prospecção estratégica do sistema de saúde brasileiro: organização e gestão do sistema de saúde* [monografia na Internet]. Rio de Janeiro: Fiocruz/Ipea/Ministério da Saúde/Secretaria de Assuntos Estratégicos da Presidência da República; 2013. Vol. 3. p. 143-182. [acessado 2018 Jan 03]. Disponível em: <http://books.scielo.org/id/98kpw/pdf/noronha-9788581100173-06.pdf>
27. Instituto Brasileiro de Geografia e Estatística (IBGE). [homepage na internet]. *Projeção da população por sexo e idade Brasil para o período 1980 – 2010 – Revisão 2008*. Rio de Janeiro: IBGE; 2013. [acessado 2018 Jan 12]. Disponível em: <https://www.ibge.gov.br/estatisticas-novoportal/sociais/populacao/9109-.html?edicao=17993&t=downloads>
28. Oliveira ATR, O'Neill MMVC. Dinâmica Demográfica e Distribuição Espacial da População: o acesso aos serviços de saúde. In Gadelha P, Noronha JC, Dain S, Pereira TR, organizadores. *Brasil Saúde Amanhã: população, economia e gestão*. Rio de Janeiro; Editora Fiocruz; 2016. p. 66.
29. Santos IS, Martins ACM, Lima CRA, Machado JP, Pessoa LR. *Relatório de Pesquisa sobre os Recursos Físicos de Saúde no Brasil*. [monografia na Internet]. Rio de Janeiro: Fiocruz; 2016. RP 01. [acessado 2018 Jan 16]. Disponível em: <https://saudeamanha.fiocruz.br/wp-content/uploads/2016/07/rp1-ISABELA-SANTOS-et-alii-Relat%C3%B3rio-Pesquisa-Recursos-F%C3%ADsicos-da-Sa%C3%BAde-no-Brasil-2014.pdf>
30. Brasil. Ministério da Saúde (MS). *SIOPS na gestão e financiamento da Saúde: indicadores*. [página na internet]. [acessado 2018 Jan 20]. Disponível em: <http://portalms.saude.gov.br/repases-financeiros/siops/indicadores>
31. Brasil. Agência Nacional de Saúde Suplementar (ANS). *Dados e indicadores do setor*. [página na internet]. [acessado 2018 Jan 20] Disponível em: <http://www.ans.gov.br/perfil-do-setor/dados-e-indicadores-do-setor>
32. Noronha JC, Santos IS, Pereira T. Relações entre o SUS e a saúde suplementar: problemas e alternativas para o futuro do sistema universal. In: Santos NR, Amarante PDC, organizadores. *Gestão pública e relação público privada na Saúde*. Rio de Janeiro: Cebes; 2011. p. 152-179.
33. Brasil. Ministério da Fazenda. Receita Federal. *Demonstrativo dos Gastos Governamentais Indiretos de Natureza Tributária (Gastos Tributários) – PLOA 2018*. [acessado 2018 Jan 21] Brasília, 2017. Disponível em: <http://idg.receita.fazenda.gov.br/dados/receitadata/renuncia-fiscal/previsoes-ploa/arquivos-e-imagens/texto-dgt-ploa-2018-arquivo-final-para-publicacao.pdf/view>
34. Viana, ALA, Miranda, AS, Silva, HP. Segmentos institucionais de gestão em saúde: descrição, tendências e cenários prospectivos. *Textos para Discussão* [periódico na Internet]. 2015, Fevereiro [acessado 2018 Jan 03]; N. 2: [18 p]. Disponível em: https://saudeamanha.fiocruz.br/wp-content/uploads/2016/07/2-PJSSaudeAmanha_Texto0002_final.pdf
35. OXFAM. Brasil. *Direitos humanos em tempos de austeridade*. [texto na internet]. [acessado 2018 Jan 20] Disponível em: https://www.oxfam.org.br/sites/default/files/arquivos/Fact_Sheet_2_Portugues_V_digital_2.pdf
36. Brasil. Constituição (1998). Emenda constitucional n.º86, 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* [periódico na Internet]. 2015; 18 mar. [acessado 2018 Jan 05]; Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/emendas/emc/emc86.htm

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