The financing of SUS in a scenario of financialization

O financiamento do SUS sob os "ventos" da financeirização

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Abstract *This article rebuilds the process of the institutionalization process of the financing of Unified Health System (SUS), impaired, initially, by the macroeconomic policy conditions, developed during the decades of 1990 and 2000, and, ultimately, by the effects caused by the present phase of capitalism, concerning financial capital supremacy. It also identifies, within the political and economic framework, conflicts existing with the economic area of the federal government, highlighting the conditions imposed to financing and the concept of health, being universal and an essential component of Social Security.*
Key words *Financial capital supremacy, Financing of SUS, Social security*

Resumo *O artigo reconstitui o processo de institucionalização do financiamento do SUS, prejudicado, em primeira instância, pelas condições da política macroeconômica desenvolvida ao longo dos anos 1990 e 2000, e, em última instância, pelos efeitos provocados pela atual fase do capitalismo financeiro. Identificam-se, também, a partir do quadro econômico e político, as tensões existentes com a área econômica do governo federal, destacando as condicionalidades impostas ao financiamento e ao conceito de saúde, enquanto universal e integrante da Seguridade Social.*
Palavras-chave *Dominância financeira, Financiamento do SUS, Seguridade social*

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Introduction

The fight for financial resources for a universal health policy in Brazil became much more intense towards the end of the 1980s. If some time ago the main hindrance to public health was the fiscal and financial crisis of the Brazilian Developmentalist State, currently its main opponent is the large financial capital and its effects on the reduction of resources for the social field in general, and specifically for health.

In this context, the macroeconomic policy of the 1990s and 2000s - and more recently that of the Lula government, has been determinant for the hard funding conditions of the Unified Health System (SUS) and of Social Security, as set forth in the 1988 Constitution. It should not be disregarded that, from the 1980s onwards, financial capital had a powerful resurgence after the repression of the 30 glorious years of capitalism, thus assigning a new "role" to the State, and ensuring full growth of its fictitious form. According to Marx, this concerns the banking, or credit capital, and the fictitious capital respectively[1]. To give an overview of its supreme power, R$ 160.0 billion were spent in Brazil in 2007 in interests of the debt, an amount corresponding to 3.3 times the amount spent by the Ministry of Health in health initiatives and public services.

This is enough evidence that the high priority given to financial capital not only makes economic growth impracticable; it is also a hindrance to a guarantee of funding to social areas, especially those linked to Brazilian public health. It is understood that financial domination in Brazil supports the permanence of an economic policy that subdues the social in Brazil. The adoption of restrictive macroeconomic policies, i.e. of policies which meet inflation targets and the settling of external accounts, always demands high primary fiscal surpluses and attempts to reduce social public expenditures.

This article focuses on subjects that derive from this broader panorama. Its goal is to rebuild the institutionalization process of the financing of SUS, determined, in the first place, by the conditions of the macroeconomic policy developed during the decades of 1990 and 2000 and, ultimately, by effects caused by the current stage of financial capitalism. It also identifies, within the political and economic framework, conflicts with the economic area of the federal government, highlighting the conditions imposed to financing and the concept of health, being universal and a part of Social Security.

This article is divided in three sections. The first section deals with aspects that regulated the financing of SUS and Social Security, highlighting the political panorama surrounding its appearance. The second section points out the general conditions of the current phase of financial capitalism. They are no longer those of the post-war period, and the article explains how that new environment interacted and subdued the course of Brazilian history, especially concerning the action of its state, creating an obstacle to the application of a full universality of health. The third section highlights, within this reference panorama, the economic restrictions to public health in the country.

SUS and social security financing model

Representatives sanctioned the guarantee of new social rights and organizational principles of social policy in the 1988 Constitution that, at least concerning its definitions, changed some basic pillars of the previous social protection system. Universal citizenship rights to health, social assistance and welfare were guaranteed under a dedicated chapter: Social Security.

In the health field the Constitution, followed by Federal Health Laws 8080/90 and 8142/90 set forth general guidelines for the organization of SUS. As can be seen further ahead, the post-constitutional course of this system was quite agitated concerning its financing issues due to insufficient resources.

The impaired situation of health financing, added to an aggravation of social issues in the country - deterioration of living conditions, unemployment, low wages, and concentrated income distribution - and to a population increase and the appearance of old diseases and new epidemics makes the health crisis even more evident.

This scenario makes it necessary to analyze the common thread that originates the problematic health financing in the 1990s. This scenario is examined from the point of view of its relationship with welfare, both pre and post-Constitution.

Funding of federal expenditures on health prior to the Constitution was largely financed by resources of the Welfare and Social Assistance Fund (FPAS). The average participation of said source in the financing was of 80%, showing an extreme dependency of health financing on the behavior of the revenues of the welfare complex, largely supported by the contributions of employers and employees.

It is important to highlight that such revenues are generated by the application of tax rates on wages. The collected amount depends on employment levels of the formal labor market and on the average wage. This means that availability for wel-

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fare – and consequently health financing in the 1980s depended on the cycles of economy.

Accordingly, the 4.41% decrease in 1981s GDP as opposed to that of 1980 caused a decrease in the contribution resource volume of 1.98%. Not only did the ongoing economic crisis of 1982 cause a new decrease in this revenue. It also increased tax rates and the ceiling, and pensioners were also required to contribute.

In the post-Constitution period, the new rights introduced in the universalization of health and in welfare were joined by an increase of resources intended for the financing of Social Security areas. The CSLL (Social Contribution on Net Income) was created, in addition to sources traditionally used by the welfare system.

In order to ensure the financing of social protection expenses, increased by the adoption of Social Security, representatives defined that such financing would be executed "by means of resources originated from the budgets of the Union, States, the Federal District and the Municipalities", and of the social contribution of employers (incident on payrolls, invoicing, COFINS (Mandatory Contribution to Fund Social Security) and profit, CSLL (Social Contribution on Net Income) of workers, and 50% of the revenue of sweepstakes (lottery). These resources would comprise the Social Security budget, and not that of the Union (OSS article 195). Its budget proposal would be jointly elaborated by the Security areas.

The incorporation of new COFINS (Mandatory Contribution to Fund Social Security) and CSLL (Social Contribution on Net Income) sources also intended to make financing less dependent on the cyclic variations of economy. However, later studies indicated that these sources were also very sensitive to the behavior of economy.

A supplementary law provides that 30% of OSS resources should be earmarked for SUS. According to the Constitution, these federal resources should be added to revenues from State and Municipal Treasuries. However, the Constitution did not define how the participation of federate entities in Social Security financing should occur. The Provisional Contribution on Financial Transactions (CPMF) was created in 1997, and its resources joined those set forth in the Constitution. It was only in 2000 that the Constitutional Amendment n. 29 was sanctioned, defining how the Union, States and Municipalities should be inserted in the financing of SUS.

The representatives also had the diligence of defining which social contributions and resources from the governmental bodies would be of exclusive use by the Social Security. Unfortunately, no government after the enactment of the 1988 Constitution complied with this provision.

Public health and the financialization of economy

For the sake of providing clear understanding of what is in dispute when health is discussed, it should be stated that the social protection standard, which ensured the right to universalization of public health in Brazil, had a late development when compared to developed countries, both with regards to time and to the historic moment that served as its base[2].

Unlike what occurred when the European and North American Social Welfare State expanded, the industrial capital no longer directed the capitalist process. From the 1980s onwards the reappearance of interest-producing capital was long lasting, and determined the economic and social relations of the contemporary capitalism. The "interest-bearing capital", according to Chesnais[3], "attempts to make money without leaving the financial sphere, in the form of loan interests, dividends and other payments by way of stock possession and interests generated by successful speculation"[3].

Ownership of this "capital" had a large impact on the social protection arrangement known as Social Welfare State (EBS) and on the capital/work relationship. Since the onset of the crisis, criticism and the demand for responses from EBS became more frequent, with several countries introducing devices that increased the user's participation in the funding of health, and limited the list of medications free of charge, among other measures[4]. In that same period the labor market underwent significant changes against its previous scenario. Unemployment, previously limited to problems resulting from an imperfect information system between demand and offer (the so-called frictional unemployment), started to show high rates in the developed world. Salaried or independent works, with no social or labor coverage, previously a characteristic of African and Latin American labor markets, became a structural component of the daily life of developed countries. Since the mid 1970s, real wage increases - a hallmark of the glorious thirty years, were forgotten and replaced by adjustments that meant a loss of purchasing power.

Productive capital, suffocated by financial domination, became a constraint to workers. The decrease in work force costs became essential, in consideration of the strength of interest bearing capital by removing the surplus generated in the production. According to Husson[5], productive cap-

ital imposed a decrease in wage levels and supported the elimination of payroll charges, and a substantial reduction of taxes, essential elements to the financing of social protection of several countries. However, in order to keep salaries low it is necessary to maintain high unemployment rates: this is the reason why the productive capital had no interest in promoting anything similar to a full employment scenario.

When Brazilian representatives were writing the Citizen Constitution of 1988, the country felt very intensely the effects of the problematic constraints resulting from this new worldwide panorama. The increase of the American interest rate promoted by the Federal Reserve from 1979-1981 had dramatic results for Latin American countries. These countries – which had been encouraged to take advantage from credits associated to the recycling of the petrodollar, suddenly saw debt services be multiplied by three or four. This situation gave rise to what became known as the debt crisis.

In Brazil, the elevation of the American interest rate occurred in the midst of an attempt to rebalance external accounts by promoting a recession. Considering the growing difficulty in obtaining funding for the deficit of the current transactions – which became evident in 1979, the military government constricted the effective demand by means, among other measures, of controlling public and state-company debts; of a sheer credit reduction; and of increasing taxes on income and imported goods. These measures resulted in a 3.1% drop in GDP, and a positive balance in the balance of trades promoted by an increase in exportations and by a decrease in importations. International interest rates, however, increased by almost 4%, in such a way that debt interests alone started to account for 40% of Brazilian exportations. In addition to this scenario, the effects of the Mexican moratorium on the Brazilian external situation made international reserves negative in approximately over US$ 2 billion.

It is evident that this article does not intend to rebuild the history of Brazilian economy from the 1980s onwards. However, it is important to highlight that since the debt crisis Brazil started to deal with a restraint that took and takes all of its attention.

From 1982 onwards there was a change in the Brazilian state. It was at that time that the country formally resorted to the International Monetary Fund and had to fulfill its conditions. The country was going through several attempts to control the escalating inflationary process that existed for the entire development of the Brazilian economic crisis, by privatizing state-owned companies and encouraging the inflow of external capital by maintaining high interest rates, which, among other reasons, turned the internal debt into a problem. This developmentalist State, which had been a key element in the industrialization process by investing in infrastructure and creating state-owned companies which produced essential raw materials and had also had the concern of developing the social protection public system, was now reduced to a few functions. Containment of public expenditures, the first guideline from the Washington Consensus of 1990, aiming at both the fight against inflation and the creation of a primary fiscal surplus, removed the State from its previous roles, associated to the developmentalism period between 1930 and 1979.

It is in this environment of new constraints to the Brazilian economy, and of a handcuffed State that the 1988 Constitution introduced the concept of social security and defined public health as a universal right. Brazil was no longer growing in a solid manner, unlike what occurred during the universalization of health in developed European countries. Its State was shrunk when compared to its past, unemployment rates were at very high levels, and informal jobs were becoming more numerous, overgrowing those which offered welfare and labor rights.

One has to admit that SUS was going through a challenging historical period. Along the decades of 1990 and 2000 financing was one of the most debated and problematic subjects in the Country's health implementation agenda. The financing crisis, within this scenario of financial capital supremacy, was intensified by the adoption of a restrictive macroeconomic policy, resulting in attempts to decrease health expenditures. It is not surprising that the framework around which financing is built has been creating hindrances for the fulfillment of the principle of SUS: universality.

Conflicts in the history of the financing of SUS

The implementation of SUS along its 20 years of existence was not devoid of political and economical strife. Examining its financing after the 1988 Constitution requires, primarily, the identification of the existence of a twofold movement in its history, resulting from a permanent and contradictory action of two overlapping principles, although each points towards specific targets[6]. On the one hand we can highlight the "principle of universality construction", which states the right of citizens to health services and initiatives, enabling the access

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of all by means of a permanent attainment of secure financial resources. On the other hand one can identify the principle of "expenditure containment", a defensive reaction that revolves around the defense of economic rationality, where a decrease in public expenditures is a key instrument in the fight against public deficit, made possible by a contractionist fiscal policy and the maintenance of high primary surplus in all spheres of state operation. It is understood that this "principle" is directly associated to the economic policy developed by the federal government during years 1990 and 2000.

This idea of a twofold movement in the path of the financing of SUS after the 1988 Constitution should not be understood as a sequential timeline, or a pendular movement. It is a permanent and contradictory movement along the implementation process of SUS. The justification of the principle of universality of health manifests primarily in the fight against the dictates of orthodox economic policy, by means of justification of assurance of financial resources.

Strife for financial resources

The financial situation of the network along all the years following the Constitution has been guided by two determining factors: the attention given to Welfare within the social security budget, and the restrictive fiscal policy implemented by the federal government in the social area, thus reducing expenses.

Concerning the relationship between SUS and OSS there is a constant tension created by the strife for resources along all these years.

The first clash occurred in 1989 and 1990, when resources of the then Finsocial were not completely allocated to the financing of Social Security. This occurred because these resources contributed to the financing of welfare charges of the Union – an expense not included in the budget of Social Security. Even though the Temporary Provisions of the Constitution have set forth that at least 30% of the total of Social Security resources – with the exception of Private Company/Government Employee Fund (PIS/PASEP) revenue, which is linked to the unemployment insurance – should be allocated to health, the approval of the Health Organic Law, at the end of 1990, enabled the then Ministry of Welfare to reduce the volume of this allocation. The transfer to the Ministry of Health, which represented 33.1% of the contributions revenue in 1991, was reduced to a mere 20.9% in 1992.

The second moment of tension and clash occurred in 1993. In that year, the Law of Budgetary Guidelines (LDO) set forth that 15.5% of the amount of collected contributions should be allocated to the health field. However, despite the provisions of LDO no allocation was made to health in May 1993. The explanation given was that Social Welfare had cashier problems of such magnitude that, should the transfers continue, it would end the year in deficit.

The financial difficulties of Welfare were not restricted to this one, and became bigger in the years following 1993, making health financing even harder. Low revenues from the contribution of employers and employees and an increase in expenditures with benefits resulted in a strategic alteration of Social Welfare within Social Security. In addition to the decision that, in practice, contributions of employers and employees would be of exclusive use by the Welfare, the latter started to gain access to other Social Security sources.

Additionally, between 1989 and 1993 there was a certain specialization of Social Security sources: budgets allocated most of COFINS (Mandatory Contribution to Fund Social Security) resources to Health, CSLL (Social Contribution on Net Income) resources to Assistance, and resources from employees and employers' contributions to Social Welfare. This method of utilization of the Social Security financing sources had its consequences, especially for health.

A third and significant conflict in the financing of SUS and Social Security occurred in 1994, with the creation of the Emergency Social Fund (later called Fiscal Stabilization Fund (FEF) and currently called Disentailment of Union Revenues – DRU), when it was decided, among other aspects, that 20% of the amount collected from social contributions would be disentailed of their purposes and would become available for use by the federal government.

In this scenario of decaying financial condition of the Welfare, where the low collection of social contributions was a consequence of the lack of economic growth, the Welfare incorporated other resources which comprise Social Security as a source of its own resources, in addition to having exclusive access to payroll contributions. The financial constraints experienced by Health was unmatched in recent history.

As a means of finding alternative resources, the National Health Council and the Social Security Committee of the Chamber found a temporary solution in the creation of the Provisional Tax on Financial Transactions (IPMF). This solution came into force in 1997 under the name of Provisional Contribution on Financial Transactions (CPMF). The participation of the CPMF that year, in cur-

rent Reais was R$ 6.7 billion, corresponding to 27.8% of the total sources of health financing. In 2005 this amount corresponded to 29.3%

CPMF did not attain the intended volume, since the COFINS (Mandatory Contribution to Fund Social Security) and the CSLL (Social Contribution on Net Income) were reduced – especially in 1997, when they were increasingly transferred to the welfare area. Additionally, part of the CPMF resources was allocated to activities alien to health through the Disentailment of FEF – from 1998 to 1999 – i.e., currently the DRU. It is important to highlight that DRU was extended until 2007 after the fiscal reform of the Lula government and that, at the end of 2007, was extended until 2011.

Between 2003 and 2005 social contributions represented by far the main health financing source, although the presence of fiscal resources is significant in some years, especially when obstacles for the continuation of the CPMF started to appear (1999). In 2005, 90.1% of the resources originated in social contributions. Since the creation of the CPMF, social contributions account for a participation above 70%.

This path evidences the growth of Welfare, as well as the utilization of a disentailment device for some Social Security resources.

The years following 1995 evidence the growth of health financial problems. Three issues clearly demonstrate the weakness of the financing of SUS. Firstly, the federal consideration was reduced from US$ 85.7 to 77.4 per capita between 1995 and 2005. Secondly, there was a growth in the irregularities of the budget execution flow of the Ministry of Health, especially after the second half of the 1990s. Lastly, there was a significant increase in the balance due of item Accounts Due (Restos a Pagar) of the Ministry of Health, especially between 2001 and 2004, when it went from R$ 9.2 million to R$ 1.8 billion (according to data from CNS's Budget and Finances Committee).

The crisis generated by not receiving contribution transfers, by the decrease of other Welfare sources and by the disentailment of the Provisional Contribution on Financial Transactions (CPMF), COFINS (Mandatory Contribution to Fund Social Security) and the CSLL (Social Contribution on Net Income) had consequences on the performance of federal health expenditures.

The net expenditure on health initiatives and services – excluding the debt amount and that of retirees and pensioners - executed by the Ministry of Health against the gross domestic product (GDP) was practically stable between 1995 and 2007. Namely: 1.73% in 1995, and 1.75% in 2007.

This small expenditure on health can also be explained by the more significant engagement of the federal government in paying interests and charges of the debt also against the GDP. In 1995 approximately 7.5% were spent on debt interests, and only 1.73% in health initiatives and services. After a decade, this discrepancy remains: 6.9% and 1.75%, respectively.

It was especially after 1995 that the adoption of a group of initiatives intended for the adjustment of public finances became clearer. Most of the times the measures implemented were focused on the intrinsic relationship that financial logic develops within the very apparatus of the State. As mentioned in section 2, the financialization becomes a part of the State, which in turn becomes a tool for its dissemination and for the valuation of financial capital, reducing expenditures on health.

Although the country was experiencing a period of economic recession, with negative consequences in the labor market, this situation has not caused a negative impact on Social Security accounts along the years 2000. Soon after the arduous financial scenario of the 1990s, had the federal government respected the concept of Social Security as set forth in the Constitution and had the device for the Disentailment of 20% of the DRU not been used, Security budget would have significant surpluses of R$ 27.3 billion in 2000 and R$ 50.9 billion in 2006 in current amounts. These surplus resources, according to the National Association of Welfare Inspectors, were allocated in the payment of fiscal expenses, or directly posted in the calculation of the primary surplus[7].

This positive result did not change the federal government's approach. During all these years it maintained the idea of justification of the Welfare deficit, thus disregarding its entailment to the Social Security budget.

The situation created by not having resources specifically allocated to the health areas gave rise to the need for a more definite solution, i.e. the entailment of budget resources of the three levels of power. The history of the construction of an agreed-upon measure concerning the entailment of resources took seven years in the Congress before the enactment of Constitutional Amendment 29 (EC 29) in August, 2000.

EC 29 set forth that states and municipalities must allocate, in the first year, at least 7% of these revenues. This amount must suffer an annual increase until it reaches at least 12% in the case of states, in 2004, and at least 15% in the case of municipalities. As for the Union, EC 29 sets forth that, for the first year, a contribution of at least 5%

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against the applied budget of the previous period; for the following years, the amount verified in the previous year is adjusted by the variation of the nominal GDP. EC 29 did not specify the source of funds for the Union and was negligent concerning Social Security, as though there were no dispute over its resources, as mentioned above.

This tension over resources was present prior to and after the establishment of EC 29. As previously mentioned, the history of SUS shows a long-standing fight for resources. For the purposes of this text, however, it is important to highlight those situations where economic constraints, especially those resulting from the effort of the economic policy logic efforts of post ***Plano Real*** governments, resulted in initiatives that would generate a decreased availability of resources for public health.

Economic policy and its effects on the financing of SUS

The macroeconomic policy of the FHC governments, and more recently that of the Lula government, have been determining the hard financing conditions of SUS. It is known that the fulfillment of inflation and primary surplus goals resulted in attempts to diminish public expenditures, especially those related to health.

As for the Lula government, three scenarios are described and analyzed, and are practically related to the federal level, even though similar events have occurred in other government levels:

1. Lack of compliance with the concept of health initiatives and services. During all the years of the first Lula government, the economic team attempted to introduce expenditure items which are not considered health expenses in the Ministry of Health's budget. Among such items there were, among others, the payment of interests and expenses with the retirement of former servants of that ministry. Although such attempts were supported by the entire economic team of the government, they did not materialize, as the bodies of the Sanitary Reform Forum (Abrasco, Cebes, Abres, Rede Unida and Ampasa), the National Health Council and the Congressional Health Committee quickly joined forces and made the government pull back.

The same cannot be said of the states. In order to comply with the provisions of EC 29 some of them included, as expenditures on health initiatives and services, expenditures on health pensioners, sanitation companies, urban dwelling, hydric resources, school lunch, food for prisoners and "closed clientele" hospitals (such as hospitals for state servants) These improper registrations occurred, despite the previous establishment of parameters defining which initiatives and services could be considered as SUS expenditures. These parameters were agreed upon between the Ministry of Health, the states and their audit courts, and incorporated to Resolution n° 322 of the National Health Council (CNS).

In some municipalities the same process occurred, whereas expenditures on health pensioners and other items were considered to be health expenditures.

2. Attempts to diminish the Ministry of Health's budget. The LDO for the 2004 budget set forth that the Union's Welfare Charges (EPU), the debt service and the resources allocated in the Fund for Poverty Eradication should be posted as Ministry of Health expenses. However, CNS's and the Congressional Health Committee's strong reaction against it determined that the Executive should send a message to the National Congress establishing that, for purposes of health initiatives, the EPU and the debt service would be deducted. The message did not mention the Poverty Fund. This omission would result in the reduction of R$ 3.5 billion in the Ministry of Health's budget for SUS.

Despite several and intense discussions which occurred between bodies linked to SUS and the Ministry of Planning, this issue remained unchanged. The government withdrew after the opinion of the Federal Public Attorney's Office, refuting the presidential decision and requesting president Lula to suspend the veto to the device that stated that resources from the Fund for Poverty Eradication could not be posted as health expenditures, under the risk of making the approved budget be considered unconstitutional.

Likewise, LDO's project for the 2006 budget, submitted to the Chamber by the federal government, set forth that expenses with hospital medical assistance of military servants and their dependents (closed system) should be taken into account in the calculation of health services and initiatives. Should this expense be taken into account, resources intended for the Ministry of Health would be decreased by approximately R$ 500 million. In view of the Ministry of Health's public statement against this interpretation, and in view of the mobilization of health bodies, the federal government was forced to withdraw and review its proposal.

3. EC 29's entailed resources are of concern to the economic field. At the end of 2003 the federal government submitted a document regarding a new agreement with IMF stating its intention to prepare a survey on the implications of the consti-

tutional entailments of social expenses – health and education – for the revenues of the budgets of the Union, the states or municipalities. The justification was supported by the idea that a greater flexibility in the allocation of public resources could ensure growth to the Country[8] (p. 3). Within the sphere of SUS, the government's intention was to exempt the Ministry of Health from the constitutional obligation to invest in health, as defined by EC 29.

When Lula was elected for the first time the general idea was that there were no hindrances for the regulation of the financing of SUS (EC 29) to finally be enacted by means of the sanctioning of PLP 01/2003. After all, the subjects comprised in the regulation had undergone long discussions among representatives of the state and municipal councils, of the CNS, the Ministry of Health, the State and Municipal Audit Courts and of other bodies associated to public health.

Among the main items of EC 29's publication project, we can highlight two: 1) modification of the calculation basis for entailment of the Union's resources, changing to at least 10% of its current gross revenue. In 2007 this would correspond to an increase of R$ 20 billion in the expense executed by the Ministry of Health (R$ 45.8 billion). The sanctioning of EC 29's regulation was expected to cause an increase in expenditures on health initiatives and services from the current range of US$ 150/200 per capita to US$ 250/300. This would still be insufficient to make SUS viable. 2) the definition of expenses that should e considered as health initiatives and services, and of those that do not fit these requirements.

EC 29's regulation was not a priority for the Lula government. Its inclusion in the Congress agenda in April, 2006 was due to an initiative of the Congressional Health Committee. Its approval, however, is still facing difficulties.

The government's interest in the regulation was only raised when the termination of the Provisional Contribution on Financial Transactions (CPMF) was being discussed, at the end of 2007. On that occasion, the government submitted a counterproposal to PLP 01/2003 where, instead of ensuring a minimum percentage of the revenues within its sphere to health, it proposed an escalating increase of the participation of the Provisional Contribution on Financial Transactions in its financing (which would reach R$ 24 billion in 2011). The government thought that this imbrications between the continuity of the Provisional Contribution on Financial Transactions (CPMF) and the financing of Health would ensure the extension of the Contribution. Many celebrated the approval of this counterproposal in the Chamber, forgetting that it was dissociated from any real concern with the present and the future conditions of the financing of SUS. However, since the Senate did not sanction the CPMF, the government's proposal for the financing of health was aborted. The financing of health is still a pending issue.

It is also necessary to consider that, in addition to approval by the Senate of the continuity of the DRU, the extinction of the Provisional Contribution on Financial Transactions (CPMF) represents considerably impairments to Health. Not only SUS does not rely on the resources generated by it, as a substitute source for it has not been defined. In 2006 the CPMF generated a revenue that corresponded to R$ 32.1 billion, whereas 40.22% were allocated to Health.

Should this approach to the economic policy be maintained, the tension between health and the government's economic areas will continue. The former committed to SUS, and therefore to ensuring its financing; the latter, restricted by an economic policy based on inflation goals and in the generation of primary surpluses. For those who are in favor of this economic approach, the PLP 01/2003 contents are seen as retrogression, as it defines expenses and minimum revenue commitments, which are contrary to efforts towards the generation of primary surpluses. On the other hand, this would limit the discretionary power of the federal government, which would not be able to allocate resources in accordance with its interests.

Given the importance of the problematic financing of SUS, it is important to highlight that this situation remained unsolved in 2008. It should be stressed that a project similar to the Chamber's PLP 01/2003 in the Senate was approved with important modifications. The calculation formula for the federal government's investment of at least 10% of the gross current revenue was altered by the creation of an escalation table. This means that in 2008 8.5% of this revenue would invested, increasing to 9% in 2009, 9.5% in 2010, and 10% in 2011. This regulation project for the EC 29, approved by the Senate in April, was submitted to the Chamber's approval under a new name: PLP 306/2008. It should enable an increase in Health resources from the R$ 48.5 billion provided for by the 2008 Budget to R$ 58.4 billion. By 2011, the extra resources would be in excess of R$ 20 billion per year. What was already provided for 2008 had its enactment postponed to 2011. It is known that the government's economic area has no interest in its approval, so every effort towards hindering it shall be made.

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The defenders of the construction of a universal health continue to demand that the federal government assures the approval of Chamber of Deputies' PLP 306/2008 to the Ministry of Health. Only then would it be possible to recover the health expenditures, impaired for over a decade by the logic of an orthodox economic policy.

Final considerations

There is evidence that the second Lula government is not very intent on increasing its participation in health expenditures. This is demonstrated both by the initiatives of the first government – the inclusion of items under the activities of the Ministry of Health that do not fall under the concept of universal health, and the recurring attempt to propose a disentailment of resources intended for health. It is also clear that there is no intention of defining dedicated sources for health funding, nor of making a commitment to the universal social policies by investing in health.

It is clear that the federal government should head towards another direction. New commitments should be conditioned to the search for economic growth and a social and economic development project. This would imply the discontinuity of the logic of the economic policy adopted throughout the 1990s and 2000s, in league with the interests of the financial capital.

Collaborators

A Mendes and RM Marques have participated to an equal extent in the preparation of the present article.

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