

The future of the SUS: impacts of neoliberal reforms on public health – austerity *versus* universality

O futuro do SUS: impactos das reformas neoliberais na saúde pública – austeridade versus universalidade

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ABSTRACT The essay analyzes the effects of the austerity policy on the Unified Health System (SUS). Budgetary and fiscal data indicate that the New Tax Regime (NTR), created by Constitutional Amendment nº 95/2016 (CA 95), has transformed chronic underfunding into reduction of the health budget. In addition, the NTR alters the relations between the fiscal and social dimensions, since the expense is now evaluated from the pressure exerted on the cap. Particularly, the universal health care system becomes an excess in relation to the limit established by CA 95, since social rights begin to appear as an object of adjustment to the fiscal frontier, from which the expense is taken as irregular. The article shows that such changes already imply reduction of the available health budget.

KEYWORDS Health system. Right to health. Austerity. Public health financing.

RESUMO O ensaio analisa os efeitos da política de austeridade sobre o Sistema Único de Saúde (SUS). Dados orçamentários e fiscais indicam que o Novo Regime Fiscal (NRF), criado pela Emenda Constitucional nº 95/2016 (EC 95), transformou o subfinanciamento crônico da saúde em desfinanciamento do SUS. Ademais, o NRF altera as relações entre as dimensões fiscal e social, uma vez que a despesa passa a ser avaliada a partir da pressão que exerce sobre o teto. Particularmente, o sistema de saúde universal se torna um excesso em relação ao limite estabelecido pela EC 95, pois os direitos sociais passam a aparecer como objeto de ajuste à fronteira fiscal, a partir da qual o gasto é tomado como irregular. Será mostrado que tais mudanças já implicam redução do orçamento disponível de saúde.

PALAVRAS-CHAVE Sistema de saúde. Direito à saúde. Austeridade. Financiamento da saúde pública.

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Introduction

The guarantee of health as a right was an achievement of Brazilian society and was directly associated with the construction of the democratic State of law, the result of a great social pact, expressed through the Federal Constitution of 1988. The Unified Health System (SUS) is recognized as one of the most inclusive public policies practiced in Brazil. Before, Brazilians were unequally divided among the rich, who cough up the money to pay for their own health care, those who had formal jobs and accessed the health services offered by public health care, and the indigents, those who lived on the margin of the formal labor market, who did not have signed labour card and went on pilgrimage in search of health care by charity or through some selective programs of public health. In the 1980s, it can be said that approximately half of the population had no access to services, and a small fraction was eventually attended by the charity of the Holy Houses¹⁻³.

Since 1988, the entire Brazilian population has become a beneficiary of the SUS and has been favored, for example, by its advances in the areas of sanitary, epidemiological and environmental surveillance, by the National Immunization Program (PNI), created in the 1970s and expanded throughout the existence of SUS, in order to ensure access to vaccines on the calendar recommended by the World Health Organization (WHO), the urgency and emergency network and the improvement of health indicators that provide greater social well-being.

The history of the SUS is marked by the constant challenge of providing adequate public funding to ensure the constitutional right to health. The conception of the constitutional text is that the SUS should be financed with resources from the social security budget, the Union, the states, the Federal District and the municipalities, as well as other sources.

However, only in 2000, with Constitutional Amendment (CA) n° 29⁴, the commitment

of the three spheres of government to health financing was guaranteed and stable sources were established, preventing crises or insolvency situations. Thus, the states were obliged to apply, at least, 12% of their tax revenue, the municipalities at least 15% of their tax revenue, and the Union, the amount applied in the previous year adjusted by the nominal variation of the Gross Domestic Product (GDP). In 2015, CA n° 86⁵ made the implementation of individual parliamentary amendments mandatory and established that minimum federal health resources would be calculated on the basis of the Net Current Revenue (NCR) of the Union, starting at 13.2%, in 2016, until it reaches 15% of NCR in 2020.

The CA 29 marks, therefore, the beginning of health budgetary commitment. It can be emphasized that the norm induced the growth of resources applied in Health Actions and Public Services (ASPS), which went from 2.9% of GDP, in 2000, to 4.1% of GDP, in 2017. This increase was, mainly, due to the linking of state and municipal health revenues.

In 2000, states and municipalities, respectively, accounted for 20% and 21% of public health spending. Expenditure was still very concentrated in the Union (58%). If we go back to the 1980s, there is a greater concentration of health spending at the federal level, with the Union participating in spending of 75% of the total⁴. Over time, the participation of states and municipalities increased, including the fact that, with CA 29, the Union had only the obligation to keep health expenditure stable relative to nominal GDP. In 2017, the states invested R\$ 68.3 billion (26%) in ASPS; and the municipalities, R\$ 82.5 billion (31%). The amounts allocated by the Union were R\$ 114.7 billion, representing only 43%.

Despite the mobilization of health and social movement managers and some initiatives in parliament aimed at expanding health resources, the SUS has never had the amount of compatible funding required for universal systems that could guarantee the premises

provided for in the Constitution. Total health spending in Brazil remains around 8% of GDP, with more than half being private spending. International evidence suggests that the universalization of health systems implies public expenditures equal to or greater than 70% of total expenditures in the sector, with Brazil being more than 20 percentage points below this level.

This essay, produced from the analysis of actors involved in SUS management in the three spheres of government over the last 30 years, seeks to show the short, medium and long term effects of austerity policy on public health. Methodologically, budgetary and fiscal data are used to show the immediate and up to 2036 effects of the New Fiscal Regime (NFR), established by the CA 95⁴, on the SUS.

It is argued that, due to the CA 95, chronic underfunding is aggravated by the unfinancing of the SUS. Before entering the empirical dimension, it is argued, based mainly on Rancière⁴ and Foucault⁵, that the spending ceiling creates a form of expression of state action (spoken and visible) that consists of disposing social policies as an excess in relation to the limit established by the expenditure freezes, so that social rights will tend to appear as an object of adjustment to the fiscal boundary from which expenditure will be assumed to be irregular.

From this perspective, the next section discusses the idea that neoliberalism in the Temer and Bolsonaro governments, is not so well represented from the traditional idea of reducing the State in the economic domain so that the market can operate freely. Under the key presented here, it must be read as a technology of government marked by state activism in defense of a society structured by the criterion of competition (extending to economic and non-economic spheres, such as social policies) and in which the market becomes a principle of criticism of State action. In other words, the principle is no longer self-limitation of the State, which must ensure that the market functions under the rules of

competition, but the opposite: it is the market that becomes the standard of regulation of the State; the market turns against the State and closes government practices in inducing competition as a social norm and in criticizing any intervention as dysfunctional to the public interest.

The Temer (2016-2018) and Bolsonaro (2019-2022) governments – neoliberalism as hyperactivity of the State at the service of the market

It is argued that the actions of the current government in Brazil, as well as the illegitimate government that preceded it, are based on neoliberalism, understood as a political practice that puts into action a market rationality. Thus, neoliberalism would not merely consist of a radicalization of self-delivered capital, marked by the withdrawal of the State from the economy, but of political-legal activism aimed at building a society governed by competition.

Under this bias, it is necessary to distinguish liberalism and neoliberalism, taking them, in the limit, as reflections that lead to opposite practices of government. In classical liberalism, it is about asking the government not to intervene, to respect the shape of the market and 'let it run', condensed demand in *laissez-faire*. In neoliberalism, it is as if the formula were reversed, making the market a standard for regulating government practices so as not to let it do so. The market is no longer an institution that limits government, but an anti-government principle that regulates it by evaluating its actions against strictly economic criteria.

It is the State itself that will have to intervene in order to produce competition, which is not the product of human nature, but of neoliberal governmentality. Competition as an

economic logic will only appear and produce effects if it is built upon an art of active government which may be called neoliberalism. In it, the essential will not be exchange (referring to equivalence/equality), but competition/inequality, which presupposes a juridical-political interventionism that can produce the circumstances for competition among agents, including in non-economic domains¹¹.

In this sense, neoliberalism distances itself from classical liberalism, and should not be understood only in terms of reducing the size of the State and limiting social policies that provide coverage against risks. Its nature is profoundly interventionist in terms of shaping a society inclined to function through competition.

Foucault¹⁰ summarizes the differences between liberalism and neoliberalism, stressing that, in the latter, self-limitation of the government is no longer imposed, but its regulation by the market. In classical liberalism, the government was asked to respect the shape of the market and to 'let it run'. Here, *laissez-faire* is transformed into not letting the government do so, in the name of a market law that will make it possible to measure and evaluate each of its activities. *Laissez-faire* thus turns in the opposite direction, and the market is no longer a principle of government self-limitation, it is a principle turned against it.

This implies the implementation of techniques that allow the State and its social policies to appear as excess to contain, once subjected to a standard of veridiction by the market, whose principle is 'do not let the State do'. Thus, from a narrative that the lack of spending was responsible for the economic crisis and the rising unemployment rate, the Temer government adopted an austerity-based economic policy as a constitutional principle to the detriment of social policies, which should imply reduction primary expenditure in relation to GDP and revenues.

The first major reform of Temer was the implementation of a fiscal adjustment policy, freezing public spending for up to 20 years.

This is the NFR, established by the CA 95, which established the constitutional limitation of public spending for up to two decades, an internationally unprecedented fact that brought with it revealing elements of the establishment of the new neoliberal project. In essence, this CA makes it impossible for the State to fulfill its constitutional obligations as laid down since 1988. The norm marks the end of the State as a guarantor of rights, since the proposal imposes a reversal of priorities, making it impossible for public services and the social protection network to function under the terms of the Federal Constitution.

If the unfunding of social policies is a result of spending caps, it is primarily because it constitutes a new form of sensitive presentation; that is, it founds a new relationship between the visible and its meaning, between the word that expresses the public (austerity and the spending limit) and social policies as excess to contain, focusing on the financing of rights.

By directing all its action to limit primary spending, the government has made invisible some of the main drainage of public resources in recent years: tax relief, tax evasion, and interest payments. For example, since the Temer administration, the pre-salt has been open to oil multinationals, which now have an exploration regime that cannot be characterized solely by the concept of 'Minimum State'. Strictly speaking, the neoliberal State is active in constructing legal rules that induce the market, for example in the form of tax benefits, low rates of local content and oil surpluses transferred from oil companies to the Union. All this architecture produces greater attractiveness to the auctions, 'verified' in the form of awards obtained in the bidding.

Among the measures for the benefit of the oil companies, it is worth mentioning the tax regime established, which resulted in the possibility of full deduction of the income tax (IR) and Social Contribution on Net Income (CSLL) calculation base of the amounts applied in the sector. Just considering royalties, oil companies will be able to make

deductions that will entail a tax loss of more than R\$ 1 trillion in about 30 years. Losses will affect states and municipalities, as 46% of income tax is distributed to federated entities via Participation Funds.

Furthermore, the government refuses to debate the unfair and inefficient tax system, which has little to do with income and property, and proportionally levies more on those who earn less. As an illustration, it is worth mentioning the profit and dividend exemption practiced by Brazil, which could add about R\$ 50 billion to public revenues annually. Among the countries of the Organization for Economic Co-operation and Development (OECD), only Estonia does not tax this type of income¹².

The above does not contradict the idea that fiscal balance is an important objective to pursue. However, the pursuit of fiscal sustainability does not necessarily involve imposing a constitutional ceiling, applied to almost all primary expenditures (including investments and social policies), implying a decrease in expenditure as a proportion of GDP, even if there is an expansion of revenues. This ceiling design, unparalleled in the rest of the world, serves primarily to construct short-term constraints, creating excess spending as enunciable and visible and, thus, adjusting the social protection model as an object of public attention in the short term.

The spending cap is the trigger of this intervention model. By turning into a rational rule¹³ the value position that advocates for reducing social spending, it produces the need for structural cutting, culminating in the revision of current constitutional pillars. It is not for any other reason that the ceiling preceded proposals such as social security reform. After all, it constitutes expenditure as an object to be controlled, as its excess is expressed by the risks of exceeding the limit set by the CA 95. Accordingly, the only possible answer is to adjust appropriations to the reality of the ceiling, constraining the

financing of social policies and demanding abrupt changes in their principles to require fewer public resources.

Therein lies the association between public interest and social security reform, which becomes an urgent agenda in the face of pressure on the ceiling. That is, the logic is not social security sustainability, which would also require measures on the side of tax revenue and stimulating economic growth. Strictly speaking, this is a tax reform induced by the spending ceiling, aimed at reducing the amount of benefits to contain the expense, including affecting pensioners and special pensions of workers exposed to health agents and people with permanent disabilities.

In addition, the restriction of access itself acts as a mechanism for social security exclusion in the case of men entering the social security system after the enactment of the reform, given the minimum contribution time increased by five years. If such a rule had been in force in recent years, more than 50% of men would not have retired by age in the urban environment in the face of unemployment, informality and labor turnover. The reform also provides for the deconstitutionalization of social security rights, illustrating the thesis of State activism in favor of the political-legal construction of an individual adaptable to economic imperatives, in terms of what Wendy Brown¹⁴ called the subject of sacrifice.

In addition, there is a risk that capitalization will be discussed again in the National Congress, attesting that the government's goal is not to make a social security reform that aims to give fiscal sustainability to the apportionment regime, given the aging population. Even because, with the capitalization system presented as an alternative (rather than complementary), the public pay system is reformed and, then, destroyed, as new jobs will have to be offered under the capitalization scheme (which, under the originally proposed government proposal, will not have mandatory contribution of

the employers). This is, strictly speaking, a radical tax reform, supported by the principle that everyone should be the manager of his/her own protection. The transition cost to the individual account system is borne by the State, as the public system will no longer have revenues from current members. In Chile, for example, the capitalization transition cost represented 130% of GDP¹⁵.

Therefore, the question is not limited to the reduction of the State, but it must be analyzed how neoliberalism becomes a type of state intervention aimed at producing the market, inducing the subject of competitive rationality, which supposes to disentangle the solidary pillars of social security (health, social security and social assistance) and create the stimuli for an individual based on competitive economic rationality, manager of his/her own protection. To this end, the State must be active, so the liberal motto is not so much *laissez-faire*. What counts is the type of market intervention, for example, measured by the tax cost of transition from allocation to capitalization, which should be borne by the State.

This is how SUS, since the Temer administration, is the object of more or less structural change proposals. As already explained, the trigger for such proposals is the spending cap, taken here as a new public form of circulation of the word and exposure of the visible, through which it is a link between austerity and ‘collective interest’. Faced with the expenditure freeze, CA 95 creates a sensitive fabric in which all expenditure expansion is experienced as pressure on the spending ceiling, turning social policies into mere control object.

In this sense, fiscal data underlie a sensory regime, expressed by common ways of understanding social policies, which are affected by austerity in at least three distinct ways: a) reduction of the available budget in the short, medium and long term; b) worsening of social indexes due to budget shortfall; c) narrative association between

the worsening of results and the defense of the revision of the assumptions of universal social policies, showing that there are no linear circuits that lead the material cause to its expression.

The next section will deal with the first aspect cited, showing empirically the impacts of CA 95 on SUS.

From chronic underfunding to SUS unfinancing

The CA 95 will lead health to an unprecedented funding crisis. Even if the Country grows and revenues react positively, primary expenditures will be (as a whole) restricted to the spending ceiling. That is, they will be reduced as a proportion of GDP or revenues.

The health budget, within the federal government, was frozen for 20 years, being readjusted only by the calculation of inflation, as measured by the Extended National Consumer Price Index (IPCA). The CA 95 disregarded the health needs of the population, the impact of population growth, the demographic transition, the necessary expansion of the public network, the impact of technology incorporation (increasing and cumulative in health) and the costs associated with changing the care profile determined by the prevalence of noncommunicable diseases and external causes, and health inflation itself., higher than other sectors of the economy at the international level. With NFR, social spending is decoupled from any revenue growth over the next 20 years. Thus, even if the federal revenue increases, there would be no more investments in social areas.

The basic principle of the CA was to prevent real gains from economic growth from being automatically transferred to primary expenditures and thus to ASPS expenditures. As far as minimum application is concerned, the problem deepens when opting for a depressed starting base due to poor economic and revenue performance. The amendment

stipulated that the minimum mandatory value for ASPS, for up to 20 years, would be 15% of the 2017 NCR, plus inflation, which represented R\$ 109 billion, a figure that did not even guarantee, in real terms, the execution of 2016, a fact aggravated by the growing commitment of the health budget with the imposing parliamentary amendments¹⁶.

Between 2003 and 2017, federal health expenditure went from 58% to 43% of total public expenditure. This means that states

and, above all, municipalities spend proportionally more on health. If the freeze is maintained, they should account for 70% of public spending by 2036.

When projecting how the expenditure with ASPS should be compared to the NCR for each financial year, considering the application floor between 2020 and 2036, it is estimated that health expenditures will correspond to about 10% of NCR in 2036, the last year of the CA 95.

Graph 1. Evolution of ASPS expenses (% of NCR)



Source: Own elaboration. Siop, STN e LOA 2019.

Note: Between 2002 and 2018, effective values. For 2019, LOA values. Between 2020 and 2036, it considers the health application floor, estimated from the CPI of 4% and NCR average annual growth of 5.7%, the same as between 2014 and 2019.

As shown in *graph 1*, if the minimum wage is to be used as an effective reference for health budget programming, there should be a drop in ASPS spending of more than 5 percentage points of RCL in about 20 years. Medium and long-term impacts can also be estimated for SUS, comparing the application on the frozen floor of the CA 95 and the mandatory values, if the previous rule were in force (15% of the RCL of the current year). The expectation,

elaborated by the authors themselves, based on the average annual growth of RCL of 5.7% and CPI of 4%, is an estimated loss to federal expenses in ASPS of R\$ 800 billion, between 2020 and 2036, in the hypothesis allocation of the health budget on the wage level of CA 95.

For those who consider the scenario unlikely, it is worth remembering that the 2019 Annual Budget Bill (Ploa) was sent by the Executive Branch with expenses practically

on the floor, demonstrating the real risk of flattening health spending by converting the floor into ceiling. The values of the Annual Budget Law (LOA) were just above the floor after the parliamentary amendments, but are already around the wage level given the announced contingency.

The current government has indicated full agreement with CA 95, which has subjected investments in social policies to the principles of fiscal austerity. The Minister of Health has publicly argued that the health budget is ‘very large’¹⁷ and that it will optimize resources by ‘improving the management’ of the department. However, it is already possible to analyze that the financing of SUS in the first year of Jair Bolsonaro’s term has a calamitous situation.

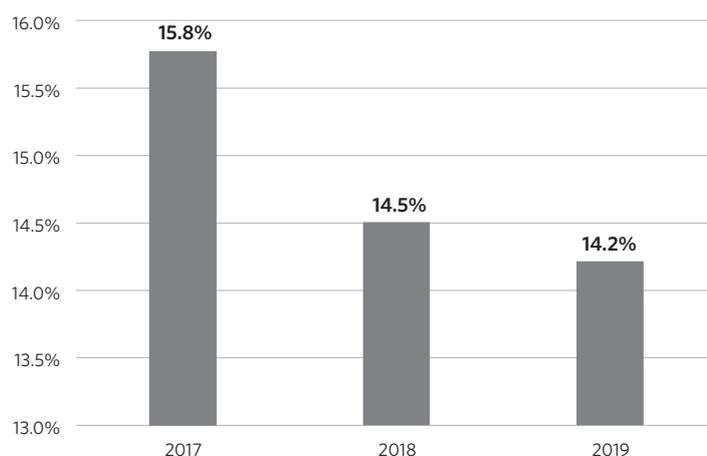
According to data from the Integrated Planning and Budgetary System (Siop), consulted in May 2019, LOA 2019 had R\$ 120.8 billion of scheduled expenses in ASPS, a nominal expansion of 2.8% over the previous year. Growth does not even replace 2018 inflation, which was 3.75% (CPI). Expenses for LOA 2019 are already scheduled close to the ceiling of CA 95, defined by the 2018 limit, readjusted by the 12-month CPI (4.39%). As a result, any health budget increases should be

offset by reductions in other areas. Given the general reduction in appropriations, especially discretionary ones, there is not even room for the real preservation of the health budget.

Of the total budget for ASPS committed in 2018 (R\$ 117.5 billion), R\$ 11.7 billion were not paid, with R\$ 1 billion referring to tax amendments, and R\$ 10.7 billion to programmatic actions. This means that the amount for payment with ASPS for 2019 should also be compressed to fit part of this additional committed and unpaid amounts in 2018, further affecting financial availability in the current year.

If ASPS expense is taken as a proportion of NCR, it is clear that between 2018 and 2019, it already decreases 1.8 percentage points. Under CA 95 rules, the 2017 application floor would be 15% of NCR, which should be updated by inflation for up to 20 years. The expense applied corresponded to 15.8% of NCR in the first year of CA 95, reducing to 14.5% of NCR in 2018 and 14.2% of NCR in 2019, according to LOA estimates. Therefore, it is clear that the effects of CA 95 on SUS financing are immediate, implying expenses below the 15% level of NCR.

Graph 2. ASPS Federal Expenditure in relation to NCR (%)



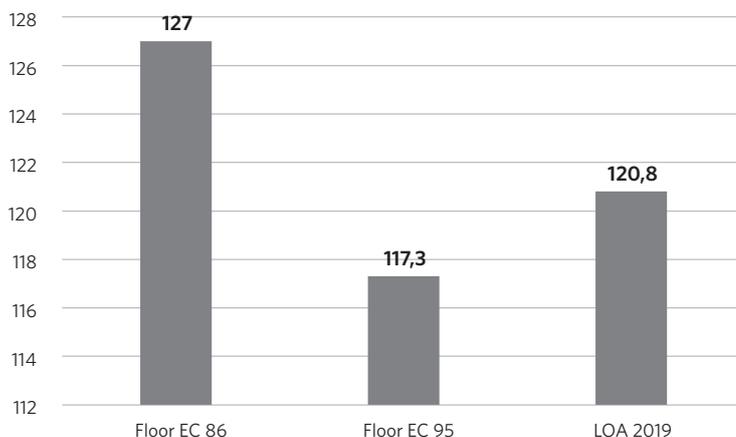
Source: Own elaboration. Siop, STN and LOA.

Note: For 2017 and 2018, effective values. For 2019, LOA forecast.

The freezing of the ASPS floor was a necessary condition for the area to be immediately impacted by the CA 95 expenditure limit. The maintenance of the mandatory minimum at the 2017 levels, which will last up to 20

years, already makes it possible to withdraw resources from SUS in the short term. It should be noted that the difference between the previous floor and the CA 95 frozen floor is almost R\$ 10 billion.

Graph 3. Comparison between application rules in ASPS (R\$ billion)



Source: Own elaboration. Siop. LOA 2019.

With the freezing of the health application floor, the sector already loses R\$ 8.2 billion in 2019, that is, if the previous floor were in force – 15% of the NCR of each year –, the health budget would be at least R\$ 8.2 billion higher than available. The estimated loss is the result of the difference between R\$ 127 billion, or 15% of the NCR forecast for 2019 (minimum required if CA 95 was not in force), and the available budget amount for 2019 of R\$ 118.8 billion (LOA allocation, subtracting the contingent amounts on the date of the Siop consultation).

It is noteworthy that the available health budget is practically on the low floor of the CA 95. For 2020, the first budget proposal submitted by the Bolsonaro government deepens the picture described here. The expected allocation of ASPS, of R\$ 122.1 billion, is almost on the frozen floor of CA 95 (R\$ 121.2 billion). If the previous floor were in force, the ASPS

budget would be more than R\$ 10 billion above the proposed value, indicating a total loss to SUS in just two years of almost R\$ 20 billion. That is, the floor has already become ceiling, materializing the submission of the health budget to the principle of austerity.

The picture could be aggravated by the government's proposal to de-index and unlink expenses, which would affect the budget of ASPS of all federated entities. A simple exercise can help to show the perverse effects of this untying proposal. If, between 2000 and 2017, the amount applied by all health entities had been corrected only by inflation, without the effect of the binding established by CA 29/00, the total amount spent on health in 2017 would have been R\$ 104.6 billion, equivalent to only 39% of current spending, which is around R\$ 265.5 billion, corresponding to a total public spending of 1.6% of GDP. Health expenditure in this period (2000-2017) would be R\$ 1.2

trillion lower than observed¹⁸. Comparing the two scenarios (with and without the decoupling PEC), Moretti estimates that, between 2020 and 2036 (taken as a reference for being the last exercise of CA 95), there would be a loss of more than R\$ 2 trillion for SUS¹⁸.

This scenario would constitute the absolute radicalization of the principle that the social protection system must conform to the competitive economic logic. After all, health expenditures would no longer be governed by any minimum enforcement obligation and their levels would depend on an economic policy guided solely by market criteria. This is the neoliberal dystopia, in which States enter the competitive logic in the form of austerity policies aimed at producing trust among investors and fiscal indicators that classify state intervention as excess to be contained.

In addition, subjects would respond to the reduction and easing of social spending by seeking individual solutions against social risks, constituting ‘companies of their own’. For this reason, we defend the argument that neoliberalism is not just a false ideology or economic theory, but a technology of government aimed at leading subjects and their conduct through a competitive rationality, aimed at dismantling the social protection system founded solidarity, and in particular the deconstruction of a universal health system that has not even been the appropriate funding instrument.

Final considerations

The impacts on the SUS occur in a context that combines health unfinancing and measures that materialize in the system positions of value strange to its constitutional assumptions. The negative effects on the health of the population could already be identified in the first hundred days of the current government. For example, the loss of 8.5 thousand Cuban doctors from the More Doctors Program, which served about 30 million Brazilians, in

2.9 thousand municipalities and indigenous villages, and the withdrawal of more than one thousand Brazilian doctors who came to occupy these vacancies (about 15% of total vacancies), leaving the population unassisted²⁰.

In addition, the Minister of Health announced the intention to municipalize primary health care and sanitation actions in indigenous villages²¹. It should be considered that, in a scenario of complete exhaustion of the capacity of federated entities to expand investments in health, the measure would have immediate negative impacts.

A major setback in mental health policy is signaled by the Ministry of Health, which advocates the resumption of bed expansion in psychiatric hospitals and now considers therapeutic communities as devices of psychosocial care networks to be funded by SUS. Attention is drawn to the transfer of the conduct of the National Drug and Alcohol Policy from the Ministry of Health to the Ministry of Citizenship, accompanied by the defense of the perspective of abstinence over the harm reduction logic with the prioritization of hospitalizations rather than humanized care in psychosocial care networks.

Measures taken in other areas also affect the health of the population, in particular the flexibility in the carrying of weapons, unrestricted release of pesticides and the creation of the group to work to reduce cigarette taxation.

It remains to be seen whether, given this scenario that combines measures that affect the health of the population and the unfinancing of the system, the loss of resources will be assimilated by SUS, with its constitutional assumptions, such as universality and comprehensiveness. As already stated above, this is the main function fulfilled by the spending cap. It creates the limit to State action as visible and speakable, requiring the adjustment of anything that constitutes a threat to the frontier from which public expenditure will be assessed as out of control. In turn, ceiling adjustments eventually clash with the very

directives of social policy erected in the 1988 Constitution, especially social security.

The situation could be further aggravated if the government intention is accomplished, through the Ministry of Economy, to refer to the PEC National Congress to untie resources from the Union, states and municipalities, in the name of a 'new federative pact'. The areas of education and health would be strongly impacted by the measure.

How to speak of a universal or health system as a right of citizenship with such a shrunken SUS? The analysis produced here indicates that we will have, objectively, if the actions of unfinancing persist, an increasingly smaller, precarious SUS, equivalent to about one third of what is now available to the Brazilian population. These premises point to the return of an exclusionary health system, to a few. It is not possible to predict the criteria that will be proposed for population stratification, much less the scope and quality of care that will be provided. However, it can be glimpsed that the substitution of the social security logic, inscribed in social security, by the capitalization regime, the deconstruction and precariousness of social assistance, health and education policies, will have harmful and immediate effects on the Brazilian population, indicating barbarism.

'New Government', 'new politics', 'new social security', 'new federative pact' are expressions that make up the speeches of the current government, at federal level. However, the projects presented so far go back to the

past, when social policy was not practiced in order to enforce rights, but to maintain the dependence on charity and the individual logic of market access, mediated by the purchasing power of each. It can be said, agreeing with sociologist Jessé Souza²², that for a country descending from slavery, the problem is not that social spending fits into the public budget, but universal rights fit into the imagination of the elites, who represent the 'rabble' as 'non-people', unworthy of rights. So, reversing the image produced by official propaganda, we can only fight against the brave old world, again dressed up, where the public budget, free of obligations and social ties, serves only to naturalize exclusion and to meet the interests of the market.

Collaborators

Menezes APR (0000-0002-1133-5776)* contributed to the conception, planning, analysis and interpretation of data; critical review of the content; and approval of the final version of the manuscript. Moretti B (0000-0002-6517-0970)* contributed to the production, conception, planning, analysis and interpretation of data; critical review of the content; and approval of the final version of the manuscript. Reis AAC (0000-0001-7184-2342)* contributed to the conception, planning, analysis and interpretation of data; critical review of the content; and approval of the final version of the manuscript. ■

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