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The Right to healthcare and fiscal austerity: the Brazilian case from an international perspective

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Abstract *The article analyzes the implications of the austerity policy in Brazil on the guarantee of universal social rights, focusing on the financing of the Unified Health System (SUS) and the right to health. The effects of the Brazilian austerity policy are analyzed in an international perspective, based on evidence produced in different contexts, identified from a literature review, in order to base the arguments developed in the article. Information on the fiscal austerity measures being implemented in Brazil is presented and its likely impacts on social protection in the country are analyzed in a context of significant economic recession. The austerity policy adopted in Brazil is not universal, since it does not affect all Brazilian society equally, nor does it have temporary effects, since it is not focused on reducing the momentary imbalance in public accounts. Its main objective is to promote the reduction of the size of the Brazilian State. Finally, we show alternative paths to the fiscal austerity policy that has been used to tackle the economic crisis. The authors argue by a national development project that is necessarily linked to social protection for the universe of citizens and based on values of solidarity.*

Key words *Health care financing, Public policy, Welfare State, Austerity*

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Introduction

This article aims to analyze the implications of the austerity policy that is being implemented in Brazil to guarantee universal social rights, focusing on health financing and on the right to healthcare. The article shows how the austerity policy is an instrument of the neoliberal ideology, which has been disseminated worldwide since the last century, resulting in weakening of universal social policies, with serious effects to society.

Austerity is a recent strategy presented by advocates of neoliberalism as a solution to the economic crisis that began in 2008. However, this article presents international experience with other possible strategies based on social justice, solidarity and on universal social policies. Therefore, the effects of the Brazilian austerity policy are analyzed from an international perspective, based on evidence from different contexts. In addition, the analysis of such effects was based on a broad review of national and international literature in order to ground the theoretical and empirical arguments developed herein. Finally, this article presents information on the actions adopted in Brazil, and data on public spending in the country.

The article contributes to the debate in Brazil on social policies and the challenges in terms of sustainability and continuation. This debate is influenced by the dispute of projects between the neoliberal ideology and a nation whose development is linked to social protection for citizens, founded on values of solidarity.

Social Policies and the origins of the austerity policy

Social rights and policies may encompass society in different ways: more egalitarian or more restricted, causing inequality among citizens. The differences on how social rights and policies are organized in each country, whether for all citizens, for some or for certain groups, depend on the degree of solidarity that defines the values within that society, as well as the relationship between citizens and the State. This relationship is built throughout the history of each country. When a social policy is universal, its effects reach every member of that population[1].

The type of state that is the most democratic and permeable to social rights and policies, and that presents the most evident conditions to be reproduces is the Welfare State (WS).

Several changes have caused the so-called WS crisis, which began in the 1970s and resulted in state reforms from the end of the 1970s and into the 1980s and 1990s. Although industrial transformation began shortly after the end of World War II, it was from the 1970s on, along with the economic crisis, that the impact of increased spendingdue to technological advance was felt, exposing the resource limits as a problem for the economies.

The economic crisis had many affects, such asrising unemployment rates, the development of new, more flexible ways of employment, reduction of working hours and home office. The increasing incorporation of women in the labor market demanded new structures to support family care and had repercussions on fertility rates. With sustainability already a concern, the aging population, combined with lower fertility rates, contributed to the imbalance of social security. Social and political pressure for changes in the sense of "a more human, rational and democratic use of resources"[2]. It is in this context that demands driven by purely individual values are gaining momentum. These changes were used to support policy proposals to address public debt and inflation in each country.

Liberalism was strengthened, especially in the United States and the UK, with the term neoliberalism, which was first used in the 1930s. In the 1980s, ideas that the investment in generous social security implied less economic growth and less job offers were widely disseminated and strengthened. Likewise, ideas that the state tends to be less efficient than the market were also disseminated. The paradigm of neoliberalism can be organized in three axes: i) privatization -the idea of "free market superiority as a mechanism for efficient resource allocation"; ii) individualism; and iii) freedom, for detriment of equality[3].

The second half of the 1980s saw the implementation of the neoliberal agenda, which was elaborated to achieve macroeconomic adjustment. Its central axis was to stabilize economies and to intervene in social policies, seen as an instrument of adjustment. In the same decade, socialist governments began to fall and models of society that those governments had built were questioned.

The spread of neoliberal ideas generated less confidence in the state's capacity for management. A consequence of this was the corroboration of the belief in individual values and in market solutions, based on the argument that, in order to counteract the management inefficiencies of the state, it has to be reformed and services must be delivered by competing private entities

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in free market. The efficiency and scope of the WS activities are questioned and the individual and individual freedom are overvalued.

The changes arising from the WS reforms in the 1980s and 1990s, with some exceptions, were more managerial in nature, and the introduction of market mechanisms in the public sector was more evident than the loss of rights to social welfare, which is different from the retraction of the role of state. However, such changes interfere in public-private agreements, including the spread of the belief that the private-sector is an alternative to the difficulties encountered in the public sector

It is in this context that the economic crisis of 2008 took place when neoliberals used the new term fiscal austerity. According to Canterberry[4], austerity is the philosophy that "seeks to transpose, without mediation, individual virtues (sobriety, parsimony, prudence), to the public sphere". When it comes to the economic dimension, it is "the policy of adjustment based on the reduction of public spending and of the state's role as promoter of economic growth and promoting social welfare"[5].

Fiscal austerity is characterized by choices that demand great sacrifices from the population because they either increase the tax burden or they implement actions that restrict the provision of public benefits, goods, and services. This results in expenditure cuts and/or in structural reforms.

The use of the term austerity and its neoliberal moral value was criticized by Bastos[6]. According to the author, in the neoliberal discourse, austerity has a different meaning from that considered fair in the field of private morality of virtue, since it is associated with the idea of restraint of desires. The author points out that the term is used by the neoliberals to justify moderation in the growth of wages and in the supply of public goods and services, in order to protect the entrepreneurs' savings, necessary for job creation and for the future well-being of consumers. Bastos says that the neoliberals do not consider to moderate profits, and by adopting these policies, they are not protecting the interests of consumers but those of the entrepreneurs. Thus, the proposed austerity does not affect the rich (who consume more) as much as it affects the workers and citizens who depend on public services, which in turn increases social injustice.

The arguments of the neoliberal discourse have been questioned by several studies and scientific analyzes, such as Piketty's[7], that allows to infer that the high levels of inequality are useful precisely for the maintenance of the richest niches in societies and that the arguments of the neoliberal discourse are used for this.

According to Stiglitz[8], austerity constitutes the ultimate manifestation of neoliberalism. The author rejects the idea that state debt is similar to household debt, arguing that governments need to invest in human resources, technology, and infrastructure to activate the economy, to promote job creation and strengthen public finances. In fact, austerity has shown to have the opposite effect, damaging European economies and representing a major obstacle to future growth. Stiglitz argues that the reduction or lack of investment in young people will diminish the potential for human capital growth.

The limits of austerity for economic growth have been recognized by professionals of the International Monetary Fund (IMF). According to a recent article[9], neoliberal policies have provoked an increase in social inequity and put a history of lasting economic growth at risk. According to Ostry et al., austerity policies not only have costs for social welfare, but also affect demand, which increases unemployment. In a study of 2017, the same authors show that opening national economies to foreign capital and economic globalization increases income inequalities[10].

On the other hand, social spending can be seen as an investment towards a more just society, as shown in a study of the Brazilian situation[11]. In the study, social spending are pointed out as a compensation of the tax system, since *regressivity* over the poorest people is "counterbalanced by the progressivity in social spending, which have these same account balance as the main recipients"[11].

Studies have shown the multiplier effect of spending on social welfare policies for the growth of Gross Domestic Product (GDP). Data analysis from 25 European countries, showed that the United States and Japan expenditures on education and on the health system have fiscal multipliers above three, meaning that for each monetary unit spent in these areas the expected increase in GDP would be of three monetary units[12].

In the Brazilian context, the GDP multiplier for health spending was calculated at 1.7, that is, for an increase in health expenditure of R$ 1.00, the expected increase in GDP would be R$ 1.70[13]. The study also verified a multiplier of GDP for education spending (1.85); the conditioned cash transfer program *Bolsa Família* (1.44); continuous cash benefit program (1.38), and General

Social Welfare Policy (1.23), resulting in a positive effect for the economy, as opposed to interest payments on public debt (0.71).

A more recent study[14] corroborated the findings above, reinforcing that government spending on certain policies is important in periods of economic recession. According to the authors, the fiscal multipliers associated with investments, social benefits and personnel during recessions are significant and larger than the unit (1.68, 1.51 and 1.33 respectively), rather than the expenditure multiplier with subsidies (0.60). The fact that the multiplier of subsidies and other expenditures is insignificant in any economic situation is evidence that the choice for fiscal policy for the period from 2011 to 2014 in Brazil, reducing investment and expanding subsidies, was the wrong decision. The authors argue that this partly explains the economy's low response to government stimulus.

A relevant issue in Brazil is income inequality, which is strongly determined by the tax system, one of the most regressive in the world. Another study[15] identified that the richest strata of society are fundamental to explain the high inequality in Brazil between 2006 and 2012. At the same time, Piketty[16] argues that reducing inequality requires a fairer tax system to (1) finance social policies and (2) reduce income concentration at the top of the pyramid.

Regardless of above mentioned studies that show the importance of social spending – special on universal social policies – for the society and economy of a country in the midst of an important economic recession, Brazil and several other governments have chosen to adopt fiscal austerity. In many cases, this is a result of direct pressure from international financial institutions.

Austerity and social policies in the world: actions and consequences

The International Monetary Fund (IMF) and the World Bank have been strongly criticized for imposing conditionalities on countries borrowing at times of economic crisis, considering that crises are already a burden in terms of risk of human rights violation, guaranteeing the right to access healthcare, work, and civil and political rights. The rationale of conditionalities on the stabilization pillars (reduction of the fiscal debt with an emphasis on reducing social spending), liberalization (elimination of trade barriers and financial capital), deregulation (repeal of regulation of economic activity) and privatization (sale of state-owned firms to the private sector) has generated significant difficulties for borrowers to protect and address these rights[17].

At the same time, the World Bank admits that it has manipulated data on its country ranking reports of economic indexes for a long time, a ranking that is determinant for loan conditions, credibility, and political pressure for economic adjustments in each country[18].

The guidelines of these international lending institutions limit the right to healthcare by changing the volume and quality of services to the population. They impose fiscal and institutional reforms on lending terms that result in actions such as targeting programs, cuts on social spending, structural adjustments for introducing tariffs and co-payments to use health services, deregulation of the health sector to increase private sector participation in service delivery and decentralization of fiscal and operational responsibilities to the subnational levels. The latter has seen greater problems of governance and local institutional fragility, undermining the guarantee of the right to healthcare[17].

Greece, Ireland, Portugal, Cyprus and Spain are examples of countries that have experienced a significant reduction in their ability to respond effectively to the demand for public services after signing financial rescue plans with the *Troika* (cooperation between the European Central Bank, the IMF and the European Commission) in the post-2008 period[19]. In health, this reduction is associated with the decrease in budgets for the sector, observed in several European countries that received an IMF loan. In the social area, the reduction of government spending has been associated with increased poverty and inequality, as well as with consequences for the health of the population of those countries[20]. In recent years, studies have produced consistent evidence on the damaging effects of the austerity policy on populations[12].

Economic crises are associated with the worsening of social problems. They increase social inequalities and worsen citizens' health situation. These consequences are aggravated by the implementation of fiscal austerity actions, which potentialize the negative effects of crises on the situation of healthcare and social conditions[21].

The mental health of populations has been affected by the economic crisis. In the post-2008 period, the increase in unemployment rates due to the crisis in high-income countries was associated with an increase in the prevalence of depression and anxiety, especially among those who had lost their jobs. Consequences included

an increase in suicide rates, a reduction in the self-assessment of health status, an increase in non-communicable chronic diseases and some infectious diseases, difficulty in accessing health services and an increased consumption of alcohol of high risk populations.[22,23]

More disaggregated analyzes of health indexes demonstrate that more socially vulnerable groups may be more negatively affected than the general population during periods of economic crisis and under fiscal austerity actions, especially regardingsuicide and alcohol abuse[24].

An analysis of the effect of negative financial events on mortality in 26 European countries showed that for each 1% increase in unemployment rate there is a 0.79% rise in suicide of people under 65. In addition, it showed that social protection systems are important in order to cushion the effects of crises on the health of the population[25].

Regarding access to health services, increased co-payment for the use of services; the spending cuts that, in turn, result in service closures and in the reduction of opening hours and workforce; and the implementation of reforms that restrict access to services for immigrants, the homeless and to drug users are among the austerity actions adopted by several EU countries. These actions are associated with an increase in the number of people whose healthcare needs were not met in the 2008 post-crisis period[26-28].

Germany, Spain and the UK, for example, have implemented structural reforms in their healthcare systems, promoting changes in the labor market, in the system regulation and in the state provision of services. In Spain, there were budget cuts, increase in co-payment, exclusion of coverage and a reduction in personnel costs. In Germany, there was a freeze on employer contributions, the rise of insurance contributions was postponed and permission was granted for the adoption of new rates by the insurance funds to encourage competition and reduce costs[29]. In the U.K, financing and service provision were separated; a reduction in managerial tasks and the system created an opening for the participation of private service providers. The evaluation of the impact of these actions on the UK's National Healthcare Service (NHS)is that they generated a more complex and fragmented management, regulation and contracting system. Additionally, the NHS was commodified, with incentives to purchase private services, which resulted in poor quality service, with longer waiting times and greater user dissatisfaction[30].

Chart 1 summarizes some of the fiscal austerity actions adopted by several countries in response to the economic crises and the social consequences presented in this section.

Fiscal austerity in Brazil: cost-cutting, federal expenditure ceiling, and other structural reforms

In Brazil, the effects of fiscal austerity may be especially severe because the social indexes and the supply of public services are below the levels found in developed countries and because Brazil presents one of the biggest social and income inequality in the world. In 2016, the richest 10% of the Brazilian population accounted for 55% of the whole income produced in the country[31]. (Figure 1) shows social results in Brazil compared to Argentina, Chile, the United States, Portugal and the United Kingdom, revealing Brazil's relatively inferior position. Despite this situation, the austerity agenda has been implemented in the country at great length in recent years.

The immediate effects of the Brazilian economic crisis, aggravated after 2014, included the decrease of tax collection in all spheres of government and the increase of unemployment rates. The current net income of the federal government suffered a real reduction of 6.7% between 2014 and 2016, going from R$ 786.8 billion to R$ 734.4 billion[32]. The percentage of unemployed people reached 13% in the second trimester of 2017, equivalent to 13.5 million people[33].

In response to the crisis and in line with the guidance of international creditors, the federal government exacerbated fiscal adjustment actions on spending, resulting in cuts in spending in several areas. Investments by the Federal Executive Branch fell by 42% between 2014 and 2016 and primary and functional expenses in strategic areas also declined[34,35] (Table 1).

On the other hand, revenue waivers increased. Tax expenditures rose by 15%, from R$ 235.6 billion to R$ 271 billion in constant values between 2014 and 2016[36]. In 2016, subsidies totaled R$ 106.9 billion[37]. Financial costs related to the payment of interest and amortization of debts, reduced by 3%. However, they remain at a very high level, corresponding to approximately R$ 1.2 trillion in 2017, which is equivalent to 40% of all Federal expenditures in 2016[38].

A relevant fiscal reform was carried out in 2016 with the approval of the Constitutional Amendment (CA) 95, instituting the so-called New Fiscal Regime. A ceiling for the Federal's

Chart 1. Fiscal austerity actions and social consequences.

Actions
• Structural reforms to reduce government spending on goods and services for the population • Cuts in government costs with personnel • Reduction of government spending with social protection and similar social expenses, including reduction in the budget for health • Discontinuing healthcare services, reduction of working hours and working force. • Establishment and/or increase of co-payment for using healthcare services and implementation of additional fees
Consequences
• Increase in unemployment • Increase in poverty and social inequality • Escalation of social problems, including violence • Restriction of the right to healthcare for part of the population such as homeless people, immigrants, drug users • Increasing difficulty to access healthcare because of economic barriers • Increasing cases of depression and anxiety • Worsening of mental health, with increasing suicide rate, especially among people under 65 years of age. • Worse results in self-perceived health surveys • Increasing cases of chronic and non-transmissible diseases, as well as some infectious diseases • Increasing alcohol consumption in high risk groups (people who often consume alcohol and the unemployed) • Alcohol abuse in social sub-groups that are vulnerable, subject to risk factors such as recent and long-term unemployment and pre-existing tendency to develop mental disease

Source: Elaborated by the authors.

primary expenditure was established, with no limitation on financial expenses[39]. From 2017 to 2036, these expenditure will be frozen in real terms of approximately R$ 1.3 trillion, which means that this amount will be adjusted annually only to recompose inflationary losses[40]. Health and education expenditures are no longer linked to revenue, and minimum investments have been frozen in the same terms as the primary expenditures. In the case of these two areas, however, the freeze starts from 2018.

A way to understand the impact of the CA 95 is to apply its provisions for a past period. If it had been in force in the period 2003-2015, for instance, the accumulated losses of expenditures in the Unified Health System (SUS) would have reached R$ 135 billion[41]. A prospective exercise shows an estimation of losses ranging from R$ 168 billion to R$ 738 billion between 2017 and 2036, depending on GDP growth[39,42]. Regarding social services, the loss of resources could reach R$ 868 billion in twenty years, making costs on assistance policies deplete to levels lower than those of 2006[43].

In practice, the main goal of the fiscal adjustment implemented in Brazil was not to control the momentary imbalance in public accounts, but rather to force the reduction of state participation in the supply of goods and services, through the spending-cuts. This would reduce the importance of primary expenditure in GDP from about 20% in 2016 to 16% - 12% of GDP by 2026, depending on the economy's performance[44].Therefore, this is considered to be the most rigid fiscal adjustment in the world[45], representing actually a non-declared reform in order to reduce the role of the state[39].

Other structural reforms are underway, such as the labor reform, approved in 2017, and the social security reform, which is being analyzed by the National Congress. Regarding the labor reform, it includes a provision stating that the agreements negotiated between employees and employers overrule the standard provided in the law, which undermines the unions. The flexibility introduced in the reform promotes a reduction of workers' bargaining power, which may result in an increase functional inequality of income in favor of employers[46].

The pension reform proposal was based on a "catastrophic" vision of the future sold to the population, making use of "alternative facts"[47], with little concern of actually providing information. This reform is one of the main IMF guidelines imposed on Brazil, which called for a broad[48] pension reform.

In the case of SUS, the ceiling rule has promoted the untying of the application in relation to revenue. Even though it does not prevent additional allocation, in practice, the austerity imposed on various public policies will make it very difficult[44]. This link between health spending and revenues, approved through CA 29, 2000, represented an achievement that created a protection mechanism for public health spending, breaking a moment of instability in terms of financing the health system that had been occurring since its inception, even though federal resources contin-

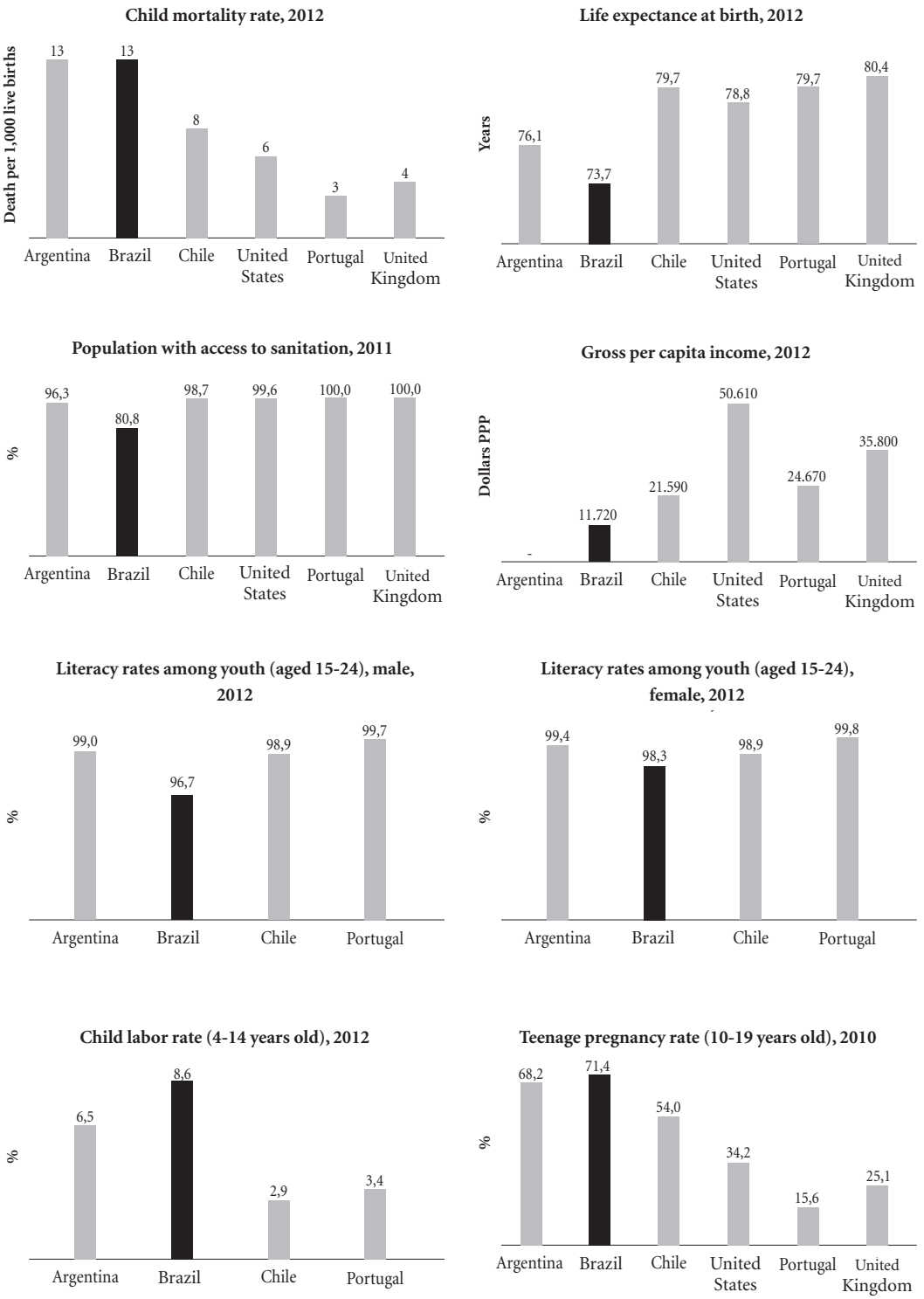

Figure 1. Social indicators in selected countries.

Source: Unicef. Cowntry Statictis. Available at: https://www.unicef.org/statistics/index_countrystats.html. Accessed on 19 January 2018.

Table 1. Variation of Union expenses between 2014 and 2016.

Expenditures	Values committed (Brazilian Reais – R$ – as of 2017)		Variation (%)
	2014	2016	
Expenditures per área			
Health	115,346,480,263.83	111,985,699,043.72	-3
Social Services	86,373,522,469.77	82,495,676,615.42	-4
Public Safety	10,970,096,542.58	10,049,732,311.04	-8
Education	100,126,606,451.98	89,850,981,277.66	-10
Work	86,956,343,610.87	74,900,763,660.01	-14
Culture	2,251,352,821.82	1,892,057,831.49	-16
Environmental management	7,888,123,383.18	5,394,897,034.82	-32
Science and Technology	10,224,472,534.41	6,601,490,992.82	-35
Transportation	19,836,393,114.93	11,133,662,332.11	-44
Sanitation	2,074,321,428.10	582,962,535.08	-72
Social Security	592,868,868,844.49	600,973,546,005.62	1
International Relations	2,988,619,286.45	3,065,313,897.90	3
National Defense	49,131,881,523.76	63,971,480,651.20	30
Energy	1,402,600,255.46	1,881,212,898.88	34
Rightsand Citizenship	1,821,237,062.52	2,491,227,136.38	37
Primary Expenditures	1,537,968,856,748.33	1,500,177,941,489.52	-2

Sources: Elaborated by the authros based on data from: i) Siga Brasil[35]; ii) Ministry of Planning, Budget and Management[36]. Values adjusted according to the index for inflation: Índice de PreçosaoConsumidorAmplo (IPCA), measured by the Brazilian Institute of Geography and Statistics (IBGE).

ue to be considered insufficient to guarantee universal and integral access to healthcare actions and services[49,50].

The economic crisis in Brazil, aggravated after 2014, is associated with the change in the rule of resource application for SUS by the Union, through CA 86, 2015, which established a minimum application from the federal government, as a percentage of current net income (CNI) from 13.2% to 15% in the period 2016 and 2020.This crisis resulted in a real decrease in the resources available to the system. Between 2014 and 2016, there was a 3.6% reduction in total spending on public health services and actions (PHSA), ranging from R$ 257 to R$ 248 billion in 2016, and a 5% decrease in PHSA costs per capita, from R$ 1,268.00 to R $ 1,202.00.

At the same time as a decrease in public spending, there is an increase in household spending on private healthcare plans. In the period 2010 to 2015, the participation of the three spheres of government in health financing decreased from 46.9% to 45.1%, while the participation of household and non-profit institutions increased from 53.1% to 54.9% in the same period[51].

Under CA 95, a rapid growth in participation of household in healthcare financing is expected in Brazil. Firstly, because the federal minimum application is frozen, regardless of the increase in population and demand for health services. Secondly, because states and municipalities have little fiscal margin to expand the resources currently allocated to SUS, in order to offset the resources that will no longer be allocated[39]. Thirdly, because the same neoliberal policy that proposes a reduction in social expenditure encourages the strengthening of the national and foreign private sector.

If, on one hand, public funding is reduced, on the other hand, solutions are sought to increase the private participation in healthcare costs. In 2016, the Ministry of Health made a proposal to the National Supplementary Health Agency to make the regulatory framework flexible for the provision of private health plans with lower healthcare coverage and with a lower price for consumers, called *Plano de Saúde Acessível* (accessible health plan). Sá[52] evaluates that this action has little capacity to help in reducing the spending of SUS. In addition, it does not solve the problem of controlling costs, and it can generate a greater segmentation and aggravate the inequity in the Brazilian healthcare system. Moreover, it can strengthen the market for private healthcare plans in detriment to SUS[53].

Thus, it will be more difficult to guarantee access to healthcare services in Brazil in a universal and integral way. This is likely to make the

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country closer to the Universal Health Coverage proposal that considers the segmentation of access, of coverage and of financing by strengthening private systems and weakening the universal right to healthcare[54,55]. In addition, as the policies that affect social determinants of health will also be affected, the concrete possibilities of guaranteeing the right to healthcare in Brazil are reduced, especially considering the Latin American context of social indexes that are worse than those of European countries.

The short and mid-term perspective is that the federal government will continue with fiscal adjustment actions in Brazil, given the explicit guidelines for major cuts in social expenditures made by the IMF[48] and the World Bank[56].

Final considerations

This article has shown that the actions that have been implemented in Brazil demonstrate a clear option for austerity. However, it is not a universal austerity that affects all Brazilian society equally. Neither is a momentary austerity, focused on reducing an occasional imbalance in the public accounts.

It is a selective austerity that preserves and enhances the richest people in the country. It is in line with the rules set by international organizations, at the cost of precarious conditions for guaranteeing social rights to the population, unemployment, economic slowdown, financialization, internationalization of capital, increasing inequality (necessary for the continuing strengthening of small private groups that are favored by the neoliberal austerity policies), reduction of social protection provided by the State for the population, as well as of healthcare and quality of life. These costs proportionately affect the most vulnerable population in the country.

The debate on ways to overcome the austerity policy must occur with those fighting against inequality. Piketty's studies[16] show that Brazil is one of the worst countries in terms of inequality, it is only behind countries in the Middle East and South Africa. Social inequality removes the principles necessary for democracy, worsens social injustice, increases risks of moralistic conservatism, racism, xenophobia, and it is at the roots of setbacks in slow-moving political agendas such as drug decriminalization, abortion, freedom of artistic thought, etc.

Austerity, has been publicized by its defenders as a virtue, as a necessary restraint. However, it is not publicized in a transparent way that itforces the reduction of the state's role and dismantles the possibility of counting on solidarity as a base and link for social policies.

The fiscal austerity that is now implanted in Brazil represents the hegemony of the neoliberal view of the functioning of the economy and role of the state in the field of social policies. It destroys the universal nature of these policies, which has serious consequences for the WS[57]. Although scientific evidence highlights the negative impacts of fiscal austerity at periods of economic crisis as an alternative for economy to resume, those who defend it continue to proclaim that reduction is necessary for the recovery of the economy.

The results of the studies researched for this article enabled an analysis that can subsidize the work on formulating alternatives to overcome the fiscal austerity policy in Brazil. However, the strategy to formulate and propose projects should be characterized by a commitment to the population and to socioeconomic development. Therefore, it is necessary to have engagement not only from the academia but from the civil society, represented by non-governmental organizations, business and social movements. This is a necessary condition to build a hegemonic strategy for the country, offering an alternative agenda to fiscal austerity policies, based on solidarity and defense of democracy and universal social rights. This is a great challenge because it means overcoming historical characteristics of Brazil's social and economic development, which make it difficult to implement public policies aimed at reducing social inequalities.

Collaborations

IS Santos and FS Vieira worked on conception, analysis, writing and critical review.

References

1. Vieira FS, Santos IS, Ocké-Reis CO, Rodrigues PHA. *Políticas Sociais e Austeridade Fiscal: como as Políticas sociais são afetadas pelo austericídio da agenda neoliberal no Brasil e no mundo*. Rio de Janeiro: Cebes; 2018.
2. Draibe SM, Henrique W. Welfare State, Crise e gestão da crise: um balanço da literatura internacional. Anpocs, *Revista Brasileira de Ciências Sociais* 1988; 6(3):53-78.
3. Ugá MAD, Marques RM. O Financiamento do SUS: Trajetória, contexto e constrangimentos. In: Lima NT, Gershman S, Edler FC, organizadores. *Saúde e Democracia: história e perspectivas do SUS*. Rio de Janeiro: Fiocruz; 2005. p. 93-233.
4. Canterberry ER. *The rise and fall of global austerity* (livro digital). London: World Scientific; 2015.
5. Rossi P. *Impactos da Austeridade Fiscal no Brasil. Audiência Pública na Comissão de Direitos Humanos do Senado Federal*. Brasília: Senado Federal; 2017.
6. Bastos PPZ. O que é a austeridade? E por que os neoliberais a defendem? *Carta Capital* 2017; 8 ago.
7. Piketty T. *O capital no século XXI*. Rio de Janeiro: Editora Intrínseca; 2014.
8. Stiglitz J. *A austeridade estrangulou o Reino Unido. Apenas o Partido Trabalhista poderá relegá-la à História*. Rio de Janeiro: Cebes; 2017.
9. Ostry JD, Loungani P, Furceri D. Neoliberalism: oversold? *Finance & Development* 2016; 53(2):38-41.
10. Carvalho L. Globalização financeira eleva desigualdade. *Jornal Folha de S Paulo* 2017; 28 dez.
11. Silveira FG, Ferreira J. *Equidade fiscal no Brasil: impactos distributivos da tributação e do gasto social*. Brasília: Ipea; 2011. [Comunicado Ipea n. 92].
12. Stuckler D, Basu S. *The body economic: why austerity kills*. New York: Basic Books; 2013.
13. Abrahão J, Mostafa J, Herculano P. Gastos com a política social: alavanca para o crescimento com distribuição de renda. *Comunicados do Ipea 75*. Brasília, 2011.
14. Orair RO, Siqueira FF, Gobetti SW. *Política fiscal e ciclo econômico: uma análise baseada em multiplicadores do gasto público*. Brasília: Monografia premiada em 2º lugar. XXI Prêmio Tesouro Nacional; 2016.
15. Medeiros M, Souza PHGF. *A Estabilidade da Desigualdade no Brasil entre 2006 e 2012: resultados adicionais*. Brasília: Ipea; 2016. [Texto para Discussão n. 2170].
16. Piketty T. 2017. Entrevista. *Jornal Folha de S Paulo* 2017; 28 nov.
17. Stubbs T, Kentikelenis A. International financial institutions and human rights: implications for public health. *Public Health Reviews* 2017; 38:27.
18. Zumbrun J, Talley I. World Bank unfairly influenced its own competitiveness rankings. *The Wall Street Journal* 2018; 12 Jan.
19. Kentikelenis A. Bailouts, austerity and the erosion of health coverage in Southern Europe and Ireland. *Eur J Public Health* 2015; 25(3):366-367.
20. Labonté R, Stuckler D. The rise of neoliberalism: how bad economics imperils health and what to do about it. *J Epidemiol Community Health* 2016; 70(3):312-318.
21. Vieira FS. *Crise econômica, austeridade fiscal e saúde: que lições podem ser aprendidas?* Brasília: Ipea; 2016. (Nota Técnica n. 26).
22. Karanikolos M, Heino P, Mckee M, Stuckler D, Legido-Quigley H. Effects of the global financial crisis on health in high-income OECD countries: a narrative review. *Int J Health Serv* 2016; 46(2):208-240.
23. Mucci N, Giorgi G, Roncaioli M, Perez JF, Arcangeli G. The correlation between stress and economic crisis: a systematic review. *Neuropsychiatr Dis Treat* 2016; 12:983-993.
24. Dom G, Samochowiec J, Evans-Lacko S, Wahlbeck K, Van Hal G, McDaid D. The impact of the 2008 economic crisis on substance use patterns in the countries of the European Union. *Int J Environ Res Public Health* 2016; 13(122):1-11.
25. Stuckler D, Basu S, Suhrcke M, Coutts A, Mckee M. The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet* 2009; 374(9686):315-323.
26. Reeves A, Mckee M, Stuckler D. The attack on universal health coverage in Europe: recession, austerity and unmet needs. *Eur J Public Health* 2015; 25(3):364-365.
27. Lopez-Valcarcel BG, Barber P. Economic crisis, austerity policies, health and fairness: lessons learned in Spain. *Appl Health Econ Health Policy* 2017; 15(1):13-21.
28. Legido-Quigley H, Karanikolos M, Hernandez-Plaza S, Freitas C, Bernardo L, Padilla B, Machado RS, Diaz-Ordaz K, Stuckler D, Mckee M. Effects of the financial crisis and Troika austerity measures on health and health care access in Portugal. *Health Policy* 2016; 120(7):833-839.
29. Giovanella L, Stegmuller K. Crise financeira europeia e sistemas de saúde: universalidade ameaçada? Tendências das reformas de saúde na Alemanha, Reino Unido e Espanha. *Cad Saude Publica* 2014; 30(11):2263-2281.
30. Giovanella L. "Austeridade" no Serviço Nacional de Saúde inglês: fragmentação e mercantilização - exemplos para não seguir. *Cad Saude Publica* 2016; 32(7):e00092716.
31. Alvaredo F, Chancel L, Piketty T, Saez E, Zucman G. *World Inequality Report 2018. Executive Summary*. Berlin: World Inequality Lab; 2017.
32. Brasil. Secretaria do Tesouro Nacional (STN). *Demonstrativo da Receita Corrente Líquida*. Brasília: STN; 2017. (Séries Históricas).
33. Instituto Brasileiro de Geografia e Estatística (IBGE). *Pesquisa Nacional por Amostra de Domicílios Contínua. Taxa de desocupação das pessoas de 14 anos ou mais de idade, na semana de referência - Brasil, Grandes Regiões e Unidades da Federação*. Rio de Janeiro: IBGE; 2017.
34. Brasil. Senado Federal. *Siga Brasil* [Sistema de Informação]. Brasília: Senado Federal; 2017.
35. Brasil. Ministério do Planejamento, Desenvolvimento e Gestão. *Despesas primárias do Governo Federal pela ótica do Uso, 2000 a 2016*. Brasília: Ministério do Planejamento, Desenvolvimento e Gestão; 2017.
36. Lima AN. *Renúncias fiscais da União. Estudo Técnico*. Brasília: Câmara dos Deputados; 2017.
37. Brasil. Tribunal de Contas da União (TCU). *Contas do Governo relativas ao exercício de 2016: Benefícios Tributários, Financeiros e Creditícios*. Brasília: TCU; 2017.
38. Brasil. Secretaria do Tesouro Nacional. *Balanço Geral da União*. Brasília: Secretaria do Tesouro Nacional; 2018.

39. 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* 2016; 10(3): 1-28.
40. Volpe RA, Mendes GR, Batista Júnior SR, Greggianin E, Cambraia T, Almeida DPB. et al. *Repercussões da Emenda Constitucional nº 95/2016 no processo orçamentário*. Brasília: Câmara dos Deputados; 2017. (Nota Técnica, n. 23).
41. Funcia FR. As "pegadinhas" da PEC 55 (antiga PEC 241) que escondem os prejuízos para o SUS. *Domingueira* 2016; 35:1-6.
42. Vieira FS, Benevides RPS. *Os impactos do Novo Regime Fiscal para o financiamento do Sistema Único de Saúde e para a efetivação do direito à saúde no Brasil*. Brasília: Ipea, 2016. (Nota Técnica, n. 28).
43. Paiva AB, Mesquita ACS, Jaccoud L, Passos L. *O Novo Regime Fiscal e suas implicações para a política de assistência social no Brasil*. Brasília: Ipea; 2016. (Nota Técnica, n. 27).
44. Fórum 21, Fundação Friedrich Ebert Stiftung (FES), GT de Macro da Sociedade Brasileira de Economia Política (SEP); Plataforma Política Social. Austeridade e retrocesso: finanças públicas e política fiscal no Brasil. São Paulo: Fórum 21; FES; SEP e Plataforma Social; 2016.
45. Pires MCC. *Nota Técnica - Análise da PEC 241*. Brasília: Ipea; 2016. (Carta de Conjuntura, n. 33).
46. Carvalho SS. Uma visão geral sobre a reforma trabalhista. *Mercado de Trabalho* 2017; 63:81-94.
47. Vianna MLTW. *Reforma da previdência: contexto atual, pós-verdade e catástrofe.* Futuros do Brasil: artigos. Rio de Janeiro: Centro de Estudos Estratégicos da Fiocruz; 2017.
48. Batista HG. FMI: é melhor uma reforma da Previdência profunda, mesmo que demore mais. *Jornal O Globo*; 2018 Jan 25.
49. Piola SF, Paiva AB, Sá EB, Servo LMS. *Financiamento público de saúde: uma história à procura de rumo*. Rio de Janeiro: Ipea; 2013. (Texto para Discussão, n. 1846).
50. Brasil. Ministério da Saúde (MS). Organização Pan-Americana da Saúde (OPAS). *Financiamento público de saúde. Série Ecos: Economia da Saúde para a Gestão do SUS*. Brasília: MS; 2013.
51. Instituto Brasileiro de Geografia e Estatística (IBGE). *Conta-Satélite de Saúde Brasil: 2010-2015*. Rio de Janeiro: IBGE; 2017.
52. Sá RB. *O público e o privado no sistema de saúde: Uma apreciação do projeto de Plano de Saúde Acessível*. Brasília: Ipea; 2018. (Nota Técnica, n. 47).
53. Santos IS. A solução para o SUS não é um Brazilcare. *Rev Eletrônica Comunic Inform & Inov em Saúde* 2016; 10(3).
54. Giovanella LG, Mendoza-Ruiz A, Pilar ACA, Rosa MC, Martins GB, Santos IS, Barata D, Vieira JMDL, Castro VG, Silva PO, Rohem ACR, Machado CV. Sistema universal de saúde e cobertura universal: desvendando pressupostos e estratégias. *Cien Saude Colet* 2018; 23(6):1763-1776.
55. Centro Brasileiro de Estudos de Saúde (CEBES). *Manifesto do Centro Brasileiro de Estudos de Saúde em defesa do direito universal à saúde – saúde é direito não é negócio*. Rio de Janeiro: Cebes; 2014.
56. Banco Mundial. *Um Ajuste Justo: Análise da eficiência e da equidade do gasto público no Brasil. Volume 1*. Grupo Banco Mundial; 2017.
57. Rodrigues PHA, Santos IS. Os novos riscos sociais não são só europeus, também chegaram ao Brasil e exigem respostas das nossas políticas sociais. In: Rodrigues PHA, Santos IS, organizadores. *Políticas e riscos sociais no Brasil e na Europa: convergências e divergências*. Rio de Janeiro: Cebes; Editora Hucitec; 2017. p. 111-141.

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