Health Financing in Brazil:

Perspectives from states and municipalities

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CONASEMS

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HEALTH FINANCING IN BRAZIL:

PERSPECTIVES FROM STATES AND MUNICIPALITIES

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The partnership between the institutions reaffirms the strength of collaborative work between the various players in the SUS and highlights the importance of initiatives that not only improve public health management, but also strengthen the national debate on the financing of the SUS and the efficient allocation of health resources, indispensable pillars for the sustainability of the system and for guaranteeing the right to health in Brazil.

We reiterate our gratitude to everyone involved and reaffirm our commitment to continue strengthening this partnership in future initiatives that promote advances in public health in Brazil.

With sincere thanks,

The Authors

PRESENTATION

The construction and consolidation of the Unified Health System (SUS) represents one of the most significant achievements of Brazilian society in the affirmation of social rights. The result of popular mobilization and the historic struggle for social justice, the SUS is today one of the largest public health systems in the world, guided by the principles of universality, integrality, equity and decentralization.

Since its creation, however, the system has been confronted by structural challenges, with adequate and sustainable funding being one of the most persistent and critical. The reality of the last few decades shows that states and municipalities have taken on a leading role in guaranteeing the right to health, increasing their financial and operational responsibilities, often in adverse contexts of fiscal retraction and regional inequalities.

This book aims to offer not only a rigorous technical diagnosis, with an analysis of state and municipal spending, bringing technical and methodological reflections that have strengthened the discussions and results of the study. It is also a political reflection on the paths needed to consolidate financing that is compatible with the civilizing mission of the SUS.

To defend adequate funding for the sustainability of the SUS is to defend democracy, social justice and the constitutional project for society. Strengthening the system involves building a new federative pact that recognizes regional specificities, promotes equity in access to health and ensures the financial sustainability of public policies.

Tânia Mara Coelho
Conass President

Hisham Mohamad Hamida
Conasems President

The Unified Health System (SUS) is one of the largest and most comprehensive public health systems in the world, the result of Brazilian society's struggle for a constitutionally guaranteed right: health as the duty of the state and the right of all. Its implementation, however, still faces historical and structural obstacles, especially chronic underfunding, the unequal distribution of resources between regions and the need for constant improvement in the application of investments.

In this context, this project, entitled Public Health Accounts Project, now a book on *Health Financing in Brazil: perspective of states and municipalities*, an unprecedented initiative developed jointly by the National Council of Health Secretaries (Conass) and the National Council of Municipal Health Secretariats (Conasems), has as its main objective to qualify and deepen knowledge about the financing of public health in Brazil. This project aims to answer a crucial question: how are state and municipal public resources being allocated to ensure the sustainability of the SUS and the effectiveness of the health services provided to the population?

This book is the result of a technical, analytical and collaborative effort involving specialists, managers and technicians from the three levels of government - federal, state and municipal. Based on an immersion in the data from 2019 to 2022 provided by the Public Health Budget Information System (Siops), this publication offers an in-depth, critical and propositional reading of the health financing cycle, highlighting the main challenges and possible ways to improve the system.

This edition presents a detailed radiography of public health accounts in Brazil, offering an overview that allows us to understand:

- How resources are distributed between the Union, states and municipalities, highlighting the complexity of the federative pact in the SUS;
- What are the main components of health expenditure, from primary care to highly complex services?

By offering an analysis based on robust data, this book strengthens the commitment to public transparency, to the governance of the SUS and to the improvement of control mechanisms and the efficiency of health spending. It also highlights the importance of combining qualified technical management, federal cooperation and adequate funding to ensure the sustainability of Brazil's public health system.

This compilation is aimed at managers, technicians, researchers and society as a whole, providing a solid basis for formulating public policies, debating health financing and strengthening the SUS as a state policy and an essential pillar of social justice in Brazil.

Conass, as the representative of the State Health Secretariats, and Conasems, as the entity that brings together the Municipal Health Secretariats, reaffirm, through this publication, their unwavering commitment to defending the SUS. More than ever, it is necessary to mobilize joint efforts to tackle underfunding, reduce inequalities, qualify the proper allocation of public resources and ensure that they achieve their purpose.

In this sense, it is important to draw attention to the need for sub-national entities to enter quality data into Siops. The system cannot be seen as a mere tool that indicates whether the constitutional minimum has been applied by the federated entities. He's more than that. It is the only tool that aggregates health budget information from sub-national entities and is a powerful tool for strengthening public health policies and, ultimately, for directing resources to provide health actions and services to citizens.

We invite managers, researchers and the whole of society to explore the information presented here, reflect on the paths of health financing in Brazil and, together, strengthen our public health system that promotes equity and consolidates health as a fundamental right.

We wish you an excellent reading!

Jurandi Frutuoso Silva
Executive Secretary – Conass

Mauro Guimarães Junqueira
Executive Secretary – Conasems

SUMMARY

FOREWORD

Health financing is a relevant and structurally complex issue in all countries. In Brazil, the challenges are greater due to the size and diversity of the territory, as well as persistent socio-economic inequalities. These factors call for even more attention to the way in which the resources earmarked for health are mobilized, distributed and used by the different levels of government.

This book makes a significant contribution to understanding health financing at the sub-national level. Based on detailed data and consistent methodology, the analysis presented here sheds light on patterns, variations and gaps in state and municipal health spending. A careful reading of the results provides a better understanding of the sector's underfunding, as well as the heterogeneity in the allocation of resourses and their implications for access and the quality of the services provided.

The use of the Public Health Budget Information System (Siops) as the central source of data for this work is particularly relevant. The system represents a valuable effort to consolidate fiscal information and offer greater transparency to public management. However, its strengthening and especially the improvement of the quality of the information declared are essential to expand its use as a planning, monitoring and evaluation tool. Consolidating Siops as a reliable and regularly used source is part of the broader process of institutionalizing health accounts in Brazil.

Several member countries of the Organization for Economic Cooperation and Development (OECD), such as Australia, Canada, Spain, the United States, Mexico and Switzerland, monitor regional health spending as part of their efforts to promote greater distributive justice and guide evidence-based public policymaking. The systematic production of health accounts at different levels of government makes it possible not only to track spending trends over time, but also to analyze their impact on health outcomes and equity in access to services.

In Brazil, the role of states and municipalities in implementing health policies is decisive, but still little understood from a financial perspective. The analysisdeveloped here contributes to filling this gap. It highlights the need for more coordinated federa-

tive governance, as well as a continuous effort to improve the quality and regularity of available data, which is an indispensable condition for the development of sustainable public policies with a greater impact on the lives of Brazilians.

The recognition that the SUS faces chronic underfunding has already been widely documented. But just as important as increasing public health funding is making progress in understanding the impact of the resources allocated. Improving the efficiency and effectiveness of public spending should not be seen as an alternative to increasing resources, but rather as a complementary and necessary way of guaranteeing better health outcomes, greater equity in investment decisions and greater sustainability for the system.

The Unified Health System, one of the largest public health systems in the world, is an achievement of Brazilian society and plays a central role in promoting social cohesion and equity in the country. Its consolidation as an effective and equitable public arrangement depends not only on the expansion of resources for health, but also on the strengthening of evidence to guide decisions, analytical capacity in all levels of government and a commitment to continuous improvement in public administration.

I believe this book offers a solid basis for this debate. By combining technical rigor with sensitivity to local specificities, this publication establishes itself as a useful reference for researchers, managers and policymakers committed to strengthening the Brazilian health system.

Frederico Guanais
Deputy Head of the Health Division
Organization for Economic Cooperation and Development (OECD)

While the Unified Health System - SUS, which serves close to 200 million residents in Brazil, is considered to be the largest public health system in the world, the same magnitude or proportion is not repeated in the specialized literature that evaluates and studies its structure, functioning, financing and spending. This mismatch is aggravated by the fact that health is not only one of the government functions that moves the most resources, but at the same time it is expressive and increasingly decentralized in the Brazilian federation, with a growing emphasis on municipalities.

A good contribution to begin addressing this lack of knowledge and debate is provided by this work, entitled *"Health Financing in Brazil: Perspectives from States and Municipalities"*, edited by Antonio Carlos Rosa de Oliveira Junior, Blenda Leite Saturnino Pereira, Jurandi Frutuoso Silva, and Mauro Guimarães Junqueira, some of whom contributed with chapters to the book along with Daniel Resende Faleiros, Gustavo Andrey de Almeida Lopes Fernandes, and Natalia Nunes Pereira Batista.

The effort made by the authors and organizers, together with the National Council of Health Secretaries (CONASS) and the National Council of Municipal Health Secretariats (CONASEMS), to gather a wide range of data on how health is financed in Brazil, with a view to providing an accurate diagnosis of its main bottlenecks, is therefore noteworthy, with a view to providing an accurate diagnosis of its main bottlenecks.

The time is also ripe for further debate on the funding of the SUS, when doubts about compliance with fiscal rules by the central level of government are once again on the agenda of economic debates. It is common in these times to leave state and municipal governments in the background, particularly neglecting their decisive and growing role in providing fundamental public services, such as health, education and public safety. In our opinion, the public and political debate needs more academic production and intervention.

Reports lack data. And although we live in the age of data, with an ever-increasing volume of it available with free and broad access, not all of it is used to support public positions and policies. In particular, the mass of data surrounding the SUS is an input

that is as precious as it is unknown to many Brazilians, not only to eventually feed sophisticated artificial intelligence models, but also to motivate studies such as the ones published in this book.

Without detracting from his merit, let there be more books, because the SUS is so large and essential that it requires greater dissemination of knowledge. In the case of this book, it is worth highlighting that it sheds light on the essential and growing role played by local federative entities - notably municipalities - in the processes of achieving and making viable public health services in the country.

Based on an essentially federative approach, the authors explain their main inference, which is: despite the significant asymmetries and disparities in the processes of allocating resources between the different levels of government, the Union is characterized by concentrating most of the tax collection, while the other subnational entities bear a considerable part of the burden of operationalizing public health services.

There is also an argument that stems from this primary diagnosis, whose more general contours can be stated as follows: on the one hand, this discrepancy jeopardizes the very sustainability of the national public health system and, on the other hand, it also undermines its ability to respond, based on the minimum levels of equity advocated by the 1988 Federal Constitution, to the substantial public health challenges facing our society, which is widely recognized for its high levels of inequality, both regionally and socio-economically.

In addition to the first chapter, which comprises a more general introduction, this book is made up of four more chapters. The second chapter is essentially based on a historical, normative and budgetary analysis of public health policies, with a view to providing an overview of the more general characteristics of the SUS. The third chapter takes a truly immersive look at state budgets for public health services, especially through interesting analyses of data extracted from the Public Health Budget Information System (Siops).

It is worth noting that the fourth chapter points out the main bottlenecks in SUS financing processes. As such, it is an invitation to reflect on the insufficient level of fiscal autonomy experienced by municipalities, especially in a scenario in which these same federative entities have borne an ever-increasing share of the costs of providing public health services.

Furthermore, the chapter also shows that smaller municipalities are still more dependent on government transfers, especially federal ones. The fifth chapter discusses

the current model of the Brazilian federative pact and its ability to guarantee basic constitutional rights, particularly with regard to universal access to basic health services.

Thus, this publication should inspire greater qualification of the national debate on ways of financing public health services, as well as on the budgetary relations established between the different federal entities. This is because the degree of relevance of this debate makes it urgent to overcome the ideological tensions and interdictions so latent in Brazilian society today, which do nothing to solve the real internal problems.

Finally, we hope that contributions to the debate, such as this book, on Health Financing, with an emphasis on states and municipalities, will stimulate the advancement of increasingly rational, analytically discerning reflections and, above all, will be motivated by a non-negotiable civic commitment to guaranteeing basic constitutional rights for all Brazilian citizens.

José Roberto R. Afonso
IDP Professor
Researcher at CAPP/ISCSP/Univ. Lisbon FIBE
Board of Directors

Edivo de Almeida Oliveira
Economist specializing in finance and monetary economics

This book represents an important step in producing the knowledge that every health system needs in order to establish an informed dialog about its financing (and the political economy involved in each specific financial arrangement, in this case at the three levels of government in Brazil). Thus, analyzing the dynamics of health spending and, above all, the evolution of shared responsibilities between the federal, state and municipal levels in relation to this spending, is key to tackling two basic questions that the Unified Health System (SUS), less than five years from 2030, should answer: what is the level of public spending and investment needed to meet the growing demands of the population? And how should fiscal priority be organized and shared between the federal, state and municipal levels in order to achieve this funding?

In 2014, PAHO Member States adopted the resolution on Universal Health (CD53.R14), which guides the way for the countries of the Americas to move towards universal health coverage, guaranteeing effective universal access to comprehensive, quality services, at the right time and at the right level, for all those who need them: individuals, their families and communities. This goal of achieving universal access is at the heart of the creation of the SUS, which seeks to make the constitutional right to health a reality for all Brazilians living in the country. PAHO's Universal Health resolution recommends, in its third line of action, a level of public spending on health that reaches at least 6% of GDP as a necessary (although not sufficient) condition for moving towards Universal Health.

After 37 years of the SUS, this book shows that in Brazil this level has still not been reached and currently stands at just 4%. The publication suggests that in recent years the fiscal priority of health at the federal level has been decreasing (23% between 2020 and 2023 according to the authors).

This is a cause for concern because the financial capacities of Brazil's 5,570 municipalities are extremely heterogeneous, which directly questions the health system's ability to maintain adequate levels of equity on access and financial protection. In fact, if this is the trend of the future, it will probably diminish the health system's ability to redistribute resources from those in good health to those who are ill, and from those with more resources to those with less (this being an expense financed mainly by tax-

es). At one end of the spectrum are municipalities with abundant resources in large metropolises and megalopolises; at the other end, especially in the North and Northeast regions, are poorer municipalities, some of which have had low economic growth for decades, have a human development index below the national average and have highly vulnerable populations.

Thus, this book is a true X-ray of municipal and state accounts from the Public Health Budget Information System (SIOPS); something that had never been done before. Although it exposes weaknesses in the system, such as the lack of standardization when filling in the data, the analysis provides valuable information. For example, the greater autonomy of states and municipalities in their own health spending stands out, with different dynamics between regions: more pronounced in the Southeast and South than in the North and Northeast. In addition, the book details the elements of expenditure, highlighting trends caused by the pandemic, such as higher spending on temporary staff and a drop in spending on prophylactic and therapeutic support (basically medicines).

For all these reasons, this work should be considered an indispensable contribution to the debates that are needed today to ensure that the SUS not only has the financial resources it needs to respond to the population's growing needs, but also that it can serve as a basis for promoting a dialogue between the three levels of government, strengthening the cohesion of SUS governance and aiming at an eminently political debate: how should the financing of the system be distributed between the federal, state and municipal levels?

Jarbas Barbosa da Silva Jr.
Director, PAHO

INTRODUCTION

1

Health, enshrined as a fundamental right in the Federal Constitution of 1988, is one of the central pillars of the Brazilian social pact, and it is the duty of the State to guarantee it through social and economic policies aimed at reducing the risks of illness and injury and universal and equal access to health actions and services. As such, to make this right viable, the Unified Health System (SUS) was established, one of the most comprehensive public health systems in the world, based on the principles of universality, integrality, equity, political-administrative decentralization and social participation.

The construction of the SUS, however, was not without contradictions and challenges. Since its creation, the system has lived with the tension between the constitutional project of a universal system and the reality of its financing, marked by structural insufficiencies, regulatory instability and regional inequalities. Chronic underfunding, weak funding sources, successive changes to the legal framework for the federal funding floor and the high dependence on states' and municipalities' own revenues are permanent obstacles to the consolidation of an equitable and sustainable health system.

In this federative arrangement, decentralization - a principle that should ensure that management is close to local needs - proved to be both an opportunity and a challenge. If, on the one hand, it has brought decision-making closer to territorial realities, on the other, it has transferred increasing responsibilities to sub-national entities without necessarily ensuring the corresponding financial capacity for their execution. States and municipalities have come to play a central role in implementing public health policies, often facing severe limitations in terms of funding, technical capacity and budgetary autonomy.

It is in this context that the Public Health Accounts Project, an unprecedented initiative by the National Council of Health Secretaries (Conass) and the National Council of Municipal Health Secretaries (Conasems), was conceived with the aim of deepening the analysis of SUS financing from a state and municipal perspective. The project seeks to understand, from a critical perspective and based on diagnoses, how public resources are collected, transferred, allocated and executed within the health system, taking into account federative specificities and local dynamics that shape health financing in Brazil.

This book is the result of this collective effort, which brought together specialists in health economics, public managers, technicians and researchers with the mission of qualifying the debate on the financing of the SUS. Based on official data, especially those extracted from the Information System on Public Health Budgets (Siops), and supported by a robust methodological approach, the study presented here sets out to offer:

- A historical and normative analysis of the evolution of public health financing in Brazil, with emphasis on the constitutional and infra-constitutional changes that redefined the minimum levels for the application of resources;
- A critical assessment of the behavior of public spending on health at state and municipal level, highlighting trends, patterns of application, implementation challenges and regional variations;
- An investigation into intergovernmental transfers, with an emphasis on the Fund-to-Fund (FAF) mechanism, analyzing its implications for the autonomy and financial sustainability of subnational entities;
- A propositional reflection on the alternatives and possible strategies to strengthen the financing of the SUS, in a context of new social demands and fiscal restrictions.

Throughout the chapters, the book reveals that, although states and municipalities have taken on an increasing role in financing the SUS, this expansion has taken place against a backdrop of federal imbalance, in which the Union, the main tax collector, has progressively reduced its proportional share of health spending. The shift of financial responsibility to sub-national entities, without the corresponding redistribution of resources, understood as a fair federative distribution, exacerbates regional disparities and compromises the effectiveness of the constitutional principles that guide the SUS.

Furthermore, an analysis of the state and municipal constitutional floors shows that, although most federated entities formally comply with the minimum percentages established by law, the challenge of financial sufficiency persists. Compliance with the constitutional floor established for expenditure on Public Health Actions and Services (PHAS), in many cases, does not guarantee adequate funding for the population's needs, especially in the face of growing demand, notably of chronic diseases, demographic transition, the emergence of new health technologies and contemporary health crises.

A more in-depth analysis of the implementation of federal transfers also reveals that the complexity of regulations, the fragmentation of transfers and the volatility of allocation criteria weaken the planning capacity of states and municipalities, affecting the efficiency and effectiveness of public health policies.

This book, therefore, does more than just describe data and trends. Its main purpose is to contribute to the construction of a critical and propositional view of the financing of Brazilian public health, strengthening the SUS as a state policy and a fundamental instrument of social justice. By offering a systematized, rigorous and accessible analysis, the book is aimed at managers, public policy makers, academics and all those who recognize health as an inalienable fundamental right.

Finally, we reaffirm the premise that the effectiveness of the right to health necessarily requires the consolidation of stable, sufficient and solidarity-based public funding. Overcoming regional inequalities, ensuring comprehensive care and strengthening the management capacity of the federated entities are tasks that require, in addition to political will, a continuous commitment to improving the financial bases that support the SUS. This book is a contribution in this direction, reaffirming the importance of applied research, federative cooperation and the uncompromising defense of the universal right to health in Brazil.

1.1 METHODOLOGICAL NOTES

The methodology used to prepare chapters 3 and 4 on states and municipalities, respectively, was structured to provide a detailed analysis of the Siops accounts. The accounting configuration of health expenditure guarantees the integrity and reliability of budgetary and financial information. The study followed an approach based on the functional classification of public expenditure and the standardization of information according to current normative and accounting criteria.

1.1.1 SOURCE AND CLASSIFICATION OF DATA

The data used in the analysis was taken directly from Siops, an official database that ensures the standardization and comparability of information between federal entities. The classification of expenses followed the structure established in Ministerial Order No. 42, of April 14th, 1999, from the Minister of State for Budget and Management, which organizes budget appropriations into **functions and subfunctions**.

Functional classification aims to answer the fundamental question: “In which area of government activity will the expenditure be carried out?”. It is made up of a prefixed list of functions and subfunctions, serving as an aggregator of public spending and allowing for the national consolidation of health spending at the three levels of government. This structure is independent of government programs and is mandatory for the Union, states, Federal District and municipalities.

In the context of health, the analysis considered the following subfunctions:

- **Primary Care**

Includes expenditure on individual and collective health actions, including health promotion and protection, disease prevention, diagnosis, treatment, rehabilitation and health maintenance.

- **Hospital and Outpatient Care**

It covers expenses for hospitalizations and outpatient care, including laboratory tests necessary for the diagnosis and treatment of diseases, carried out directly by the government system or through contracts and agreements with private entities or other levels of government.

- **Prophylactic and Therapeutic Support**

Refers to expenditure on actions aimed at the production, distribution and supply of medicines and other pharmaceutical products in general.

- **Health Surveillance**

It encompasses a set of actions capable of eliminating, reducing or preventing health risks and intervening in health problems arising from the environment, the production and circulation of goods and the provision of services. It includes health surveillance actions at borders, sea and river ports and airports, as well as the control of activities related to the analysis and licensing of medicines, foodstuffs, among others.

- **Epidemiological Surveillance**

Includes expenditure on actions that promote the detection and prevention of communicable diseases and health problems and their risk factors, combating the spread of communicable diseases, especially those with epidemic potential.

- **Food and Nutrition**

It involves spending on actions aimed at reducing or eliminating nutritional deficiencies, advising citizens on the nutritional values of food and making up for food shortages.

- **Administration**

It covers administrative expenses and concentrates management and maintenance actions of government bodies.

This categorization made it possible to identify patterns in the allocation of resources, assess the consistency of the information reported by the municipalities and detect possible distortions in budget and financial execution.

1.1.2 EXPENDITURE ANALYSIS PROCEDURES

The methodology adopted an approach based on the **expenditure settlement phase,** as provided for in Article 63 of Law No. 4.320/1964. Settlement is the process of verifying the right acquired by the creditor, based on the securities and documents supporting the respective claim, and its purpose is to ascertain whether the good or service has been properly delivered or provided. Thus, it corresponds to the value equivalent to what has been acquired in goods and services by the Public Administration. This approach allowed for a careful analysis of expenditure, identifying any inconsistencies and improving the reliability of the data analyzed.

1.1.3 REVENUE AND EXPENDITURE CLASSIFICATION AND STRUCTURE

The methodology also included a detailed analysis of the **composition of health income and expenditure at municipal and state level**, following the budget classifications in force.

1.1.3.1 BUDGET REVENUE

The revenues analyzed in the study refer to **available funds that enter the budget of the entities throughout the fiscal year.** These revenues enable the implementation of public policies and are classified as follows:

- **Own revenues,** collected directly either by the municipalities or by the Federative Units (states) (e.g. taxes, fees and improvement contributions);
- **Current transfers,** from the Union and/or the states, intended to finance expenditure on the maintenance of public services.

Current transfers include **constitutional transfers,** such as the Municipal Participation Fund (FPM) and the State and Federal District Participation Fund (FPE), as well as **legal transfers**, which include FAF transfers, which do not depend on covenants, pacts or specific agreements between the federal entities.

1.1.3.2 BUDGET EXPENDITURE

The expenditures of the states and municipalities were analyzed according to their economic classification, which distinguishes:

- **Current expenditure**, aimed at maintaining public services, including personnel, the purchase of goods and services and transfers to private non-profit organizations.
- **Capital expenditure,** which involves investments in infrastructure and the acquisition of equipment, essential for the expansion and modernization of the health network.

1.1.4 FEDERAL DISTRICT: EXPERIENCES OF SIOPS' CONTRIBUTORY STRUCTURE

It is worth mentioning that, due to its specific characteristics, the Federal District has a different accounting structure from the health accounts of the other states. The main distinction is that it has a unique administrative and legal regime. Unlike the states, which are divided into municipalities, the Federal District accumulates the typical competencies of a state and its municipalities. This means that Siops accounts need to reflect this centralization of public functions, organizing, in an integrated manner, revenues, expenses and transfers that, in other states, would be segregated between state and municipal governments. In other words, the accounting structure of this Federative Unit is adapted to cover all of its financial management, taking into account its legal and operational particularities. Furthermore, unlike the states, the Federal District does not transfer funds to municipalities.

However, due to the level of aggregation used in this study, these differences are not relevant and have not affected the analysis and conclusions obtained.

1.1.5 REGIONAL AND TIME ANALYSES

The methodology also included a **regional and temporal** analysis, covering the period from 2018 to 2022. This approach made it possible:

- **Identify trends in health investments** and assess dependence on intergovernmental transfers.
- **Examine the variation in fiscal autonomy,** considering population size and geographical location.
- **To compare financing patterns between Brazilian regions,** highlighting structural inequalities that impact on the management of health resources.

1.1.6 DATA COLLECTION AND ANALYSIS DIFFICULTIES

During the data collection and processing process, various factors were identified that made it difficult to obtain accurate information. Among the main challenges faced are:

- **Revenues and expenses with negative values**, possibly due to errors in entering or transmitting data. These inconsistencies were duly reported to the responsible bodies, helping to correct the problems and improve the integrity and reliability of the information.
- **Inconsistencies in aggregation accounts,** in which some categories did not correctly reflect the sum of their parts, generating discrepancies in the reported values.
- **Changes in accounting definitions as of 2020** due to the obligation to follow the rules established by the National Treasury (art. 163A of the Federal Constitution), making it difficult to compare data over the years.
- **Lack of standardization when filling in various accounts,** either because they are difficult to understand or because of problems with nomenclature.
- **Lack of distinction between absence of information and null values,** which compromised the assessment of the completeness of the database and made it difficult to identify municipalities that did not send information.

In addition, it can be seen that the **constant changes in the aggregation of Siops accounts** make it difficult to build and monitor aggregate indicators. In this context, the achievement of a global vision was hampered, causing difficulties in converging on common points and perhaps the necessary agreements on structural reforms. The lack of standardization in the filling in of various accounts limits the detail of the analysis, because as we expand the detail of the accounts, we come across more divergences arising from the different filling in of the information. Thus, the declaration of expenditure in specific subfunctions and/or economic categories is very heterogeneous between municipal and/or state entities, which made comparison difficult, considering the timeline.

To mitigate these problems, **validation workshops** were held in the Metropolitan Region of Porto Alegre and in municipalities in the state of Rio Grande do Norte, involving technicians and municipal managers as well as representatives from the State Health Departments of Rio Grande do Sul (SES-RS) and Rio Grande do Norte (SES-RN). The aim was to discuss operational difficulties in classifying and using health budget data. In these workshops, the health expenditure of the participating municipalities was presented and discussed, as well as the main challenges in the application and execution of the resources earmarked for health actions and services. In the case of state managers, in order to obtain a larger sample, an online survey was applied[I]. It was observed that both the workshops and the application of the survey to state health managers were

I This will be discussed in Chapter 3.

fundamental in correcting inconsistencies, understanding nomenclatures, reviewing the allocation of resources and improving the quality of the database used in the analysis.

These challenges required a precise examination of the Siops accounts in order to ascertain the most appropriate level of disaggregation of the accounts, particularly expenditure. At the same time, most of the information was aggregated according to region and population size.

1.1.7 METHODOLOGY CONCLUSION

The triangulation between **Siops data, the results of the validation workshops and statistical analysis** made it possible to draw up a comprehensive diagnosis of health financing patterns at state and municipal level. This process made it possible not only to identify challenges in the management of resources, but also to subsidize the formulation of more effective public policies aimed at improving the allocation of funds and strengthening the fiscal sustainability of municipalities and states. In addition, this diagnosis highlights the chronic underfunding of the sector, coupled with a fragile criteria for allocating resources, which are not always in line with the provisions of Supplementary Law (LC) No. 141/2012, potentially putting pressure on health spending for states and municipalities, which limits investment capacity and jeopardizes the quality and continuity of services provided to the population.

FINANCING OF THE UNIFIED HEALTH SYSTEM 2

The SUS is one of the largest public health systems in the world, which aims to provide universal and comprehensive access to health care for the entire population. However, its adequate and sustainable financing has been a critical issue over the years, with challenges related to secure sources of funding, resource allocation, efficiency and equity in access to health services[1].

Brazil is an important political and economic center, a power in terms of territorial extension, natural resources and cultural diversity. Despite this, it suffers from the classic problems of developing countries, such as social inequality, urban violence and poor management of public resources. Until recently, public health issues were dealt with without a central government strategy to meet the demands and actions of the state, and were restricted to emergency situations, such as epidemics in urban centers. In 1988, with the Federal Constitution, Brazil was guaranteed health and a public, universal, comprehensive, equitable and free system[1].

2.1 HEALTH SPENDING IN BRAZIL AND AROUND THE WORLD

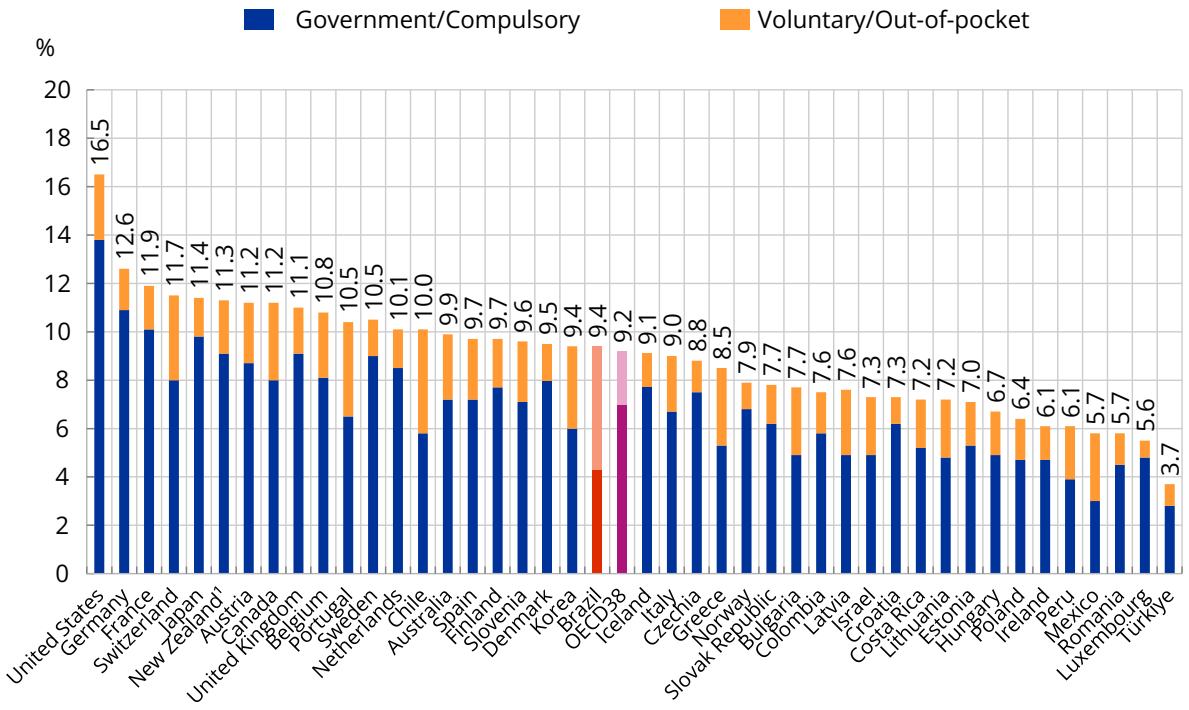
Data from the Organization for Economic Cooperation and Development (OECD) for 2019 show that public spending on health in Brazil represents only 3.93% of Gross Domestic Product (GDP), far below developed countries and even some emerging countries. Spending as a percentage of GDP expresses the size of health spending in the total value of the economy. In Brazil, low public participation reflects the limitations in the financing of the SUS, which faces challenges in serving the population in a context of underfunding.

Brazil's private spending, on the other hand, is 5.39% of GDP, one of the highest in graph 2.1 below, indicating a high dependence on private health insurance and direct spending by families. This scenario highlights significant inequalities in access to healthcare and financial pressures on individuals.

In comparison, countries with universal and well-funded health systems, such as Germany, France and the Nordic countries, have a greater share of public spending, which promotes greater equity and access. On the other hand, countries like Brazil, with

relatively low public spending and high dependence on private resources, face significant challenges in guaranteeing universal access and reducing inequalities.

Graph 2.1. Health spending as a proportion of GDP - OECD and Brazil, 2022



Source: OECD Health Statistics 2024[2].

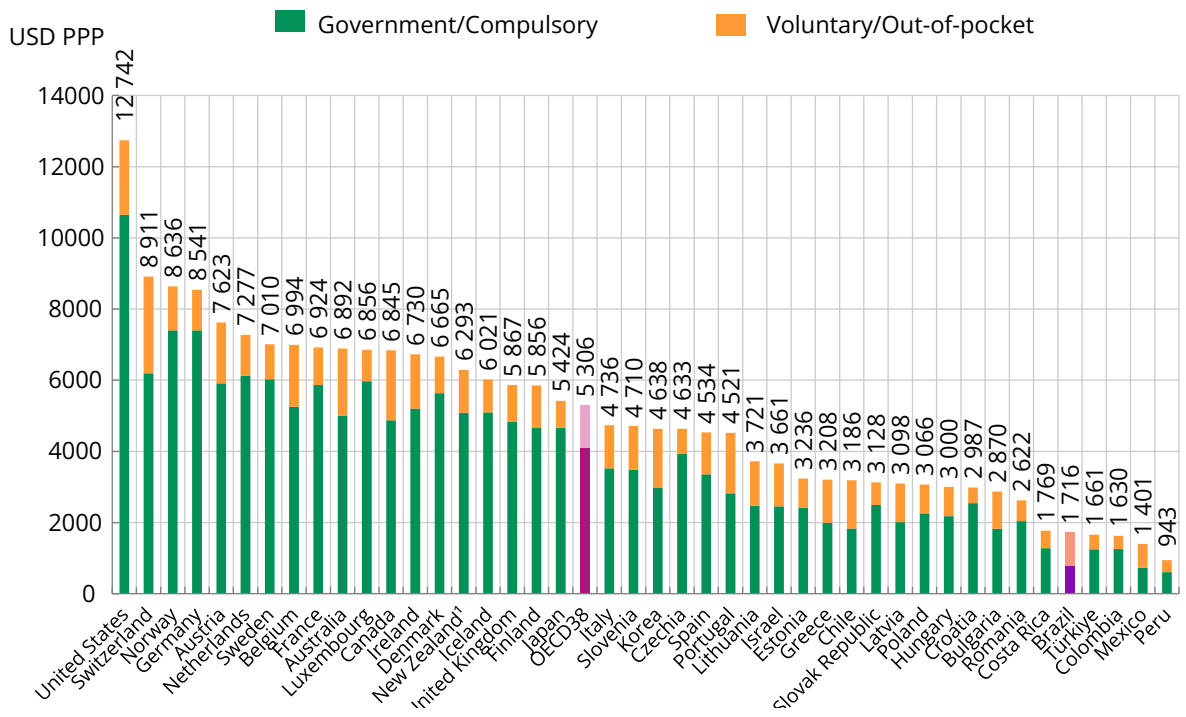
Graph 2.1, with data for 2022 taken from the OECD, shows the disparities in health financing between different countries and how health systems are structured in terms of public and private sector participation.

In countries like the United States of America (USA), Germany and France, public spending as a proportion of GDP is among the highest. The US leads this ranking with 16.5%, a figure which, although significant, reflects the high cost of the US system, which combines substantial public investments with a high dependence on private insurance and direct disbursements, evidenced by private spending of 2.7% of GDP. Germany and France also have high levels of public spending, with 10.9% and 10.1%, respectively, characterizing solid, well-funded universal systems that minimize dependence on private spending.

Initially considering health spending as a proportion of GDP, it can be seen that Brazil allocated around 9.4% of its GDP to the sector in 2022, a figure similar to the OECD average. However, this relative parity hides significant disparities in absolute terms and in the composition of funding.

An analysis of the per capita health expenditure data provided by the OECD for the same year shows profound asymmetries between the countries investigated, especially with regard to public participation in financing and the ability to guarantee universal coverage with equity.

Graph 2.2. Per capita expenditure on health in 2022



Source: OECD Health Statistics 2024[2].

Brazil has one of the lowest total per capita health expenditures, at US$ 1,716.10, which is only about a third of the average in OECD countries (US$ 5,306.40)[2]. From this total, less than half (US$ 778.80) comes from government or compulsory sources, configuring a financing pattern that imposes a high financial burden on families, whose voluntary and direct spending (US$937.30) exceeds the public component. This structure contrasts sharply with that of countries with consolidated universal systems, such as the

United Kingdom, France and Germany, where government participation exceeds 80% of total spending, guaranteeing greater protection against the financial risk associated with illness. Even more contrasting is the comparison with the USA, whose public spending per capita (US$10,648.50) is more than 13 times higher than Brazil's, even in a system with a strong private presence. These figures reiterate the historical underfunding of the SUS and point to the urgent need to reconfigure the federative arrangement, the available fiscal space and the distributive priorities of the Brazilian state, in order to ensure minimum levels of funding compatible with the constitutional principles of universality, integrality and equity.

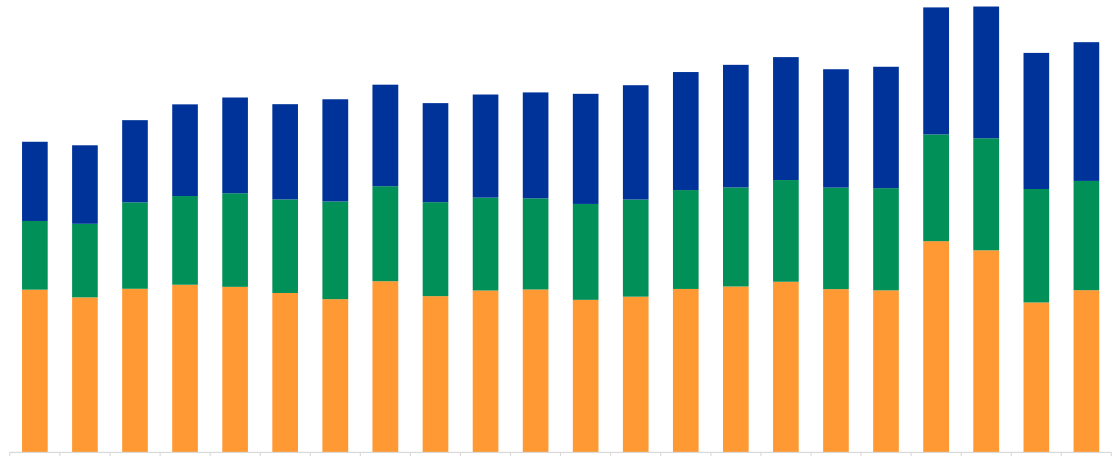
2.1.1 PUBLIC SPENDING ON HEALTH IN BRAZIL

SUS funding is made up of resources from taxes collected by the three levels of government, including constitutional transfers to the states, Federal District and municipalities. However, this funding has proved insufficient to guarantee the allocation of adequate financial resources for the full operation of the public system.

According to Figueiredo et al.[3], the resources made available have been lower than those needed to meet the population's health demands, even diverging from the level initially envisaged in the design of the SUS. This situation was further aggravated by the adoption of fiscal austerity policies in the country, which further limited the system's funding capacity[3].

Brazil, despite having a constitutional mandate for a public health system with universal access, has higher private spending on health than public spending. Countries with similar health systems, i.e. universal and public, spend an average of 8% of GDP.

Graph 2.3. Public health expenditure in Brazil as a proportion of GDP - Siops, 2002 to 2023



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
MUNICIPAL	0.81%	0.80%	0.84%	0.93%	0.98%	0.97%	1.04%	1.04%	1.01%	1.05%	1.08%	1.12%	1.17%	1.20%	1.25%	1.25%	1.21%	1.24%	1.30%	1.34%	1.39%	1.42%
STATE	0.70%	0.75%	0.88%	0.91%	0.95%	0.95%	1.00%	0.97%	0.96%	0.95%	0.93%	0.98%	0.99%	1.01%	1.01%	1.04%	1.04%	1.04%	1.09%	1.14%	1.16%	1.11%
FEDERAL	1.66%	1.58%	1.67%	1.71%	1.69%	1.63%	1.57%	1.75%	1.59%	1.65%	1.66%	1.56%	1.59%	1.67%	1.69%	1.74%	1.67%	1.65%	2.16%	2.06%	1.53%	1.66%

Source: Siops/MS - IBGE.

Public spending on health in relation to GDP in Brazil between 2002 and 2023 reveals relevant perspectives on the evolution of health financing at the federal, state and municipal levels (graph 2.3). The average percentages over the period show the different levels of government involved in maintaining the SUS. At the federal level, the average was 1.69% of GDP, with the Union as the main source of public health funding in Brazil. In turn, the states had an average of 0.98% while the municipalities recorded an average of 1.11%, highlighting the growing importance of municipal administrations in the costing and management of health services.

The behavior of spending over the period shows different performances between the levels of government. The federal share remained practically stable, at 1.66% in both 2002 and 2023, indicating a lack of growth proportional to GDP. On the other hand, the states had an increase of 0.41 percentage points, from 0.70% in 2002 to 1.11% in 2023, showing a greater involvement of state governments in health financing. Municipalities, in turn, recorded the greatest relative growth, with an increase of 0.61 percentage points, from 0.81% in 2002 to 1.42% in 2023, reinforcing the leading role of municipal entities in the context of SUS decentralization.

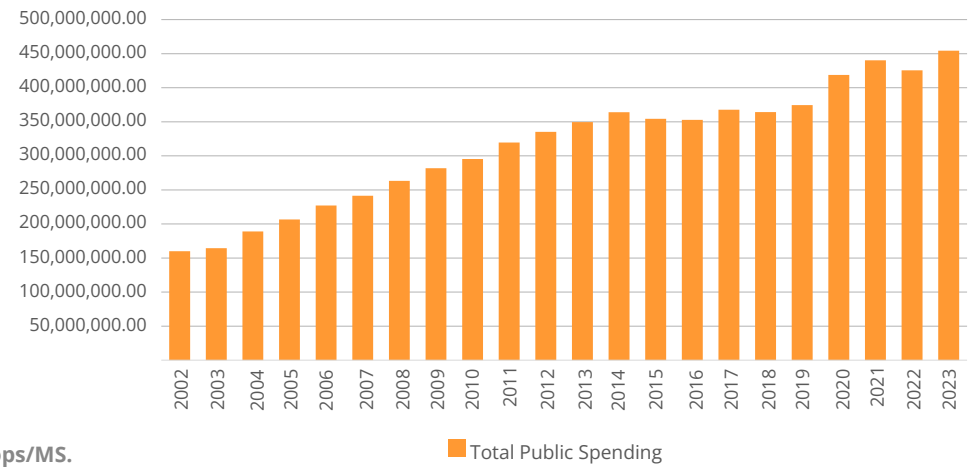
This data indicates that, over the last two decades, the burden of health financing has been progressively shifted to the states and, above all, to the municipalities. This movement raises concerns about the fiscal sustainability of subnational entities, espe-

cially in contexts of economic crisis or reduced federal transfers. On the other hand, the stability of the federal percentages, although significant in absolute terms, may indicate limitations in the expansion of the Union's participation in financing proportional to the growing health demands in the country.

This panorama shows the fragility of the federative pact in public health financing, considering the challenges of equity and financial sustainability that permeate the system. Thus, it is essential to strengthen coordination between the levels of government and guarantee the allocation of resources in a way that is appropriate to local and regional needs, ensuring the continuity and quality of health services for the Brazilian population.

Graph 2.4 shows the evolution of total public spending in the SUS. Considering values adjusted by the Broad National Consumer Price Index (IPCA) for 2023, the evolution of total public spending on health is shown. At the beginning of the period, in 2002, total corrected public spending was approximately R$160 billion, while in 2023, it reached R$454 billion. This growth is equivalent to a real increase of around 184%, showing a significant expansion in SUS funding. However, it reveals significant fluctuations in the rate of growth over time, related to economic conditions and the policies adopted in different periods.

Graph 2.4. Total public spending on health - Brazil, 2002 - 2023. In millions of Reais (updated to IPCA/2023)



Source: Siops/MS.

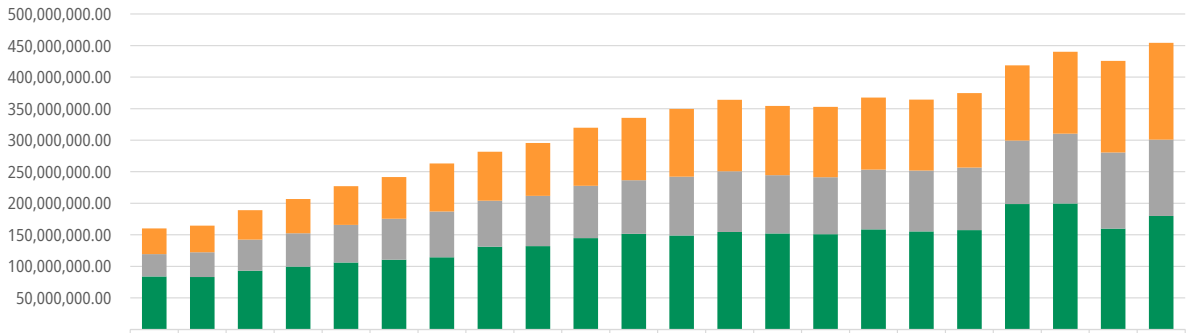
From 2002 to 2008, total public spending in the country grew steadily, but at a moderate pace, suggesting a gradual expansion of the SUS's financing capacity during this period. Since 2009, economic growth has accelerated and health policies have been strengthened.

Between 2015 and 2019, the series shows a slowdown in real spending growth, reflecting the fiscal restrictions imposed by the economic crisis and the austerity policies adopted in Brazil. This period coincides with the approval of measures such as the public spending ceiling - Constitutional Amendment (EC) No. 95 of December 15th, 2016 - which limited the growth of primary spending, including health.

The year 2020 saw a significant jump in spending due to the covid-19 pandemic, which required resources from extraordinary credits to finance emergency actions, such as the purchase of medical supplies, equipment, vaccinations, expansion of hospital beds, among others. Total corrected spending reached R$418 billion that year, representing one of the largest investments ever recorded. This high level was maintained in 2021 due to the continuing demands related to the pandemic.

After the peak observed in 2020 and 2021, the years 2022 and 2023 show a drop in growth, although it is still high. In 2023, total corrected public spending reached the highest value in the series, R$454 billion. Although public spending on health has grown significantly in real terms, part of this growth has been driven by extraordinary events, such as the Covid-19 pandemic.

Graph 2.5. Total public spending on health - Brazil, 2002 to 2023. In millions of Reais (updated to IPCA/2023)



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Municipality	40,78	42,03	46,73	54,39	61,33	66,01	76,24	77,82	83,79	92,00	98,60	107,3	113,2	109,9	111,6	114,3	112,5	117,9	119,4	129,9	144,9	153,6
State	35,41	39,40	49,18	52,72	59,80	64,87	72,73	72,71	79,54	83,01	84,94	93,42	96,35	92,13	90,03	94,66	96,42	99,16	100,5	110,6	120,7	121,0
Federal	83,86	83,00	93,13	99,59	106,0	110,6	114,2	131,2	132,1	144,6	151,7	148,7	154,5	152,2	151,1	158,7	155,3	157,4	198,7	199,6	159,8	179,8

Source: Siops/MS.

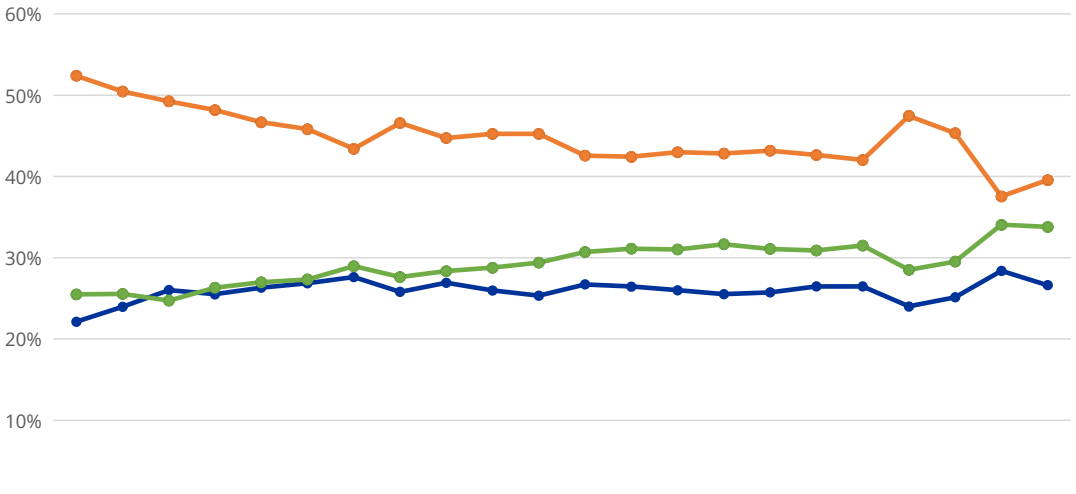
As can be seen in graph 2.5, between 2002 and 2023, total public spending on health, discounting inflation, grew from R$160.07 billion to R$454.46 billion, which corresponds to an increase of approximately 184% over the period. This growth reflects a significant

increase in investment in public health in Brazil, but with significant variations in the relative contribution of each levelof government.

2.1.1.1 COMPOSITION OF PUBLIC EXPENDITURE ON HEALTH

Considering the real growth in investment in health and the various changes to the rule for minimum amounts invested by the federal government, it can be seen that the composition of public spending over the last two decades has changed significantly, highlighting the leading role played by sub-national entities in financing the SUS.

Gráfico 2.6. Composição do gasto com ações e serviços públicos de saúde, Brasil, 2002 – 2023



Spending	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Federal	52%	50%	49%	48%	47%	46%	43%	47%	45%	45%	45%	43%	42%	43%	43%	43%	43%	42%	47%	45%	38%	40%
State	22%	24%	26%	26%	26%	27%	28%	26%	27%	26%	25%	27%	26%	26%	26%	26%	26%	26%	24%	25%	28%	27%
Municipalities	25%	26%	25%	26%	27%	27%	29%	28%	28%	29%	29%	31%	31%	31%	32%	31%	31%	31%	29%	30%	34%	34%

Fonte: elaboração própria com base em Siops, Siop, RAG MS (2023).

The data in Graph 2.6 shows significant changes in the composition of this spending, highlighting a process of transferring budgetary responsibility from the Union to the states and, above all, the municipalities.

At the beginning of the period analyzed, in 2002, the federal government played a dominant role, accounting for 52% of health spending. However, over the years, there has been a progressive reduction in this share. In 2023, **the proportion of federal spending fell to 40%, which represents a negative cumulative rate of change of 23% over 21 years.** The

biggest reduction was recorded in the period between 2021 and 2022, when the federal share fell from 45% to 38%. Despite this abrupt reduction, there was a partial recovery the following year, with the federal share returning to 40% in 2023, coinciding with the change in the federal floor methodology defined by LC 201 of October 24, 2023.

State governments showed a more stable funding trend, but with moderate growth over the period. In 2002, the states accounted for 22% of health spending, while in 2023, this proportion reached 27%. This reflects an accumulated growth of 22.7% over two decades. This relative stability suggests that the budgetary weight of the states in health has increased at a slow pace, without significant fluctuations.

Municipalities, on the other hand, recorded the most significant growth in public spending on health. In 2002, municipalities accounted for 25% of the total share, rising to 34% in 2023. This increase reflects a cumulative variation of 32% over the period analyzed, indicating a significant increase in its financial responsibilities in the sector. The constant growth is indicative of the greater budgetary pressure on municipalities, which face growing demands for localized health services, often without a corresponding increase in their revenues.

In general terms, the data point to a process of responsibility transfer in the financing of public health in Brazil. While the federal share has seen a steady decline, states and municipalities have gradually increased their contributions. This scenario reinforces the need for an in-depth analysis of intergovernmental transfer mechanisms, such as FAF transfers and parliamentary amendments, which may be redistributing financial responsibilities without guaranteeing balanced revenues.

2.2 REGULATORY HISTORY OF SUS FINANCING

The right to health in Brazil rose to the status of a constitutional guarantee with the promulgation of the Federal Constitution in 1988, which also established the means to achieve it, starting with the creation of the SUS. However, Brazilian society, especially during the decade that began in the 1980s had already become aware of their right to health and - both those millions of people still completely on the margins of the consumer market and the economic and social elites - began to demand that the right to health be guaranteed[4].

Among the different concepts of health throughout history, the one adopted by the World Health Organization (WHO) was the one that best understood health as a human right in the most comprehensive way[5]. Thus, the recognition of the right to health and the State's obligation to promote and protect it became the object of the WHO, which

recorded in the preamble to its Constitution (1946) the concept of health as "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity"[6]. However, the demands of society and international organizations alone were not enough to guarantee the right to health, making it essential to establish concrete means to achieve it.

In the case of Brazil, the scope and comprehensiveness of the current health policy are defined in Articles 196 to 200 of the Federal Constitution. Medici (1994) points out that, from the point of view of federal interests, three issues upstage as relevant:

a) the existence of a single command in each level of government; b) decentralization in such a way that health actions become the co-responsibility of the Union, the states, the Federal District and the municipalities, with the sub-national entities being responsible for the provision of services and the federal level for defining the national health policy as well as its norms, regulations and general rules; c) the financing of health policies that are the responsibility of the Union, the states, the Federal District and the municipalities[7].

In this context, the history of SUS financing is marked by constant evolution, from its creation to the present day. Although the constituents congressman had established the participation of the three levels of government in the financing of the SUS and provided for sources of revenue and the allocation of minimum resources by the Union, these constitutional precepts were largely neglected throughout the 1990s. This negligence has resulted, and still persists, in significant difficulties in financing the public health system, which requires adequate resources to meet the needs of the population, in order to guarantee the constitutional right.

Until the constitutional guarantee of the right to health was established in the country, federal funding for health came from up to 30% of the Social Security budget, excluding unemployment insurance. After 1988, the first constitutional initiative to guarantee secure sources of funding for public health actions and services was the Proposed Amendment to the Constitution (PEC) No. 82, of March 27th, 1995, which culminated in the enactment of EC No. 29, of September 13th, 2000[8,9].

The main objective of PEC No. 82/1995, presented by Congressman Carlos Mosconi and other parliamentarians, was to ensure a stable and specific source of funding for the SUS. The proposal aimed to allocate funds from employers' contributions on turnover and profit exclusively to the SUS, seeking to mitigate the lack of predictability and financial security that characterized the system at the time. In practice, this meant a guarantee that these resources, which are essential for the functioning of the SUS, would be allo-

cated directly in the health area. The justification for PEC No. 82/1995 highlighted the difficulties the system was facing because it did not have a source of funding linked to revenue. Instead of relying on earmarked revenues, the system depended on inter-ministerial transfers, which created an environment of financial uncertainty and made it difficult to plan and implement public health policies. The proposal therefore sought to establish a fixed destination for the funds collected, offering more security and autonomy for public health management in the country. This specific targeting was intended to prevent resources from being redirected to other areas, thus ensuring that the state's health obligations were met.

When it was presented to the Constitution and Justice Committee (CCJ), the PEC was analyzed as to its admissibility and constitutionality. It was considered to be compatible with the Constitution's fundamental clauses, including the preservation of the federal form of state and fundamental rights. The CCJ therefore recommended its approval, with drafting adjustments. The rapporteur of the proposal, when debating the issue of earmarking, argued that PEC 82/1995 did not violate Article 167, IV of the Federal Constitution, which prohibits the earmarking of tax revenues for specific bodies. In the rapporteur's opinion, the new provision represented a valid exception, justified by the imperative need to guarantee resources for the SUS. The proposal also sought to specify the contributions directed to health within the social security budget, giving more transparency and clarity to the allocation of these resources.

PEC 82/1995 also received amendments, one of them from the rapporteur. This amendment determined that revenues from employers' contributions on turnover and profit would be fully used to finance the SUS. If there were any surpluses, they would be redirected to the social security budget as provided for in the annual health budget. The process of passing PEC 82/1995 enjoyed broad parliamentary support, evidenced by the extensive list of signatories representing various states and parties. This support facilitated its passage through both houses of parliament. After being approved in two rounds in the Chamber of Deputies, the proposal went to the Senate, where it received further adjustments before being finally approved.

In these adjustments, the sources of funding were changed. The new text established clear and permanent rules to ensure a minimum application of public resources to health, determining that the Union, states, Federal District and municipalities should allocate fixed percentages of their revenues to financing the SUS; as well as strengthening the management of these revenues through health funds. This measure was fundamental in creating a stable resource base for the Brazilian public health system.

On September 14th, 2000, the proposal, consolidating the original objectives of PEC No. 82/1995, was finally enacted as EC No. 29/2000 - through changes in the text of Art. 198, which constitutes the single system for PHAS in the country. This established the need to create an LC (Complementary Law), which would be re-evaluated every five years, establishing minimum percentages of resources from the three levels of management of the SUS, to be invested on PHAS, as well as rules for monitoring, evaluating and controlling health expenditure. The LC should also establish the criteria for apportioning the Union's resources to the states, the Federal District and the municipalities, and the states' resources to their respective municipalities, with the aim of progressively reducing regional disparities, which, in fact, has not yet happened.

By means of the Transitional Constitutional Provisions Act (ADCT), however, EC No. 29/2000 stipulated that, until the LC was published, the Union should apply, in 2000, the amount committed to PHAS in 1999, plus at least 5%. For the years 2000 to 2004, the minimum amount dedicated to health would be the amount spent in the previous year plus the nominal variation in GDP[8].

In the case of the states and the Federal District, it was established that the minimum amount to be earmarked for PHAS would be 12% of their own tax revenues and transfers received for PHAS. Municipalities, in turn, were obliged to spend at least 15% of their revenue from taxes and transfers in this sector. In both cases, for the sub-national entities that applied amounts below the newly-defined minimum percentages in 1999, a range of minimum percentages was established for the years 2000 to 2004, varying from 7% to 12% for states and up to 15% for municipalities. These minimum application obligations were intended to ensure that the financing of the SUS did not depend exclusively on annual budget decisions, creating a protection against arbitrary cuts in financial resources.

Box 2.1. Statement of the base binding to tax collections, for compliance with the constitutional minimum for public health in Brazil, according to EC No. 29/2000

	Municipalities + DF	State + DF	Union
Total tax revenue	Tax on Services of Any Kind	Tax on the Circulation of Goods and Services - ICMS	Value calculated in the previous year, corrected for the nominal variation in GDP
	Urban Property Tax - IPTU	Motor Vehicle Ownership Tax - IPVA	
	Real Estate Transfer Tax - ITBI	Causa Mortis and Donation Transfer Tax - ITCMD	

Box 2.1. Statement of the base binding to tax collections, for compliance with the constitutional minimum for public health in Brazil, according to EC No. 29/2000

	Municipalities + DF	State + DF	Union
(+) Income from transfers from the Union:	FPM Share	FPE Share	
	Share of Rural Property Tax - ITR	Share of Tax on Industrialized Products - IPI - Exports	
	Share of LC 87/96 (Kandir Law)	Transfers from LC 87/1996 (Kandir Law)	
	(+) Withholding Income Tax - IRRF	IRRF Share	
(+) State transfer revenues	ICMS Share		
	IPVA share		
	IPI Share - Exports		
(+) Other Current Income:	Revenue from Active Tax Debt, Fines, Interest on Arrears and Monetary Correction	Revenue from Active Tax Debt, Fines, Interest on Arrears and Monetary Correction	
Binding Base	15%	12%	

Source: own elaboration based on EC No. 29/2000[8].

Amendment 29/2000 brought about an important change in the sources of funding for the SUS. Since this amendment, the financing of the system has directly included the proceeds of tax collection as a fundamental source of its funding. This mechanism has made it possible for health resources to be applied directly to PHAS, reducing the dependence on annual budget negotiations and expanding the basis of public health financing. This inclusion of taxes as a direct source of revenue strengthened the Brazilian state's commitment to the SUS, seeking to ensure a more predictable and regular inflow of funds.

Another important aspect brought in by EC No. 29/2000 was the constitutional obligation to create Health Funds in each sub-national entity, which are responsible for the application and control of the resources earmarked for the area. The new regulations also reinforced the supervision of spending by civil society, requiring the Health Councils to act to guarantee transparency and efficiency in the management of resources. This measure sought to ensure that resources are not used for purposes other than health, thus protecting the budget earmarked for the SUS. This protection was essential to prevent

governments from using public health system resources to cover deficits in other areas, which could jeopardize the supply and quality of public health services.

EC No. 29/2000 therefore represented a milestone in the history of public health financing in Brazil, defining a constitutional commitment to the SUS, guaranteeing that a specific portion of public resources would be earmarked for the sector. This amendment brought predictability to the health budget and created control and transparency mechanisms, strengthening the financial sustainability of the SUS, as well as promoting more efficient and transparent management of the resources earmarked for public health in the country.

Currently, states, the Federal District and municipalities follow the rule established by EC No. 29/2000. However, as shown in Table 2.2, successive changes have been made to the Union's constitutional minimum rule. Over the last decade, a series of changes have had repercussions on the allocation of federal resources, with inflections and setbacks for the financing of the SUS[10].

Box 2.2. Record of the successive changes to the constitutional grounds for financing PHAS by the Federal Government after the enactment of EC No. 29/2000

Period	Standard		Method of calculating the minimum to be applied to PHAS
From 1988	CF/88	ADCT, art. 55	30% of the Social Security Budget, excluding unemployment insurance
2000	EC No. 29/2000	ADCT, art. 77, I, a	Amount committed in 1999 plus at least 5%
2001 - 2004	EC No. 29/2000	ADCT, art. 77, I, b	Amount committed in the previous year plus the nominal variation in GDP
2005 - 2011		ADCT, art. 77, § 4	Continuation of the previous rule
2012 - 2015	LC 141/2012	Art. 5, caput and §2	Continuation of the previous rule, and in the event of a negative variation in GDP, the amount may not be reduced in nominal terms from one financial year to the next.
2016	EC No. 86/2015	CF, art. 198, § 2, I	13.2% of Net Current Revenue (NCR) in 2016, staggered up to 15% in 2020
2017	EC No. 95/2016	ADCT, art. 110, I	15% of NCR in 2017 (realized revenue)
2018 - 2020	EC No. 95/2016 (Transitional)	ADCT, art. 110, II	15% of the NCR in 2017, and in the following years, this amount plus the IPCA (revenue realized from July of the previous year to June of the year of budget preparation)

Box 2.2. Record of the successive changes to the constitutional grounds for financing PHAS by the Federal Government after the enactment of EC No. 29/2000

Period	Standard		Method of calculating the minimum to be applied to PHAS
2021 - 2022	EC no. 113/2021 (Transitional)	ADCT, art. 107, § 12	15% of the NCR in 2017, and in the following years, this amount plus the IPCA (measured from January to June and estimated from July to December of the year of budget preparation)
2023	EC No. 126/2023 LC No. 200/2023 EC No. 86/2015	CF, art. 198, § 2, I	15% of the NCR for the respective financial year (realized revenue)
	LC 201/2023	Art. 15	In 2023, the NCR estimated in Law 14,535/2023 will be taken into account.
2024 and beyond	EC No. 86/2015	CF, art. 198, § 2, I	15% of the NCR for the respective financial year (realized revenue)

Source: Federal Constitution, LC No. 141/2012, LC No. 200/2023 and No. 201/2023[11-14].

The aim of EC No. 29/2000 was to give stability to the financing of the health sector, with resources from the three levels of government, based on percentages of revenue defined by law. In 2003, a discussion began in the National Congress based on the Complementary Law Project (PLC) No. 01/2003, by deputy Roberto Gouveia (PT-SP), which aimed to define what the PHAS would be for the purpose of calculating the constitutional minimum to be applied to the SUS, as well as establishing the allocation of 10% of the Union's Gross Current Revenues (GCR) to public health in the country.

In 2007, PLC No. 01/2003 had several amendments to its original text, including a return to the rules of EC No. 29/2000, relating to the Union's minimum participation in the financing of the SUS, plus percentages of the Provisional Contribution on Financial Transactions (CPMF). The non-extension of the CPMF made it difficult for the bill to progress in the Senate, where it was coupled with Senate Bill (PLS) 156/2007, authored by Senator Marconi Perillo (PSDB-GO).

In April 2008, PLS No. 121/2007, authored by Senator Tião Viana (PT-AC), was unanimously approved, providing for 10% of the GCR to be earmarked for health. When it was sent to the Chamber of Deputies, it was approved in the form of a substitute, as PLP No. 306/2008, on September 21, 2008, with deputy Pepe Vargas (PT-RS) as rapporteur. In this substitute, the Chamber of Commerce of Deputies rejected the Senate's proposal to allocate 10% of the Union's GCR and the creation of the Social Contribution for Health

(CSS), resulting in no increase in federal resources for the SUS. Returned to the Senate, the substitute was again processed as PLS No. 121/2007, and was approved on December 7th, 2011, regulating EC No. 29/2000 with the same rules for linkingresources[15].

However, there was still a need to regulate the non-self-applicable provisions, in order to guarantee correct execution by the federal entities and supervision by the Courts of Auditors. Thus, 12 years after it was enacted, its regulation was materialized through LC 141, of January 13th, 2012, which regulated § 3 of Art. 198 of the Federal Constitution, establishing the minimum amounts that the Union, the states, the Federal District and the municipalities must invest annually in what was established as PHAS[13]. LC 141/2012 established the need to create an annual methodology of criteria for apportioning health transfer funds, as well as rules for monitoring, evaluating and controlling spending by the three levels of government, repealing provisions of Laws 8.080, of September 19, 1990, and 8.689, of July 27, 1993[13]. However, the law did not establish a new allocation of federal funds for health, frustrating expectations of an increase in funding for the sector. On the other hand, the norm defined what can be considered expenditure on PHAS, valuing the planning process and social control and establishing the regular and automatic transfer of resources for costs and investments through health funds[15].

Box 2.3. Statement of expenditure considered to be public health actions and services in accordance with articles 2 and 3 of LC 141/2012

Expenditures considered as PHAS

• Those aimed at the promotion, protection and recovery of health that simultaneously meet the principles set out in Article 7 of Law No. 8.080, of September 19th, 1990, and the following guidelines:

I - are earmarked for public health actions and services with universal, equal and free access;

II - are in line with the objectives and targets set out in the Health Plans of each Federation entity; and

III - are the specific responsibility of the health sector and do not apply to expenses related to other public policies that act on social and economic determinants, even if they affect the health conditions of the population.

Sole paragraph. In addition to meeting the criteria set out in the caput, expenditure on public health actions and services by the Federal Government, the states, the Federal District and the municipalities must be financed with resources moved through the respective health funds.

• With due regard for the provisions of Article 200 of the Federal Constitution, Article 6 of Law No. 8.080, of September 19th, 1990, and Article 2 of this Complementary Law, for the purposes of calculating the application of the minimum resources established herein, expenditure on public health actions and services will be considered to refer to:

I - health surveillance, including epidemiological and sanitary surveillance;

II - comprehensive and universal health care at all levels of complexity, including therapeutic assistance and recovery from nutritional deficiencies;

Box 2.3. Statement of expenditure considered to be public health actions and services in accordance with articles 2 and 3 of LC 141/2012

Expenditures considered as PHAS
III - training of SUS health personnel;
IV - scientific and technological development and quality control promoted by SUS institutions;
V - production, acquisition and distribution of specific products for SUS health services, such as immunobiologicals, blood and blood products, medicines and medical and dental equipment;
VI - basic sanitation of households or small communities, as long as it is approved by the Health Council of the entity of the Federation financing the action and is in accordance with the guidelines of the other determinations provided for in this Complementary Law;
VII - basic sanitation in special indigenous health districts and quilombo communities;
VIII - environmental management directly linked to the control of disease vectors;
IX - investment in the physical network of the SUS, including the execution of recovery, renovation, expansion and construction works in public health facilities;
X - remuneration of active health personnel working on the actions referred to in this article, including social charges;
XI - administrative support actions carried out by SUS public institutions and essential to the execution of public health actions and services; and
XII - management of the public health system and operation of units providing public health services.
XIII - costing and investment in federal university hospitals, including through the public entity responsible for their administration, provided that the expenses are approved by the Ministry of Health and are in accordance with the guidelines of the other determinations provided for in this Complementary Law. (Included by Complementary Law no. 209, of 2024)

Source: LC 141/2012[13].

The first change to the federal health floor took place 15 years after the enactment of EC 29/2000, through EC 86 of March 17th, 2015[16]. The issue of health financing was one of the central points of debate during the debate on the bill, which originated with PEC 358 of November 26th, 2013. The proposal, which initially sought to establish a compulsory budget for individual parliamentary amendments, took on a new dimension with the inclusion of a specific rule for the minimum application of federal resources to PHAS. PEC No. 358/2013 initially provided for the mandatory execution of parliamentary amendments, seeking to give the National Congress greater control over the resources it allocates. However, throughout the process, there has been growing interest in linking part of this tax budget to health, in order to secure additional resources for the SUS and thus possibly strengthen the sector's funding. In the midst of these debates, the text of PEC No. 358/2013 was expanded to include a new federal health floor, linked to the Union's NCR. This new funding floor established that, as of 2016, the Federal Government should

apply a progressive percentage of its NCR to health, starting at 13.2% and increasing annually until it reaches 15% in 2020.

In addition to setting this increasing percentage of the NCR, EC No. 86/2015 also specified that 50% of the value of individual amendments from parliamentarians should be obligatorily applied to PHAS, reinforcing the sector's funding through a direct complementation of resources. The inclusion of a new health floor led to significant changes in the allocation of federal resources to the SUS. These changes cannot be considered an achievement for public health, as they did not guarantee an increasing share of the federal budget for the sector, since parliamentary amendments are now counted as amounts that make up the federal floor, and not as additional resources. As a result, subnational entities have been forced over the years to allocate more and more resources to financing health in their territories.

The losses in the Ministry of Health's budget began in the first year of EC 86/2015. In 2016, according to data provided by the Ministry of Health's Undersecretariat for Planning and Budget (SPO), the Union's constitutional minimum, provided for by the new rule, for application on PHAS was R$100 billion. However, according to the previous rule, taking into account the expenditure committed in the previous year and the variation in GDP, the constitutional minimum would be R$103.7 billion, i.e. a decrease of R$3.7 billion in resources earmarked for health in 2016.

Table 2.1. Union Constitutional Minimum (2015 and 2016) for PHAS: EC No. 29/2000 versus EC No. 86/2015

				Values in millions	
Rule		**PHAS value 2015**	**PHAS value 2016**	**Increase annual**	**Annual increase (%)**
EC 29	Amount committed previous year + GDP variation (old rule until 2015)	98,378.80	103,718.50	5,339.70	5,4%
EC 86	13.2% of NCR (new rule)	–	100,247.47	1,868.67	1,9%

Source: SPO/MS[8,16].

The main difference between the two rules was in the method of adjustment. EC 29/2000, by using the variation in GDP, allowed health financing to follow the country's

economic growth more closely, which tends to reflect the growing need for investment in the sector, especially in scenarios of economic expansion. On the other hand, EC 86/2015, by setting a percentage of the NCR, established a floor, which, however, over the years became a ceiling, which was limited to the growth of resources, regardless of the expansion of demands in health actions and services.

Not long after the enactment of EC No. 86/2015, another change was made. The unstable economic and political scenario at the time and the impeachment of then President Dilma Rousseff once again led to the modification of the federal floor through PEC No. 241, of June 15th, 2016, transformed into EC No. 95, of December 15th, 2016, the so-called "Spending Ceiling Bill (PEC)"[17].

EC No. 95/2016 introduced the New Fiscal Regime, a budgetary control measure aimed at combating fiscal imbalance and stabilizing Brazil's federal public debt. This EC promised a set of guidelines aimed at limiting the growth of the Union's primary public spending, adjusted annually by the official Brazilian inflation index. This limitation was intended to reduce state indebtedness, promote economic stability and restore investor confidence in the Brazilian economy.

The New Fiscal Regime introduced by EC No. 95/2016 established a ceiling for the growth of the Union's primary expenses, setting the initial limit at the amount of expenses incurred in 2016, adjusted by the IPCA. This amount would be updated annually based on the accumulated inflation of the previous year, according to the IPCA index, and the regime would remain in force for 20 years, with the possibility of revision from the tenth year onwards, with the approval of the National Congress[18].

A fundamental aspect of the regime was the individualization of spending limits for each branch of government - the Executive, Legislative and Judiciary - and for bodies with administrative and financial autonomy, such as the Federal Court of Accounts (TCU), the Public Prosecutor's Office and the Public Defender's Office. With this provision, the self-governance of these entities would be preserved, avoiding the centralization of financial control in the hands of the executive branch. This measure would have the potential to allow greater control over public spending, establishing a distributed and, at the same time, decentralized fiscal responsibility. Certain categories of expenditure were excluded from the limit established by the New Fiscal Regime, such as constitutional transfers to states and municipalities, electoral expenses, extraordinary credits and capitalizations of non-dependent state companies[18]. These exceptions were intended to protect strategic investments and safeguard constitutional obligations, which supposedly ensured that essential resources for the implementation of priority public policies would not be jeopardized.

The context demonstrated by the federal government of fiscal deterioration, evidenced by the increase in public debt, justified, at the time, the adoption of the New Fiscal Regime. According to the bill's justification, between 2008 and 2015, the Union's primary expenditure grew significantly above inflation while revenue advanced at a considerably slower pace. This imbalance contributed to public debt reaching 67.5% of GDP in 2016, with projections of exponential growth. By establishing strict spending limits, PEC No. 241/2016 sought to halt the advance of public debt and restore fiscal stability in the country[17].

The purpose of limiting spending, according to the bill's justification text, was also to improve predictability and strengthen market confidence in Brazil's fiscal management. By strictly controlling the growth of spending, it was hoped to create a more stable environment for the economy, attracting investment and making it possible to reduce interest rates in the long term. This reduction in the cost of financing public debt could, in turn, encourage a positive cycle of investment and economic recovery, resulting in significant benefits for Brazil's development.

Another point in the proposal was the attempt to reduce the volatility of public spending. By decoupling spending growth from the economic cycle, EC No. 95/2016 introduced a counter-cyclical dynamic. In periods of economic expansion, spending would not increase disproportionately, avoiding inflationary pressures; in periods of recession, the regime would ensure that spending cuts were moderate, reducing the negative impact on the economy. The spending limits would be adjusted based on the estimated inflation for the following year.

Thus, the enactment of EC No. 95/2016 imposed a freeze on the federal government's primary spending, in principle for two decades, against a backdrop of the strengthening of the neoliberal agenda and the implementation of austerity policies. In health, the spending ceiling determined the freezing, in real terms, of the minimum federal spending as of 2018, at the level of the previous year, with the untying of spending from the revenues collected by the Union, culminating in a decrease in the resources available for the SUS[10]. Although the regime preserved the minimum compulsory expenditure on health and education, the corrections to these figures were based exclusively on inflation. This change limited the potential for expanding resources for these sectors in periods of growing tax revenues, which restricted additional investment in health and education.

Studies published at the time showed the losses to the SUS during the possible 20 years that EC 95/2016 would be in force. A technical note published in 2016 by Conass and Conasems already showed the concern of the entities representing state and municipal health managers about the proposal[19].

Box 2.4. Impact on the Union's PHAS expenditure - EC No. 86/2015 versus PEC No. 241/2016 - forecast for the 20 years of its validity

Year	NCR	Federal spending on health (PHAS)								Losses with PEC 241	
		EC 86				PEC 241					
	R$ billion	R$ billion	R$ billion (updated 2016 IPCA)	Share of GDP (%)	Share of NCR (%)	R$ bilhões	R$ billion (updated 2016 IPCA)	Share of GDP (%)	Share of NCR (%)	As a % of the budget calculated by EC 86	In R$ billion 2016
2017	733.2	100.4	95.4	1.51	13.7	97.5	92.6	1.47	13.3	-3.0%	-2.82
2026	1,302.2	195.3	124.8	1.65	15.0	146.0	93.3	1.24	11.2	-25.3%	-31.55
2036	2,465.1	369.8	152.2	1.65	15.0	226.7	93.3	1.01	9.2	-38.7%	-58.89
									Estimated loss 2017- 2036		-654.04

Source: Note on PEC No. 241/2016 - Conasems/Conass[19].

According to the Technical Note, the managers expressed their concern, since freezing federal financial resources for the SUS for 20 years, which is growing year on year according to the needs of the population, was ignoring the constitutional rule that establishes the right to health guaranteed through economic policies aimed at reducing the risk of disease and other illnesses and universal and equal access to health promotion, protection and recovery services.

The proposed measures, once implemented, could lead to a reduction in financial resources of R$654.04 billion over the 20 years envisaged. This would further aggravate the financial asphyxiation that the SUS was going through, since the increase in disinvestment, unemployment and the fall in income itself would force people to seek out the SUS even more[19]. In addition, it was necessary to take into account the natural growth of the population, its greater longevity, as well as the increase in chronic diseases. The demonstrations had an effect: the freeze proposed by EC No. 95/2016 for the health budget only began in 2018, based not on the value of the 2016 floor, but on the value of the 2017 floor, already under the aegis of EC No. 86/2015 (15% of the NCR), which made it possible to increase the value of the calculation base by more than R$15 billion.

In 2021, EC No. 95/2016 was amended again by EC No. 113, of December 8, 2021[20]. Criticism of the unfeasibility of the spending ceiling in the medium and long term has

demonstrated its inefficiency in controlling the growth of public spending. These changes were seen as a way of temporarily relaxing the spending ceiling in response to exceptional situations, such as increased social spending and the payment of court-ordered debt.

EC No. 113/2021 introduced important changes to the spending ceiling, opening up fiscal space in the budget, especially with a view to making it possible to pay social benefits and court-ordered debt, as well as establishing new rules for the management of public spending. One of the main changes was the modification of the calculation of the spending ceiling for the year 2022, taking into account the accumulated inflation from January to December 2021 instead of the period from July to June as the original rule provided. The creation of a special regime for the payment of court-ordered debt, with the possibility of payment in installments and debt negotiation, was also a measure adopted to ease the pressure on the budget and thus the spending ceiling.

Thus, EC No. 113/2021 allowed for an increase in resources for social programs, such as the federal floor for the SUS. Thus, the federal manager's minimum application of PHAS became the value of the minimum for the immediately preceding financial year, adjusted by the IPCA from January to June and estimated from July to December of the year in which the budget was drawn up.

Box 2.5. Statement of the impact of EC No. 113/21 on the federal floor for PHAS funding for 2022 - R$ billion

	EC no. 95/2016	EC no. 113/2021
PHAS Federal Minimum	134,48	139,62
Estimated Increase	5,45	

Source: Own elaboration based on figures from PLOA 2022 SPO/SE/MS; Central Bank of Brazil; IBGE/ME.

However, just one year after the enactment of EC No. 113/2021, EC No. 126 of December 21, 2022 was enacted. Known as the "Transition PEC", it defined, among other things, that the federal spending ceiling rule, created by EC No. 95/2016, would be replaced, by August 2023, by a new framework of fiscal rules, by sending a PLC to the National Congress[21].

In addition, EC No. 126/2022 brought changes to the Federal Constitution with the aim of establishing new guidelines for individual amendments to the Budget Bill (Ploa)

and adjusting the ADCT in order to exclude certain expenses from the limits imposed by the spending ceiling. This amendment also defined specific rules applicable to the transition period of the Presidency of the Republic in the 2023 Budget Law.

Among the main points, EC No. 126/2022 excluded from the spending limit expenses related to socio-environmental projects funded by donations, as well as expenses of educational institutions and scientific innovation funded with their own income or from agreements. In addition, the amendment established an increase of R$145 billion to the spending limit for the 2023 financial year, which made it possible to increase the government's investment capacity in strategic areas.

Another important guideline brought in by EC No. 126/2022 was the determination to send to the National Congress, by August 2023, a PCL that would establish a sustainable New Fiscal Regime. This new regime sought to replace the spending ceiling rule established by EC No. 95/2016 in order to ensure the country's macroeconomic stability and, at the same time, have the potential to create suitable conditions for socioeconomic growth.

The federal Spending Ceiling rule altered the constitutional minimums earmarked for PHAS, and for Maintenance and Development of Education (MDE) actions. Before the New Fiscal Regime introduced with EC No. 95/2016, the Federal Constitution stipulated that the Union should invest a minimum of 18% of its Tax Revenue (RRI) in Education (art. 212, CF) and 15% of the NCR in Health (art. 198, CF)[11]. With the repeal of the Federal Spending Ceiling introduced by EC No. 95/2016, the old floors for Health and Education are back in force (since the changes made by EC No. 95/2016 were in the "transitional" part of the Constitution, the ADCT)[21].

Despite the positive change brought about by EC No. 126/2022, there was still the need for regulation by means of a LC, which was materialized in 2023, by means of LC No. 200, of August 30th, 2023[14]. LC 200/2023 established the sustainable fiscal regime and, in short, repealed articles 106, 107, 109, 110, 111, 111-A, 112 and 114 of the ADCT, which made up the "New Fiscal Regime" established by EC 95/2016.

However, the debate about compliance with the constitutional floor for the year 2023 persisted. Although the spending ceiling amendment was repealed with the approval of the new fiscal framework, with the consequent return of the federal floor on PHAS to the level of 15% of the Union's NCR, demonstrations against the maintenance of minimum spending on health and education began to circulate in the media, on the grounds that they constitute threats to compliance with the new fiscal rule and to the funding of other public policies[22]. On the other hand, even with the wording of EC No. 86/2015, the federal government claimed that the Union would only be under the aegis of EC No. 86/2015 from 2024 onwards.

In addition, in the context of LC 201 of October 24th, 2023, which deals with financial compensation owed by the Federal Government to the other Federation entities, the National Congress approved a provision that changed the way the federal PHAS floor was calculated in 2023[12]. Article 15 of this law determined that, in 2023, the calculation of the minimum application of 15% of the NCR would be based on the revenue estimated in the Annual Budget Law (LOA), and not on the revenue realized during the financial year as was traditionally done. In the LOA 2023, the estimated NCR was R$1.14 trillion, while the revenue realized in the last 12 months, up to August 2023, reached R$1.21 trillion.

In the meantime, the Court of Accounts report accompanying the prior opinion on the annual accounts of the President of the Republic for 2023 addressed the change in tax regimes. In it, it was pointed out that the Minister of Finance formulated a consultation, registered on September 29th, 2023, on the applicability of the minimum funding limits on MDE and PHAS expenses. These limits were calculated according to the general rule established by EC No. 95/2016, which used the IPCA as the correction factor, based on the expenditure paid in 2016. In line with this rule, Law No. 14.535/2023 (LOA 2023) approved the funding of MDE and PHAS in accordance with EC No. 95/2016[23].

The report also clarified that "the annual nature of the budget and financial year cycle prevents an intermediate change in the fiscal regime from causing an abrupt reprogramming of the minimum costs of PHAS and MDE", concluding that "the 2023 financial year remains subject to the fiscal regime in force at the time of the enactment of the 2023 Budget Law" and points to compliance with the constitutional floor.

However, even with compliance with the constitutional floor attested to by the TCU, experts once again point to a reduction in the federal floor. According to Vieira et al.[22], based on the realized NCR, the minimum application on PHAS would be R$181.1 billion, compared to the R$170.8 billion calculated based on the LOA estimate, resulting in a difference of R$10.3 billion.

According to Pinto et al·[24], the Federal Government should prioritize the application of the floors in the 2023 financial year, even if this requires emergency restructuring of the budget. Much remains to be done to improve the quality of the health and education floors, but denying them their constitutionally bound resources is the most abusive way of trapping them in a vicious circle of fiscal precariousness, low social appreciation for the cor- responding public services, increased demand for their private counterparts and deviations that prevent them from achieving their respective sectoral plans[24].

It is worth noting that LC 200/2023 reaffirmed the importance of the constitutional floors for health and education as pillars of public funding. Thus, the debate around the immediate application of the new budget limits exposes the challenges of fiscal balance in the face of social demands, but also demonstrates that fundamental rights, guaranteed by the Constitution, cannot be relaxed in the name of administrative convenience.

2.3 APLICATION OF THE CONSTITUTIONAL MINIMUM BY THE STATES AND MUNICIPALITIES

As mentioned, LC 141/2012 regulated the constitutional floor, establishing that states and the Federal District must allocate 12% and municipalities 15% of their own revenues to PHAS. According to the data (graph 2.2) extracted from the Ministry of Health's Siops page, it can be seen that subnational entities have progressively increased their spending on health, which is reflected in the application of the minimum percentages required by the constitutional floor.

Table 2.2. Percentage of application on PHAS in municipalities by population group

% of Own Resources in Health-EC 29 by Population Group according to Year Period: 2012-2023								
Year	Up to 5,000 hab	From 5,001 to 10.0,00 hab	From 10,001 to 20,000 hab	From 20,001 to 50,000 hab	From 50,001 to 100,000 hab	From 100,001 to 200,000 hab	From 200,001 a 400,000 hab	Above 400,001
2012	19.64	20.75	21.1	21.43	21.91	22.05	22.77	20.99
2013	20.04	21.35	22.08	22.51	23.26	22.94	23.8	21.27
2014	20.77	22.16	22.98	23.37	24.09	24.28	25.01	21.83
2015	20.64	21.85	22.78	23.32	24.43	24.37	25.23	22.66
2016	20.22	21.61	22.54	22.87	24.62	24.84	25.48	24.48
2017	21.58	22.63	23.68	24.01	24.92	24.78	25.33	24.21
2018	20.39	21.63	22.39	22.78	23.91	23.69	24.73	22.55
2019	20.55	21.68	22.46	22.6	23.83	23.7	25.04	22.01
2020	21.56	22.59	23.52	23.61	24.41	24.43	25.47	23.22
2021	20.39	21.83	22.94	23.15	23.75	24.06	24.04	22.3
2022	20.67	22.32	23.17	23.69	24.03	24.28	24.83	23.02
2023	21.54	22.94	23.78	24.42	25.06	25.2	25.42	23.73

Source: Siops/MS, extracted on December 7th, 2024.

Table 2.2 shows that, between 2012 and 2023, all population groups of municipalities applied average percentages of their own resources to health above the constitutional floor of 15%. Smaller municipalities, with up to 5,000 inhabitants, grew from 19.64% in 2012 to 21.54% in 2023. The larger ones, with more than 400,001 inhabitants, reached 23.73% in 2023. The highlight was the 200,001 to 400,000 inhabitants, which showed the highest percentage in 2023, with 25.42%. Despite occasional fluctuations in some brackets, the data confirms consistent compliance with the constitutional floor by all population groups throughout the period.

For the states, table 2.3 shows the percentages of application of the constitutional floor, showing that most Brazilian states have remained in line with the constitutional floor of 12%, with some fluctuations over the years.

Table 2.3. Percentage of state investment on PHAS

3.2 % of Own Resources in Health-EC 29 per Year by state Period: 2012-2023												
State	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Rondônia	12.13	14.28	13.52	14.53	12.89	14.69	13.01	13.02	13.76	13.25	14.23	15.66
Acre	16.31	16.64	17.32	15.37	14.25	15.05	14.23	13.07	14.57	13.2	15.64	15.59
Amazonas	21	22.87	22.21	20.78	22.32	17.81	19.44	16.34	20.62	18.57	20.01	19.3
Roraima	14.16	17.31	12.23	16.03	16.58	18.37	18.21	16.33	12.1	17.06	19.87	17.73
Pará	13.54	13.54	12.97	13.66	13.9	14.9	15.26	13.97	15.46	14.45	13.93	13.92
Amapá	12.54	15.57	13.39	14.08	16.7	12.45	12.93	13.28	19.44	17.75	15.4	19.39
Tocantins	18.48	20.68	21.47	19.17	17.95	18.03	16.46	16.79	15.6	16.51	17.4	18.2
Maranhão	12.45	12.43	13.62	13.49	12.31	14.08	14.46	14.37	15.11	15.67	14.67	15.1
Piauí	11.64	12.74	13.39	13.52	12.31	12.76	12.26	12.06	16.02	14.59	15.59	14.05
Ceará	13.77	13.83	15.76	14.25	13.8	14.65	15.45	13.43	16.54	15.68	16.99	16.44
Rio Grande do Norte	14.15	13.89	13.88	15.2	12.44	12.15	10.56	12.2	14.4	12.69	13.49	12.63
Paraíba	13.45	13.44	13.69	13	12.51	13.66	12.27	12.22	12.4	12.7	12.97	14.45
Pernambuco	15.74	14.96	16.58	16.23	15	16.35	15.35	14.98	16.58	17.21	18.82	17.6
Alagoas	12.06	12.11	12.06	12.95	12.19	12.34	12.16	12.08	12.56	16.27	17.23	13.74
Sergipe	12.77	12.93	12.72	12.4	12.15	12.14	12.32	12.28	12.59	14.5	16.56	15.84
Bahia	12.19	12.02	12.94	12.45	12.26	13	12.05	12.97	13.26	13.31	14.75	15.32
Minas Gerais	12.03	12.29	12.15	12.3	12.38	12.09	10.22	12.75	12.29	12.55	12.16	12.15

Table 2.3. Percentage of state investment on PHAS

3.2 % of Own Resources in Health-EC 29 per Year by state Period: 2012-2023												
State	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Espírito Santo	13.24	15.95	18.53	18.99	18.12	18.75	18.96	17.57	16.9	14.51	15.66	17.19
Rio de Janeiro	12.1	12.04	12.06	12.34	10.35	12.22	12.16	12.05	12.03	12.55	12.84	12.34
São Paulo	12.43	12.43	12.46	12.5	13.19	13.24	13.37	13.32	13.97	12.73	12.85	12.71
Paraná	9.94	11.22	12.29	12.03	12.08	12.07	12.17	12.21	12.96	12.27	12.4	12.29
Santa Catarina	12.14	12.02	12.37	12.87	12.82	13	14.1	12.91	14.63	14.45	15.51	14.79
Rio Grande do Sul	9.71	12.47	12.72	12.2	12.13	12.25	12.16	12.15	12.15	12.19	12.16	12.18
Mato Grosso do Sul	12.06	12.5	12.11	16.67	16.39	18.05	14.17	14.04	14.39	14.31	13.59	12.31
Mato Grosso	12.67	12.58	12.6	13.01	14.12	12.5	12.21	12.18	12.46	13.31	14.63	14.49
Goiás	12.12	11.72	12.7	12.07	12.03	12.09	12.11	12.17	12.78	13.5	13.62	14
TOTAL	13.26	14.02	14.14	14.31	13.97	14.18	13.77	13.49	14.45	14.45	15.11	14.98

Source: Siops/MS, extracted on December 7th, 2024.

States such as Rondônia, Acre, Amazonas, Pará and Pernambuco often have percentages higher than the minimum required, especially in Amazonas, which reached figures above 20% in several years, including 2020 (20.62%) and 2022 (20.01%). Pernambuco also maintained high percentages, ending 2023 with 17.6%. States such as Alagoas, Sergipe and Goiás have shown progress over the period, with increases in the percentage of application, although they have faced some fluctuations in specific years. Sergipe, for example, reached 15.84% in 2023, above the floor.

Among the states that did not meet the constitutional floor at some point are Minas Gerais, which did not reach the minimum in 2018 (10.22%), Rio Grande do Sul, with percentages below 12% in 2012 (9.71%), and Paraná, which presented 9.94% in the same year. The state of Goiás also had critical years, such as 2013, when it reached just 11.72%. On the other hand, states such as Amazonas, Espírito Santo, Pernambuco and Ceará consistently exceeded the constitutional floor, with the highlight being Amazonas, which reached percentages above 20% in several years, such as 2020 (20.62%) and 2022 (20.01%). Espírito Santo stood out for having the highest percentages between 2014 and 2018, reaching 18.96% in 2018, although it showed a gradual drop in the following years, ending 2023 with 17.19%.

The growth in the use of own resources in health highlights inequalities between municipalities and states. Larger municipalities, with greater revenue capacity, maintained consistent growth, while smaller ones faced greater volatility due to financial limitations. Although all municipalities invest more than the 15% constitutional floor, the differences in investment capacity reinforce the need for public policies that promote a more balanced and equitable distribution of resources.

In the states, although the constitutional floor of 12% was largely met, some faced difficulties in maintaining the sustainability of funding, especially in the North and South, which showed marked differences in the percentages applied. These challenges highlight the urgency of strategies to reduce regional inequalities and strengthen public health financing in a sustainable and equitable way.

2.4 FEDERAL TRANSFERS AND HEALTH FUNDS

As already noted, the 1988 Federal Constitution profoundly redefined the public health model in Brazil by consolidating health as a right for all and a duty of the state. This guideline imposed on the public authorities the responsibility for formulating and implementing social and economic policies aimed at reducing the risk of disease and other health problems, as well as health promotion, protection and recovery. In addition, health actions and services were qualified as being of public relevance, subjecting them to state regulation, supervision and control, although indirect execution by private entities was allowed. In this context, the SUS was established, organized in a regionalized and hierarchical manner, based on the principles of universality, political-administrative decentralization, comprehensiveness, gratuity and community participation[11].

The effectiveness of these constitutional principles required the establishment of mechanisms to make decentralized financing of the PHAS viable. Among these instruments, the creation of Health Funds in each levelof government stands out, as budget and management units essential to the management of resources linked to the health sector. The creation of the National Health Fund (FNS), authorized by Decree-Law No. 701 of 1969 and regulated by Decree No. 64.867 of the same year, was a precursor to the institutionalization of this model, which was later consolidated with the promulgation of the 1988 Constitution.

The transfer of financial resources in the FAF modality has emerged as a central mechanism for guaranteeing the administrative decentralization and autonomy of sub-national entities within the SUS. This system allows for the direct transfer of funds from the Federal Government to the State, District and Municipal Health Funds, with

the aim of ensuring consistency, efficiency and adherence to local realities, without the need to formalize agreements to fund ongoing actions.

In terms of their legal nature, the Health Funds are characterized as special public funds, established by specific law, in line with the provisions of the Federal Constitution and Law No. 4.320/1964. These funds bring together revenues linked to the execution of specific objectives, with specific rules for the movement and application of resources[25]. The Manual of Accounting Applied to the Public Sector (MCASP) establishes guidelines for the recognition, accounting and control of income and expenses related to FAF transfers, reinforcing the obligation to link resources and provide transparent and timely accounts[26].

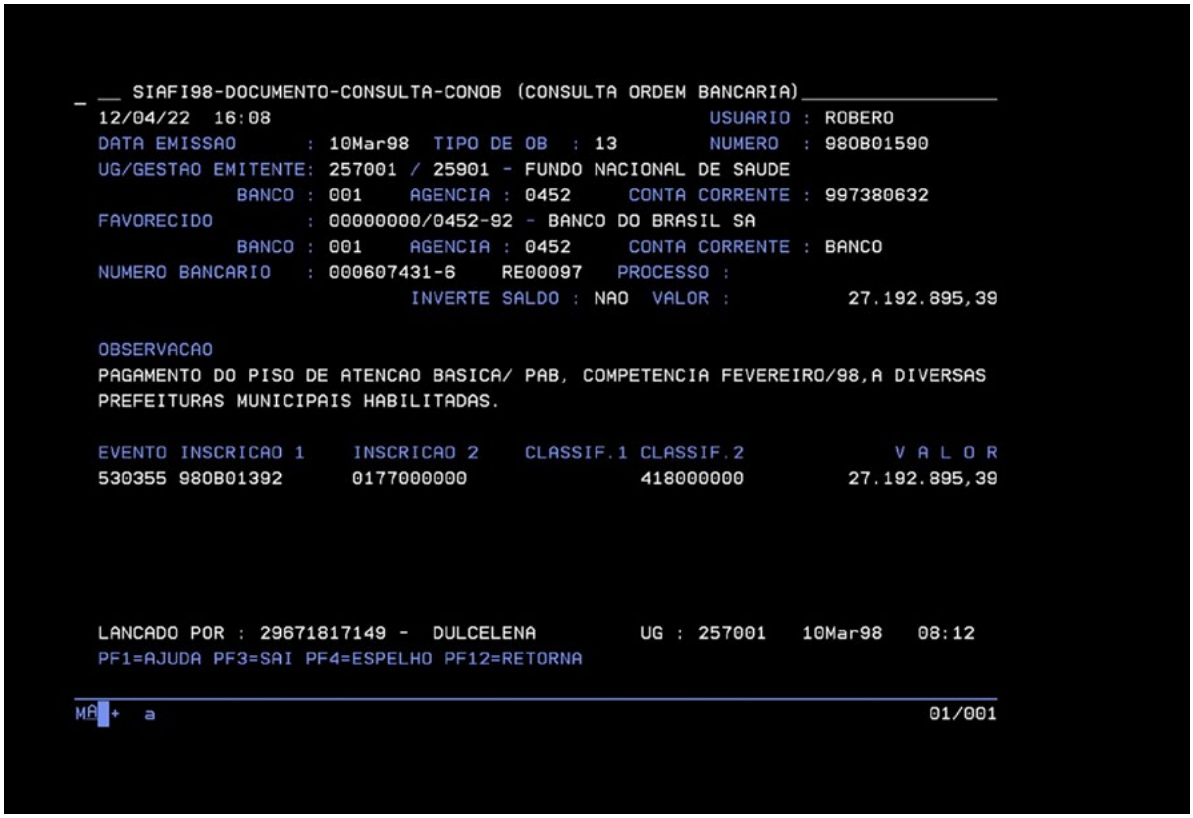
It is important to note that, although they are registered with the National Register of Legal Entities (CNPJ) as parent companies, the Health Funds do not have their own legal personality. This prevents them from carrying out acts typical of autonomous entities, such as signing contracts or entering into legal obligations[26]. Its management is the responsibility of the Health Secretariats, which act as the management unit for the respective resources, and are responsible for planning, executing and accounting for spending.

In order to ensure the regular transfer of funds, the legislation requires the federal entities to comply with specific conditions, such as the formal existence of a Fund of Health, the installation and functioning of a Health Council with equal composition, the preparation and approval of a Health Plan, as well as the production of Management Reports[27,28]. These requirements aim not only to guarantee the technical and administrative capacity of entities, but also to foster social control over the use of public resources.

The definition of the amounts transferred to the FAF complies with objective technical criteria set out in art. 35 of Law no. 8.080/1990 and reinforced by LC 141/2012, which include the demographic and epidemiological profile of the population, the installed capacity of the health services network, the technical, economic and financial performance of the entity in the previous period, among others. These parameters seek to ensure an equitable distribution of resources and the effectiveness of the principle of equity, which is so dear to the SUS.

The first bank order issued in FAF form by the FNS was only issued on March 10th, 1998, when the Basic Care Floor (PAB) was legally transferred to the municipalities eligible for this program.

Figure 2.1. Transfer statement - Siafi - Payment - PAB



Source: SIAFI

With regard to transfer modalities, the FAF system is carried out on a regular basis, with a periodicity previously established in normative acts of the Ministry of Health, and automatically, without the need for formal instruments of adjustment.

Understanding the modalities for transferring resources within the SUS is based on different current regulations, which outline the operational concepts set out below.

The FAF transfer refers to the transfer of financial resources from the FNS to the Health Funds of the states, the Federal District and the municipalities, intended to finance investments in the service network, outpatient and hospital care coverage and other health actions and services. This mechanism is governed by Law No. 8.142/1990, Art. 2, sole paragraph[28]. It should be noted that, in the intergovernmental scenario, it is also possible to make transfers from State Health Funds to Municipal Funds, also using their own resources.

The regular FAF transfer is characterized by periodic and continuous transfers from the FNS to the State, District and Municipal Health Funds, in accordance with previously defined intervals. Transfers also take place from State Funds to Municipal Funds with their own resources, respecting the autonomy of the federative entities.

The automatic FAF transfer, in turn, consists of the transfer of funds from the FNS to the Health Funds of the states, the Federal District and the municipalities, regardless of the need to sign agreements or similar instruments. Similarly, this practice also occurs from state to municipal funds, using their own revenues.

From this conceptualization, it can be seen that the regular and automatic FAF transfer translates into periodic and continuous financial transfers between health funds, without the need to formalize agreements or similar instruments.This guarantees greater speed and effectiveness in the execution of PHAS within the scope of the SUS.

Transfers made by the Union to sub-national entities can be classified as constitutional, legal and voluntary. The constitutional ones derive from the distribution of tax revenues provided for in the Federal Constitution; the legal ones are instituted by ordinary or complementary laws; and the voluntary ones are carried out through agreements or transfer contracts, regulated by Decree No. 11.531/2023, and involve the execution of projects of common interest between the federated entities.

Pursuant to Decree No. 11.531, of May 16th, 2023[29], voluntary transfers of federal funds to other subnational entities can be made through the following instruments:

- The agreement is a legal instrument that, in the absence of specific legislation, regulates the transfer of financial resources from the Federal Fiscal and Social Security Budgets, intended for the execution of programs, projects and activities of mutual interest, under a regime of mutual collaboration between the participants.
- On-lending contracts, on the other hand, are also collaborative in nature, whereby the transfer of financial resources is carried out through an official federal financial institution or financial agent mandated by the Federal Government, which is responsible for the operational execution of the agreement.

The regulatory framework consolidated by LC 141/2012 reinforced the obligation to implement HSAs exclusively through the respective Health Funds and prohibited the imposition of restrictions that compromise the delivery of health resources, except for the requirement of minimum management requirements, such as the existence of a fund, a health council and a health plan. In addition, this legislation determined that the funds

transferred by the Union must be deposited in specific accounts opened with official federal financial institutions, ensuring traceability and transparency in the use of funds.

It is important to note that the management of resources is the responsibility of local health managers and that the Health Fund is not exempt from control by the Courts of Auditors and monitoring by the Legislative Branch, ensuring compliance with the constitutional principles of public administration. The single command provided for in art. 198 of the Constitution and art. 9 of Law no. 8.080/1990 refers to the unity of technical, administrative and financial management within the SUS and does not exclude subjection to inspection and control mechanisms[27].

Thus, the proper structuring and functioning of Health Funds are essential elements to ensure the effectiveness of decentralized financing, transparency in the management of public resources and, ultimately, the promotion of the fundamental right to health for the entire Brazilian population.

As can be seen below, there is a clear difference between FAF transfers and transfers using agreements.

Box 2.6. Transfer methods used for federal transfers

	Transfers by:	
	Fund to Fund	**Agreement**
Legal basis:	Complementary Law 141/2012;	Decree no. 11.531/2023;
Favored:	Health Funds of Subnational Entities;	Health Funds of Subnational Entities; Private non-profit entities;
Conditions:	Health Fund and Health Council up and running; Health Plan drafting;	Be qualified in accordance with current regulations. See Primer for Submitting Proposals to MS 2024 - https://portalfns.saude.gov.br
Features:	Ongoing actions;	Specific projects;
Proof of expenditure:	RREO - Quarterly Budget Execution Summary Report, RAG - Annual Management Report;	PC - Accountability and RAG;
Instruments used:	Health Plan (multi-annual); PAS - Annual Health Program;	Work Plan/Application Plan,

Box 2.6. Transfer methods used for federal transfers

	Transfers by:	
	Fund to Fund	**Agreement**
Deadline for sending proof:	RREO - in May, September and February of each financial year; RAG - by March 30th of the year following financial execution;	In accordance with specific rules, depending on the amount of public funds involved; It is fixed in the transfer instrument;
Approval of Reports:	Health Council of the Subnational Entity, Legislative House of the Subnational Entity.	Ministry of Health.

Source: own elaboration.

The following chronology is important for understanding FAF transfers:

Box 2.7. Regulatory framework for fund-to-fund transfers

Year	Regulatory Framework and Important Facts for Fund-to-Fund Transfers
1964	Law No. 4.320 - Establishes general rules of financial law for the preparation and control of the budgets and balance sheets of the Union, the States, the Municipalities and the Federal District.
1969	Law No. 4.320 - Establishes general rules of financial law for the preparation and control of the budgets and balance sheets of the Union, the States, the Municipalities and the Federal District.
1988	The Constitution of the Federative Republic of Brazil is promulgated;
1990	Law No. 8.080 - Provides for the conditions for the promotion, protection and recovery of health, the organization and operation of the corresponding services and makes other provisions; Law No. 8.142 - Provides for community participation in the management of the Unified Health System (SUS) and intergovernmental transfers of financial resources in the health area, and makes other provisions;
1992	Decree No. 1.232 - Provides for the conditions and form of regular and automatic transfer of funds from the National Health Fund to state, municipal and Federal District health funds, and makes other provisions;
1995	Decree No. 1.651 - Regulates the National Audit System within the Unified Health System;
1998	The first fund-to-fund bank order was issued by the National Health Fund to pay the Primary Care Floor (PAB) to the qualified municipalities;

Box 2.7. Regulatory framework for fund-to-fund transfers

Year	Regulatory Framework and Important Facts for Fund-to-Fund Transfers
2000	Constitutional Amendment No. 29 - Amends articles 34, 35, 156, 160, 167 and 198 of the Federal Constitution and adds an article to the Transitional Constitutional Provisions Act to ensure minimum resources for financing public health actions and services;
2007	Ordinance GM/MS No. 204 - Regulates the financing and transfer of federal resources for health actions and services, in the form of financing blocks, with the respective monitoring and control.
2012	Complementary Law no. 141 - Regulates § 3 of Art. 198 of the Federal Constitution to provide for the minimum amounts to be invested annually by the Union, States, Federal District and Municipalities in public health actions and services; establishes the criteria for the apportionment of health transfer resources and the rules for monitoring, evaluating and controlling health expenditure in the three levels of government; repeals provisions of Laws No. 8.080, of September 19th, 1990, and No. 8.689, of July 27th, 1993; and makes other provisions.
2017	Ordinance GM/MS No. 3.992 - Amends Consolidation Ordinance No. 6/GM/MS, of September 28th, 2017, to provide for the financing and transfer of federal resources for public health actions and services of the Unified Health System.
2022	Normative Instruction of the Federal Revenue of Brazil No. 2119 - Provides for the National Register of Legal Entities (CNPJ).
2024	Tripartite document signed by the Ministry of Health, Conass and Conasems reinforcing governance in the distribution of resources and strengthening the Tripartite Management Commission (CIT) as the regulatory body for transfers (https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:f459292d-d25a-4d25-bd87-1dc327824962).

Source: own elaboration.

Strict compliance with the SUS planning instruments is essential for the correct execution of the funds transferred under the FAF modality. These instruments must be used appropriately, guiding the allocation and execution of public expenditure and revenue in line with the health policy set out in the respective plans and with all the rules applicable to the matter. Respect for this framework ensures integration between planning, budgeting and financial execution, strengthening the transparency and effectiveness of health management.

In September 2024, an important document was signed by the Ministry of Health, Conass and Conasems, detailing strategic aspects for resource management within the SUS. This document reinforces the need for solid tripartite governance, based on a commitment to transparency and shared responsibility in the use of public resources.

Among the points highlighted is the fundamental role of the Tripartite Inter-Management Commission (CIT) as the body that agrees on and regulates the criteria for the distribution of federal health funds, in accordance with the provisions of LC 141/2012 and the guidelines established in TCU Ruling 2.888/2015 of the TCU. The Ruling proposes the integration of financial incentives, with the aim of simplifying transfers and reducing the regulatory burden currently placed on federal entities.

Ordinance GM/MS No. 3.992/2017 is recognized as a milestone in the process of simplifying SUS financing by consolidating resources into just two blocks - funding and investment - giving local managers greater financial flexibility. This structure seeks to make financial execution compatible with Health Plans, Annual Health Plans (PAS) and the respective LOAs, strengthening the link between resources and territorial planning[30].

Also in this context, the document signed in 2024 emphasizes the need for effective integration between parliamentary budget amendments, the Health Plan and the PAS of the federative entities, ensuring that extraordinary financial contributions are aligned with local priorities and the health needs of the population. It also emphasizes the importance of collaborative and strategic governance, promoting not only efficiency in the management of resources, but also increased transparency and social control, which are essential elements for building a democratic and responsive public administration.

It is also necessary to maintain a focus on the continuous improvement of the mechanisms for monitoring, following up and evaluating the implementation of resources transferred in FAF mode. Transparency vis-à-vis society and control bodies is an indispensable condition for definitively consolidating this financing model, overcoming any misconceptions that still confuse regular and automatic transfers with the agreement system.

In view of the above, the Health Funds are strategic instruments for managing the resources earmarked for financing PHAS at all levels of government. Their importance transcends the merely operational dimension, as the funds also play a central role in sectoral planning by allowing managers to have an integrated and accurate view of the resources available, the expenses incurred and the income earned, including those from financial investments. At the same time, the Health Funds strengthen the control and accountability of public health management, essential pillars for the effectiveness of the fundamental right to health in Brazil.

2.5 HEALTH PUBLIC BUDGET INFORMATION SYSTEM

Siops is a computerized system developed by the Ministry of Health with the aim of collecting, consolidating and making available accounting data on revenues and expenditure on PHAS from the three levels of government. Its main purpose is to guarantee transparency and compliance with the legal rules that determine the minimum application of resources to health, as established by LC 141/2012[13]. The system is an important instrument of transparency, which aims to guarantee the proper application of public resources in the area of health.

Through it, it is possible to monitor the budget execution of states and municipalities, identifying possible irregularities and opportunities for improvement in the management of resources. Siops contributes to strengthening the planning and evaluation of public health policies, allowing for greater effectiveness and efficiency in the use of available resources. As such, it is the database used in this study, which carries out a detailed analysis of the fiscal and operational impacts of spending on PHAS in Brazil.

Siops[31] timeline:

- Until 1990 - lack of monitoring, control and transparency mechanisms or consolidated information on the resources invested in the SUS.
- 1994 - The Attorney General's Office (PGR) opened two Public Civil Inquiries (No. 001/94 and No. 002/94) in order to develop a system to consolidate data and information on public health spending in the SUS.
- 1996 - The process gained momentum at the 10th National Health Conference with a partnership between the National Health Council, DataSUS and the Public Prosecutor's Office.
- 1999 - Interministerial Ordinance No. 529, of April 30, 1999, can be seen as the legal framework for the creation of Siops. Joint teams from the Ministry of Health and the PGR began the project to implement Siops, including a study of the rules for budgeting the health sector within public accounts.
- 2000 - EC No. 29/2000 determines minimum percentages to be invested on PHAS for the three levels of SUS management, highlighting the need for a data and information system.
- 2003 - Resolution No. 322/2003 presents new guidelines for the application of EC No. 29/2000, including the definition of the calculation basis for the min-

imum resources to be invested on PHAS and the urgency of instruments for monitoring, supervising and controlling the data reported.

- 2004 - Joint Ordinance No. 446/2004 established the system's control bodies, such as the technical guidance and evaluation chamber and the state Siops support center, further strengthening governance over public health resources in Brazil.
- 2008 - As of Interministerial Ordinance No. 127/2008, Siops is now verified by the Single Registry of Agreements (Cauc), an auxiliary information service for voluntary transfers from the National Treasury Secretariat, with regard to compliance with the minimum limits for the application of resources to health.
- 2012 - LC No. 141/2012, supplemented by Decree No. 7.827/2012, made it compulsory to feed Siops.
- 2013 - Ordinance No. 53/2013 of the Ministry of Health established updated guidelines for the operation of the system.
- 2017 - Consolidation Ordinance No. 1 of the Ministry of Health incorporated Ordinance No. 53/2013 and began to regulate the current Siops rules.

The system seeks to serve a wide range of purposes, including centralizing financial records related to public health, providing inputs for planning and formulating public policies, and promoting transparency through public access to information. Siops also plays a crucial role in standardizing accounting information between the federative entities, allowing a consolidated view of public spending on health and the preparation of detailed diagnoses of the sector. It also presents financial indicators that allow the population to know the amounts invested in health by each state.

Interoperability is another key element of Siops. The system is integrated with platforms such as Cauc and DigiSUS Gestor, allowing the exchange of financial and administrative information between different databases. This integration seeks to strengthen the planning and execution of public policies, facilitating oversight by control bodies.

Digital certification is a mandatory requirement for the operation of Siops, guaranteeing the security and authenticity of the information transmitted. This measure ensures that only authorized users, such as health managers, can approve the data in the system. The lack of approval or non-compliance with the minimum percentage of application on PHAS entails penalties such as the suspension of constitutional and voluntary transfers, which reinforces the need for strict compliance with the rules.

Although Siops is an indispensable tool for budget management of the resources that finance the SUS, the system still faces challenges that need to be overcome in order to achieve greater efficiency, reliability and strategic use. Improvements in technical training, integration with other systems and simplification of processes could help to mitigate these limitations and further strengthen the role of Siops in SUS management. Despite its relevance as a monitoring and transparency tool, this system faces some limitations that can impact its performance.

Within the scope of this study, some limitations were observed both in the extraction of data and in the operation of the system. These observations result from the analysis of the data used to prepare this publication, taking into account the technical, operational and regulatory aspects that make it difficult to fully and accurately consolidate the data related to public health budgets.

One of the main limitations observed was the lack of criticism in the process of reporting accounting data; as the system is declaratory in nature, its quality and reliability are directly linked to the accuracy of the data entered. Discrepancies in accounting classification, filling errors or delays in approval can compromise the reliability of the information, hindering consistent and reliable analysis. Even though the system applies penalties in cases of non-approval, such as the suspension of constitutional and voluntary transfers, inconsistencies were still found in the data of some subnational entities. Another critical point is the technical complexity associated with filling in and transmitting the data. The system requires detailed knowledge of accounting and financial rules, which can create difficulties for managers, especially in municipalities with less technical capacity.

In addition, Siops faces limitations related to the monitoring of specific income and expenditure. Although it is efficient for consolidating general data on health budgets, there are difficulties in capturing all the sources of funds or the details of some financial applications. This may be due to the incorrect classification of expenses or the lack of standardization between federal entities. Another limitation is the system's low use as a strategic planning tool. Even though Siops provides valuable inputs for formulating public policies, most managers still use it primarily to comply with legal obligations, such as proving minimum spending on health, rather than exploiting its analytical potential for planning and managing resources more efficiently.

There is no doubt whatsoever that Siops is an essential tool for managing public health financing in Brazil. It not only fulfills a regulatory role by ensuring the application of minimum resources to health, but also promotes transparency, social control and administrative efficiency.

HEALTH ACCOUNTS FROM A STATE PERSPECTIVE 3

This chapter presents a diagnosis of the income and expenditure of the PHAS carried out by the states and the Federal District. This analysis represents the final link in a chain of activities that included several meetings with Siops' technical staff, visits to two State Health Secretariat-SES (Rio Grande do Norte and Rio Grande do Sul), and the application of an online questionnaire to state health managers.

The main contribution of this project is the detailed analysis of the integration of the functional and expenditure group perspectives, implemented by Siops as of 2018, as well as presenting an overview of the regional situation regarding the financing of PHAS. In our view, this project is a first step towards the SES having a more in-depth view of resource allocation. It is worth mentioning that the central diagnosis was validated by the managers consulted. We also carried out an online survey, which 23 Health Secretariats took part in, in order to find out more about how the states feed and use the data made available to Siops. Our aim is to broaden the debate on the existing bottlenecks in the application and execution of resources dedicated to the PHAS at state level.

The diagnosis of spending on PHAS was based on revenue and expenditure data, analyzing in detail the allocation of resources according to subfunction, the source of revenue, the interaction between the two levels, and spending by economic category. The critical examination of the Siops accounts, necessary to certify the conformity of the information made available by the system, has brought us the challenges pointed out in chapter 2. As far as state accounts are concerned, we have decided to present most of the information aggregated according to the region and population size of the state.

This chapter has three sections. The first focuses the analysis on the revenue that the states have to provide the health services they are responsible for. The second exposes the profile of spending on PHAS according to subfunction, the source of revenue, the interaction between both levels; and by economic category. The third section summarizes the analysis and makes specific recommendations for improving the financial management of the states' health budgets. We end the chapter by presenting the results of the survey carried out with the Health Secretariats at the end of 2023.

3.1 STATE REVENUES

In order to analyze spending on PHAS, it is necessary to evaluate the available revenue that each state has to carry out this expenditure. Due to the economic and social diversity of the national territory, we are faced with different levels of own revenue generation. As different fiscal capacities impact both the supply of health services and the potential for investment with own resources, this analysis is crucial if we are to take into account the limitations of resource allocation choices.

We analyzed the revenues accounted for in the public health budgets of the states. Siops data provides information for four revenue phases. In addition to the revenue initially budgeted, the system provides the revenue realized in three phases: Gross; Net and that referring to the basis for calculating the percentage of application on PHAS. This study used **Realized Net Revenues**, focusing on two aggregates:

I. Tax revenues

II. Transfers

We ended by answering the question "What is the value of the total resources available for health in the states?".

3.1.1 TAX CAPACITY

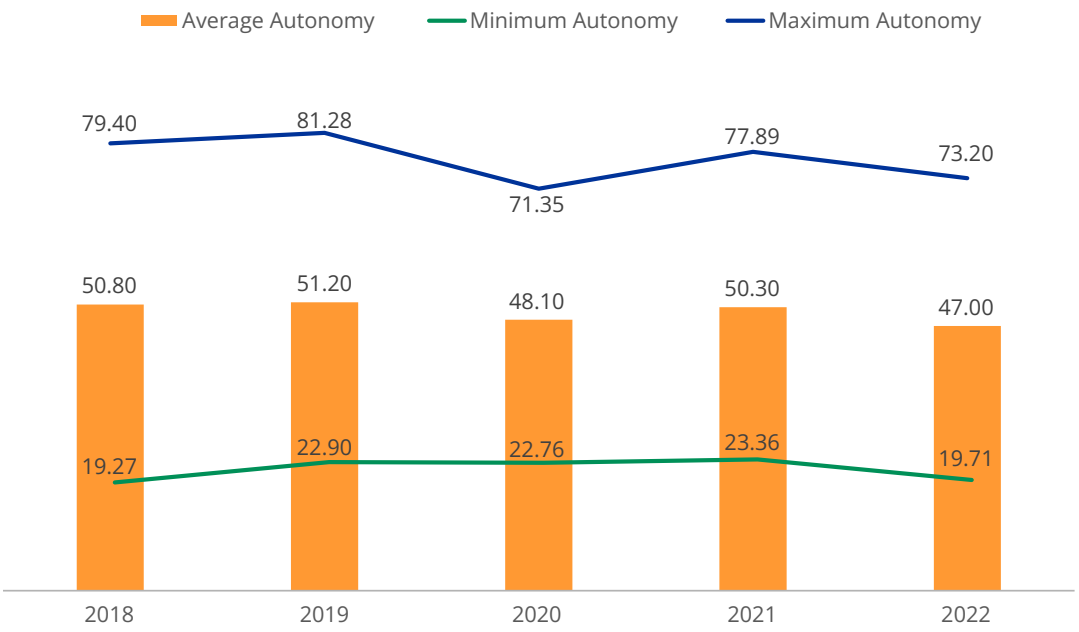
In the context of the reduction in the federal government's share of health spending, autonomy in obtaining resources has become of fundamental importance for maintaining the system's services in each of the states. The calculation of fiscal capacity refers to the proportion of tax revenue (taxes, fees and contributions) in total current revenue. In general, graph 3.1 shows that during the period from 2018 to 2022, the fiscal autonomy of the Brazilian states remained relatively stable at around 49.5%.

This means that for every R$10 in revenue, approximately R$5 came from self-taxation. In this context, we consider the FPE to be a transfer, as its collection is outside the direct management of the state[II]. Graph 3.1 shows that the fiscal capacity of the states was not only greater in 2018, but also more stable until 2019. From 2020 onwards, the average range becomes more volatile.

II The FPE is a federal transfer to the states and the Federal District, the purpose of which is to equalize the fiscal capacity of the states. It transfers 21.5% of income tax and IPI revenue to the states.

It is known that the occurrence of the covid-19 pandemic in 2020 was an important specificity that affected the dynamics of SUS resources. Initially, this event reduced the autonomy of the states in 2020 due to a drop of 2.61 percentage points (pp) in average tax revenue compared to 2019 and, consequently, a relative increase in the weight of transfers from the Union.

Graph 3.1. Average autonomy of Brazilian states (%)



Source: own elaboration based on Siops.

Although the drop in real tax revenue in 2020 was practically generalized, we can still see that nine states (concentrated in the North and Central-West regions) showed an increase in this resource. On the other hand, in 2021, real revenue from taxes, fees and contributions grew by an average of 13.4 pp compared to the previous year. This increase in tax revenue observed in 2021 occurred in all states without exception.

In addition to the average autonomy, Graph 3.1 shows the minimum and maximum autonomy recorded each year. There is great inequality between the states in their ability to generate their own revenue. Table 3.1 shows the lower and upper limits of each region's average degree of autonomy for the period from 2018 to 2022. You can see that the maximum limits of autonomy in the North and Northeast (48% and 52.8% respectively) are below the lower limit of autonomy observed in the other regions. As expected, the state of São Paulo has the highest proportion of tax revenues in relation to

current revenues, and no other state exceeds the 70% autonomy threshold. Among the other states, 13 have a degree of autonomy below 50% (North and Northeast regions); and the other 13 are distributed in the 50.2% to 69.9% range (Southeast, South and Central-West regions).

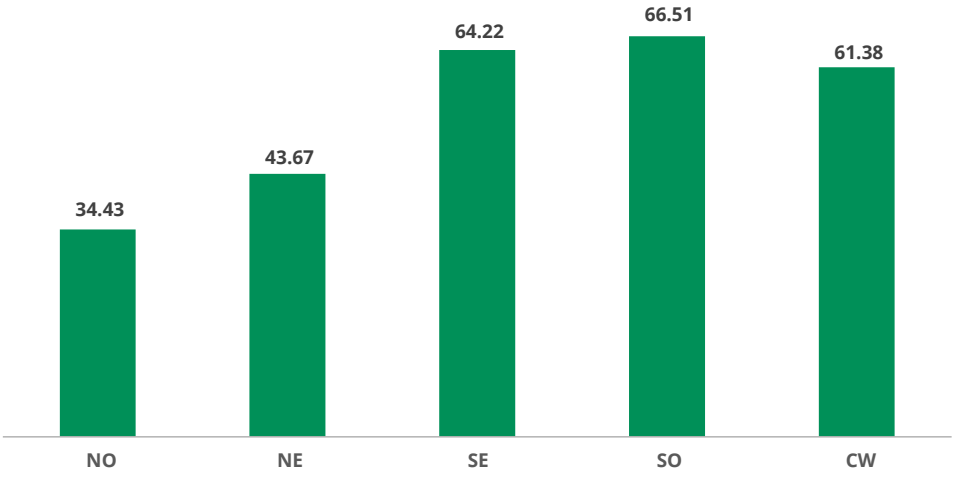
Table 3.1. Minimum and maximum levels of autonomy by region

Region	Average autonomy 2018-2022		State	Max-Min difference	Intraregional inequality
North	Smaller	22.9	Amapá	25.1 pp	1º
	Larger	48.0	Pará		
North East	Smaller	35.7	Sergipe	17.0 pp	3º
	Larger	52.8	Bahia		
South East	Smaller	56.2	Rio de Janeiro	20.4 pp	2º
	Larger	76.6	São Paulo		
South	Smaller	61.1	Paraná	8.8 pp	5º
	Larger	69.9	Santa Catarina		
Central-West	Smaller	55.6	Mato Grosso	13.4 pp	4º
	Larger	68.9	Goiás		

Source: own elaboration based on Siops.

Graph 3.2 shows the average level of fiscal autonomy in each region. The division between above and below 50% is clear, demonstrating the susceptibility of the North and Northeast regions to their own revenues and, consequently, a greater dependence on federal transfers.

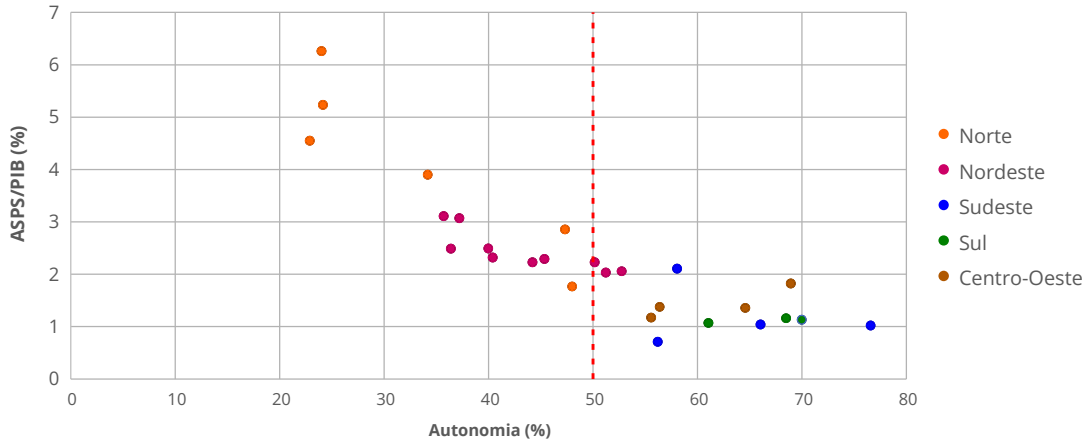
Graph 3.2. Autonomy of geographical regions (%). Average 2018-2022



Source: own elaboration based on Siops.

In addition to the difference between regions, we also have a not insignificant inequality within each region. Graph 3.3 contrasts the proportion of spending on PHAS by GDP for each FU with its degree of autonomy. All the states in the northern regions are below 50% and have a higher expenditure on PHAS in relation to GDP than most of the other states. In the case of the Northeast, only the states of Ceará, Pernambuco and Bahia are able to generate at least 50% of current revenue through their own taxation.

Graph 3.3. Autonomy of geographical regions (%). Average 2018-2022

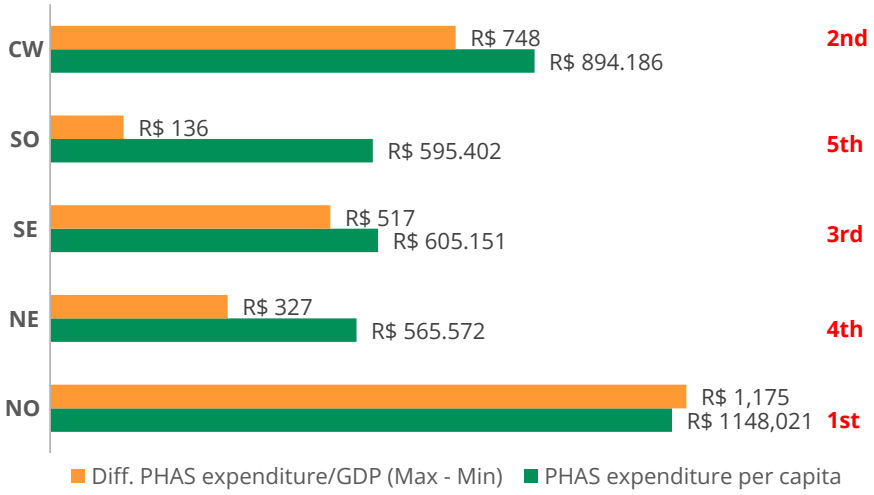


Source: Siops and Finbra.

In parallel with the ranking according to degree of autonomy, it can be seen that the greatest inequality between the states in terms of degree of autonomy, as well as in the PHAS/GDP ratio, occurs in the North. At each extreme, we have Acre (with the lowest levels of autonomyIII[III] and the highest PHAS/GDP) and Pará (with the highest autonomy and the lowest PHAS/GDP). The Southeast is the region with the second highest level of internal inequality in terms of autonomy, since the high fiscal capacity of the state of São Paulo widens the discrepancy between the region's states. The South is the region with the greatest equality, with a difference of just 8.8 pp between the lowest and highest levels of autonomy.

Since revenue autonomy guarantees more mechanisms for maintaining health spending, regions that are more unequal in this regard show a greater discrepancy in per capita PHAS spending. This view is confirmed by graph 3.4, in which greater and lesser inequality in the degree of autonomy (North and South regions respectively) correspond precisely to greater and lesser differences in average spending on PHAS per capita for the 2018-2022 period.

Graph 3.4. Real PHAS expenditure per capita (R$). Average 2018-2022

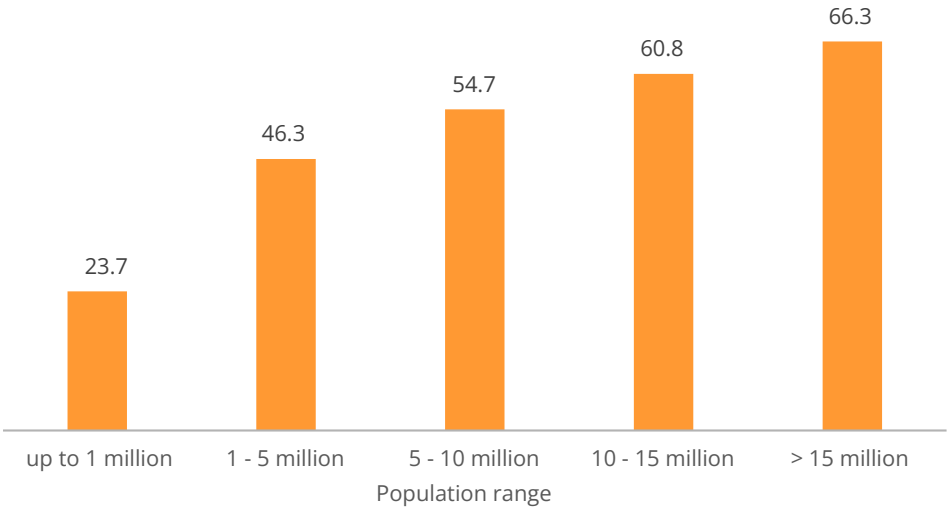


Source: own elaboration based on Siops.

As autonomy depends on the state's ability to raise tax revenue, it is natural that the more populous states - and consequently more dynamic (economically) - are more independent in generating their own revenue. Graph 3.5 shows exactly this relationship: the degree of autonomy increases with the (population) size of the state.

III The three states with the lowest level of autonomy in the North are: Amapá (22.9%); Acre (24%) and Roraima (22.2%).

Graph 3.5. Average autonomy of Brazilian states by population group (%)



Source: own elaboration based on Siops.

Table 3.2 shows the distribution of states according to population size. It should be noted that the lowest degree of autonomy in states with up to 1 million people is concentrated in the North[IV]; while the opposite extreme refers to the three most populous states in the Southeast[V].

Table 3.2. Distribution of states by region according to population size

Region	Millions of people in the state				
	up to 1	1 – 5	5 – 10	10 – 15	> 15
North	3	3	1		
North East		5	3	1	
South East		1			3
South			1	2	
Central-West		3	1		
Total of states	3	12	6	3	3

Source: own elaboration based on IBGE

IV Acre, Roraima and Amapá.

V Minas Gerais, São Paulo and Rio de Janeiro.

This intrinsic difference in collection capacity between the states means that the transfer mechanism plays a role in equalizing inequality. Next, we analyze the behavior of resources from transfers.

3.1.2 REVENUES WITH TRANSFER

Transfer revenues include amounts originating from inter-governmental resources, private institutions, abroad, agreements and individuals. At the state level, the most important transfers are those from the federal government (FAF, agreements, transfer contracts and terms of cooperation). However, given that in the case of the states, average fiscal autonomy is high, transfers are not the main source of revenue for most states. Here, we take the percentage of federal transfers in relation to current revenues as an indicator of the link that each state has with the federal government in order to implement PHAS in its territory. The greater the autonomy, the lesser the link and vice versa. In this calculation, we include the FPE.

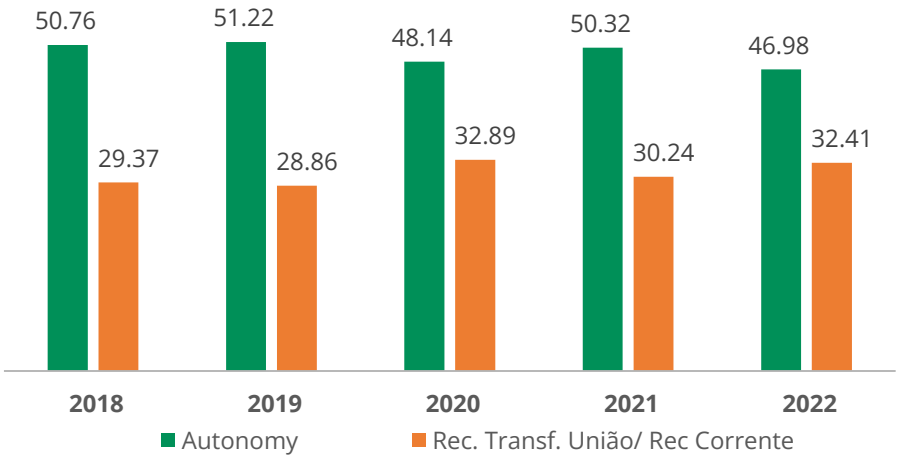
$$Federal\ Gov.\ link\ (\%) = \frac{Union\ Rev.\ Transf.}{Current\ Revs.}\ X\ 100$$

Given that the degree of autonomy and the link to the federal government are complementary, the dynamics of the latter go in the opposite direction to that observed for the degree of autonomy. However, unlike tax resources, the change in the Siops accounting calculation structure (which took place in 2021 and 2022) affected the aggregation of revenue from current transfers.

Until 2020, funds from agreements had a separate accounting account from constitutional transfers (Union, states and municipalities). However, the change in accounting codes implemented as of 2021 incorporated these amounts into each entity's transfers. For this reason, the amounts of federal transfers for the years 2021 and 2022 should be analyzed with caution, since they include amounts from agreements made by the federal government and its entities with the states[VI]. As such, these figures are not directly comparable with those obtained in the previous period (2018-2020).

VI These agreements, which were previously broken down into a separate account ("Transfers from Federal Government Agreements and their Entities" - 1.7.61.00.00.00) relate to Federal Government Agreements for the SUS system, or those for Education or Basic Sanitation programs - which, as of 2021, may be incorporated into "Transfers from the Federal Government and its Entities". In addition, the "Transfers from Individual Parliamentary Amendments" account, which until 2020 was broken down (1.7.21.38.00.00) and included in the "Transfers from the Union" account (1.7.21.00.00.00), was eliminated. As a result, funds from this source are now accounted for in a dispersed manner between the codes, making it difficult to compare the accounts over time.

Graph 3.6. Autonomy and links with the federal government. States average (%)



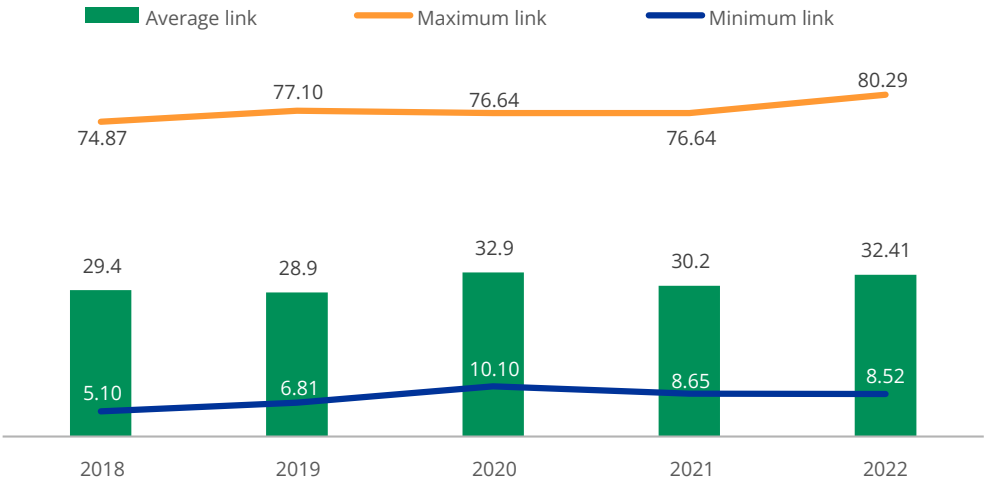
Source: own elaboration based on Siops.

Graph 3.6 shows that the average share of revenue from federal transfers in the states' current revenue between 2018 and 2022 was 30.8%[VII]. The average share of federal transfers to the states in current revenue between 2018 and 2020 is 30.4%, but for the 2021-2022 period it will reach 31.3%, with growth concentrated on 2022. It can be seen that the variation in ties with the federal government between these two periods increased considerably in seven states[VIII], where the growth was over 10%. It is worth mentioning that the sum of the share of tax revenue (autonomy) and federal transfers does not account for 100%, as there are also funds from private institutions, from abroad, from individuals and from agreements, the latter being the most relevant.

VII With the exception of 2020 (covid-19), the increase in the link to the federal government after 2020 refers to the change in the calculation of the participation of Agreements (change in the accounting structure in Siops).

VIII They are: Amazonas, Pará, Ceará, Pernambuco, Bahia, Rio de Janeiro and Mato Grosso.

Graph 3.7. link to the federal government. Average for Brazilian states (%)



Source: own elaboration based on Siops.

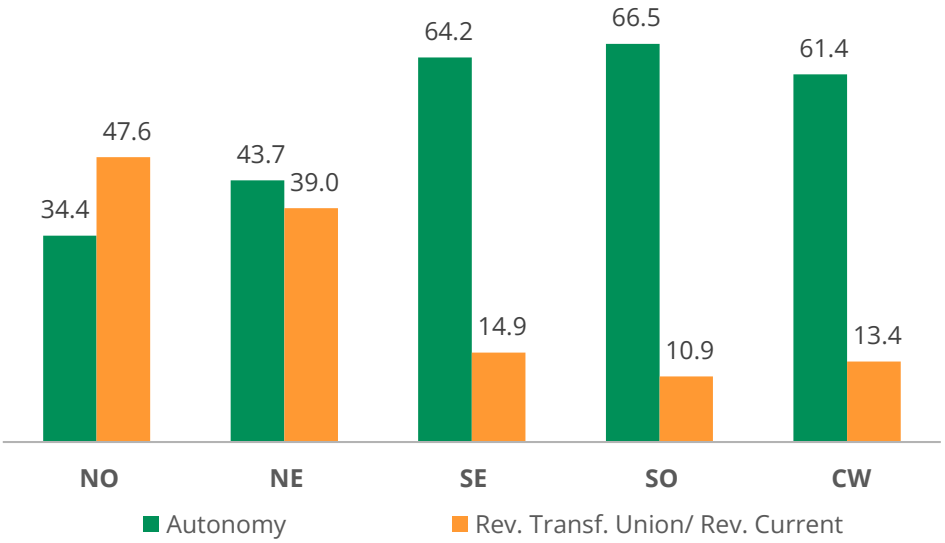
Graph 3.7 shows the average share of federal transfers in current revenue. We can see that the level of around 31% seen in the period was driven by two specific years: the year of the pandemic (2020) and the election year (2022). In 2020, the average growth in the share of federal transfers in current revenue (around 24.8%) affected practically all the states[IX]. On the other hand, the specificity of the increase observed in 2022 (concentrated in specific states[X]) leads us to assume that the change in the accounting calculation affected the trajectory of each state differently (depending particularly on the size of specific resources such as covenants, on-lending contracts and terms of cooperation).

The complementarity between own revenues and federal transfers in each region is shown in Graph 3.8. This ratio shows that, between 2018 and 2022, of every R$1 in revenue, almost half (R$0.50) comes from own taxation, and another R$0.30 comes from taxation for which the federal government is responsible. The amount of R$0.20 needed to complete R$1 corresponds, for the most part, to agreements. Since the northern region has the lowest level of fiscal autonomy, this region has the highest share of federal transfers in current revenue (47.6%). At the other extreme, the South has the highest level of fiscal autonomy and the least ties to the federal government (11%).

IX The exceptions were Amapá, Sergipe and Mato Grosso, which showed no growth in the share of federal transfers in relation to current revenue in 2020 compared to 2019.

X Between 2021 and 2022, the states of Pernambuco, Alagoas, Bahia and São Paulo showed an increase in resources coming from the Union above the increase in their respective tax revenues. In the case of São Paulo, despite the high degree of autonomy, transfers from the Union in 2022 reached nominal values very close to those verified in the year of the pandemic (31 million in 2022 and 33 million in 2020).

Graph 3.8. Evolution of autonomy and ties with the federal government (%) by region. Average 2018-2022



Source: own elaboration based on Siops.

While graph 3.8 shows how the importance of federal transfers differs between the regions, table 3.3 shows the difference between the states with the least and most ties to the federal government. It can be seen that due to the interdependence of the share of tax revenues and transfers from the federal government in the composition of revenues, the position of each region in terms of intra-regional inequality of fiscal ties with the federal government is identical to that observed in table 3.1. Thus, regions with an unequal share of tax revenue in relation to current revenue will also be unequal in terms of the share of transfers from the federal government[XI]. In the case of the Southern region, the states with the maximum and minimum levels in each case (autonomy and fiscal ties with the federal government) simply swap positions.

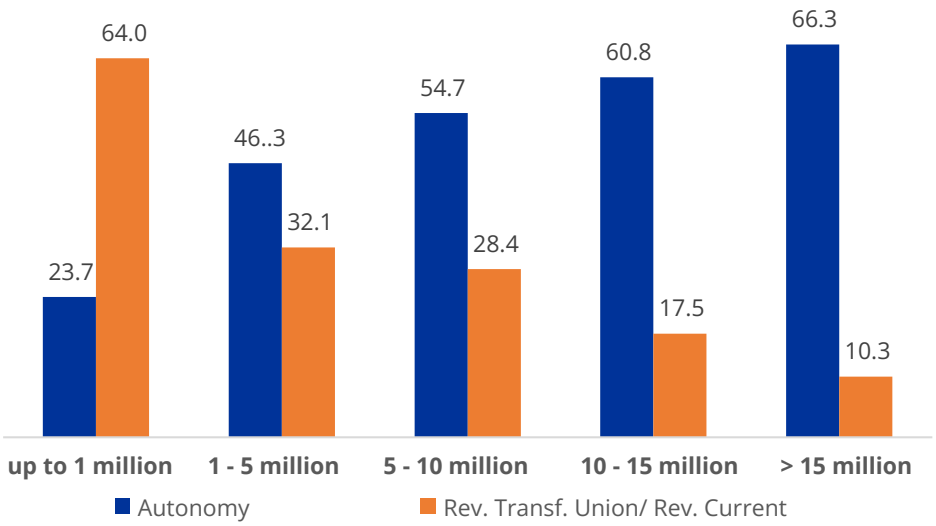
XI And the opposite (greater equality) is also true.

Table 3.3. Ratio of the highest and lowest levels of employment with the federal government by region

Region	Link to federal government average 2018-2022		State	Max-Min difference	Intraregional inequality
North	Smaller	24.5	Amazonas	52.6 pp	1º
	Larger	77.1	Amapá		
North East	Smaller	29.6	Bahia	16.4 pp	3º
	Larger	46.0	Maranhão		
South East	Smaller	8.0	Rio de Janeiro	20.9 pp	2º
	Larger	28.9	Espírito santo		
South	Smaller	9.8	Santa Catarina	3.1 pp	5º
	Larger	13.0	Paraná		
Central-West	Smaller	11.8	Distrito Federal	4.2 pp	4º
	Larger	15.9	Goiás		

Source: own elaboration based on Siops.

Graph 3.9. Autonomy and link to the federal government (%) by population size - Average 2018-2022



Source: own elaboration based on Siops.

The association between link to the federal government and population size is another dynamic that is symmetrically opposed to that observed in relation to the degree of autonomy. Graph 3.9 shows how the relevance of federal transfers in Current Revenue decreases as the population size of the state increases, precisely because it increases the possibility of obtaining its own resources (autonomy).

It can be seen that the greatest dependence on transfers from the Union occurs in states with populations of up to 1 million people, which are located in the North (table 3.2) - Acre, Roraima and Amapá. In population terms, we are talking about a total of 2.3 million people, or 1.1% of the Brazilian population.

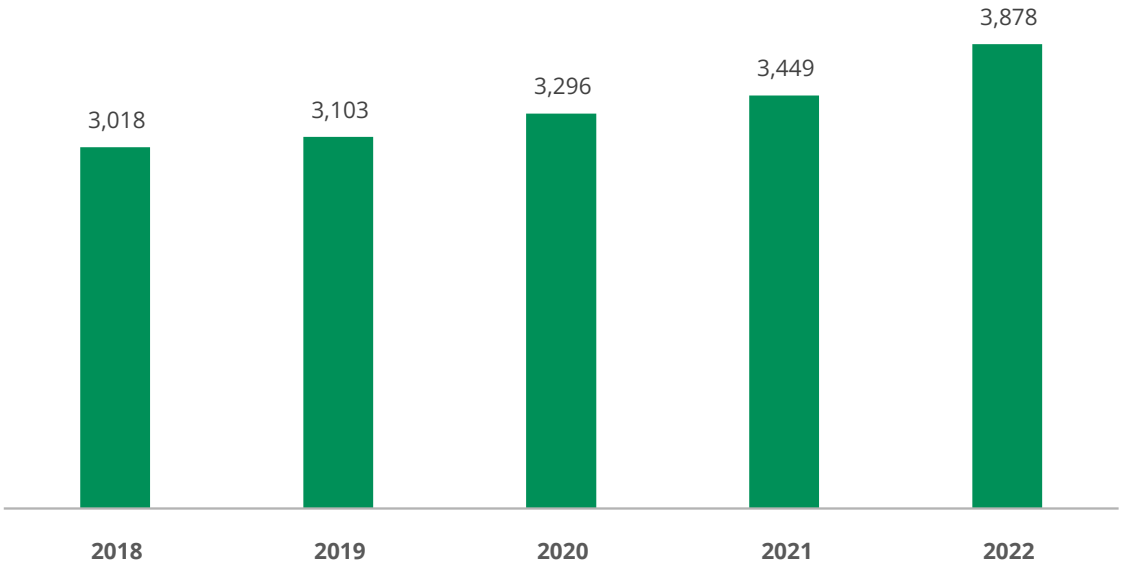
After all, how much money is available for health in the states?

In order to check the total resources available for spending on PHAS by the states, we added up tax revenues and all transfers (federal, state and municipal). It is worth mentioning that although the average share of transfers between states, and from municipalities to states, is very low, they were included in the calculation[XII]. From this sum, we obtain the real value of "available resources per capita" by dividing this amount by the population of each state and deflating by the IPCA of Jan./2023.

Graphs 3.10 A, B and C show that the average available resources per capita for the 2018-2022 period was R$3,349, and that over these five years there has been a 28.5% increase in these figures in real terms. In addition, the North and Northeast regions have the highest and lowest resources average per capita available (R$ 4,755 and R$ 2,616 respectively). If we look at the distribution of states according to population size (table 3.2), we can see that the high amount of resources available per capita in states with a population of up to 1 million is due to the fact that this group includes only states in the Northern region. As for the group of states with a population of between 5 and 10 million inhabitants, since half of these States are in the region with the lowest per capita resources (Northeast), the average ends up being biased downwards.

XII The average proportions correspond to 0.7% and 2.8% for transfers between states (1.7.22.00.00.00); and from municipalities to state (1.7.23.00.00.00) respectively. In the case of the share of revenue from municipal transfers in relation to current revenue, Siops data shows a significant drop between the 2018-2020 period (1.8%) and 2021-2022 (4.2%). We credit this difference to the change made to the RREO calculation structure (Joint STN/SOF Ordinance No. 20, of 02/23/2021) with regard to transfers from agreements, on-lending contracts and cooperation terms between states and municipalities.

Graph 3.10 A. Resources available per person (R$) - real values (Jan./2023) - states average

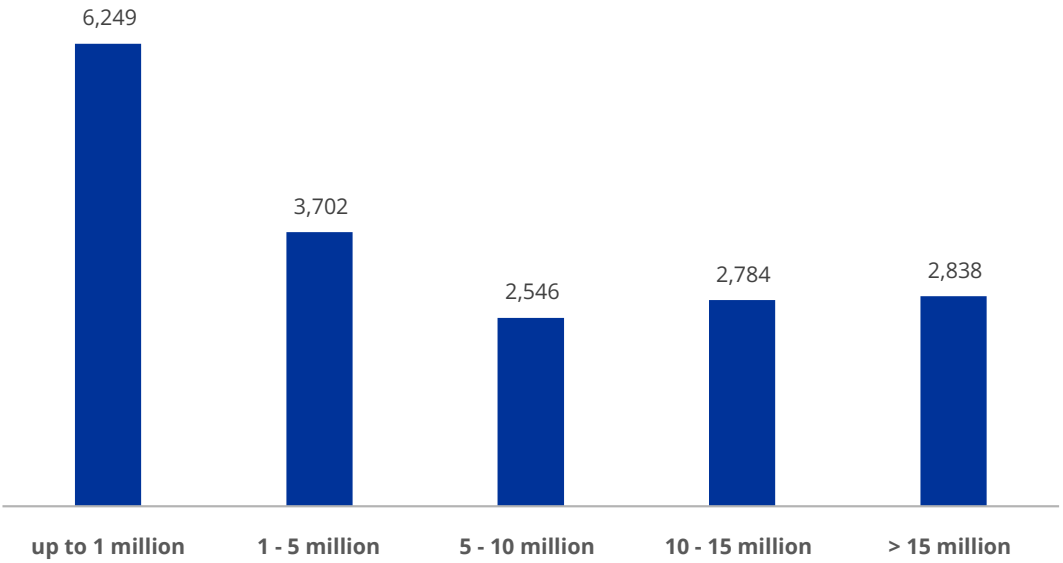


Source: own elaboration based on Siops.

Graph 3.10 B. Resources available per person (R$) - real values (Jan./2023) - average of states by region

Source: own elaboration based on Siops.

Graph 3.10 C. Resources available per person (R$) - real values (Jan./2023) - average of states, according to population size

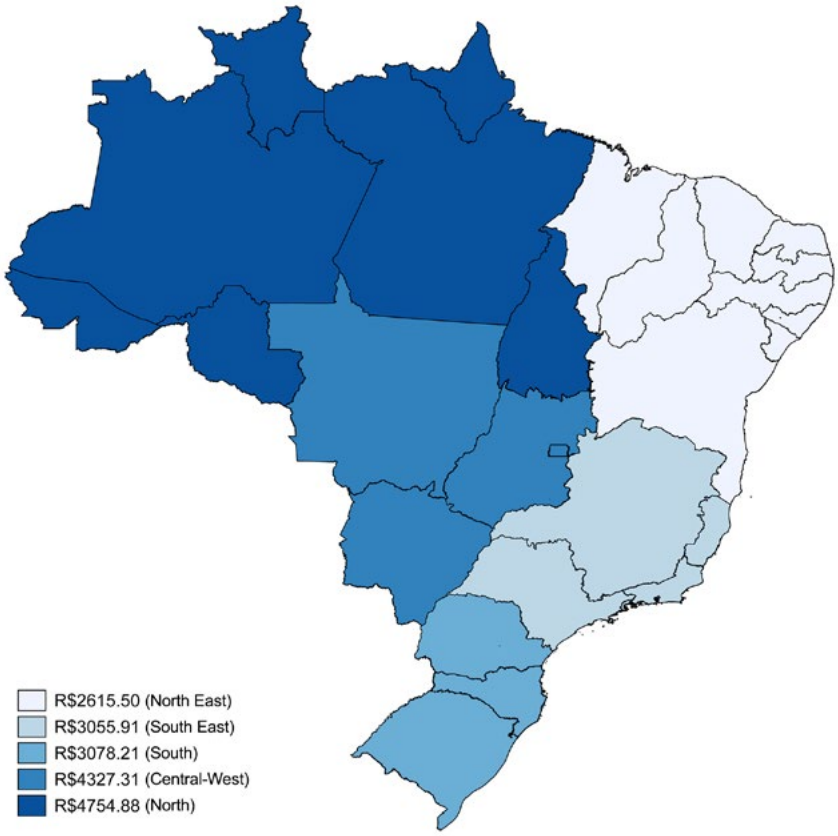


Source: own elaboration based on Siops.

The distribution of resources per capita by region (graph 3.10 B) shows that the resources available per capita in the Northeast (R$ 2,616/inhab.) is approximately half (55%) of the average per capita value in the North (R$ 4,755). When analyzed in terms of population, we see that the per capita resources in states with a population of between 5 and 10 million inhabitants is 59.2% of the average amount in states with a population of up to 1 million people. Maps 1A and 1B show the distribution of resources per capita by region (1A) and by state (1B)[XIII], reflecting the heterogeneity of economic and population growth.

XIII The average real values for the period 2018-2022 by state.

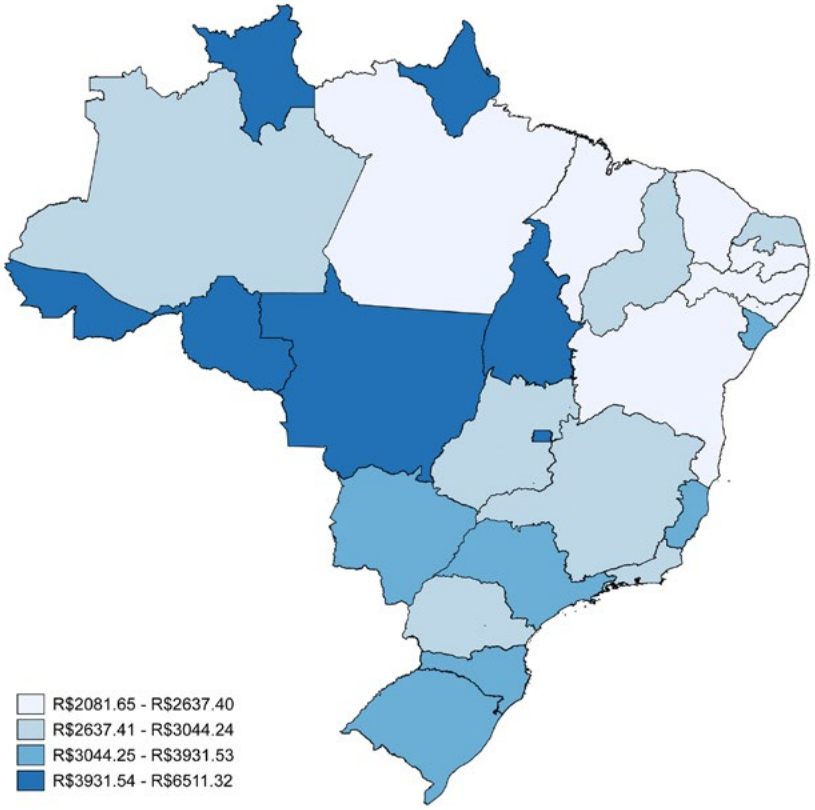
Map 1A. Resources available per person (R$) - real values (Jan./2023) - average 2018-2022 - by region



Source: own elaboration based on Siops.

Given that between 2018 and 2022 the national average of available resources per capita is R$3,530/person, map 1A shows that only the averages for the North and Central-West regions are above this amount. It's worth mentioning that the Central-West average is driven by the Federal District's resources, which are the third highest in the country (R$6,217/person), behind only the average values of Amapá and Roraima (R$6,511 and R$6,379 per person respectively). The other three regions are below the national average: the averages for the South and Southeast are close to the national average, and the average for the Northeast is approximately 27% lower than the national average.

Map 1B. Resources available per person (R$) - real values (Jan./2023) - average 2018-2022 - by state



Source: own elaboration based on Siops.

Table 3.4 shows the average real values of the amount of resources per person (R$/inhab.) for each region and state for the period 2018-2022, and map 1B shows the inequalities by positioning the values for each state according to the quartile of the national distribution. The North region (highest average R$/hab.) is the one with the greatest inequality, with a difference between the maximum and minimum R$/hab. of R$ 4,080. At the other extreme, we again have the South region, with the smallest difference between the maximum and minimum R$/hab. of R$ 388. In the case of the Central-West region, the high value of resources per person in the Federal District means that the difference between the maximum and minimum R$/person in the region reaches R$ 3,418; but if we exclude this state from the calculation, this discrepancy drops to R$ 1,802. As for the Northeast and Southeast regions, the difference between the maximum and minimum values per person within regions is practically the same (R$1,137 and R$1,064 respectively). In other words, both regions have similar inequality between the availability of resources per person in their states.

Table 3.4. Resources available per person (R$) - average 2018-2022 - by state

Region	State	R$/person*		Area
		Region	State	graph
North	Rondônia	4,755	4,159	B
	Acre		5,863	B
	Amazonas		3,046	D
	Roraima		6,390	B
	Pará		2,418	A
	Amapá		6,485	B
	Tocantins		4,924	B
North East	Maranhão	2,584	2,097	A
	Piauí		2,912	A
	Ceará		2,249	A
	Rio Grande do Norte		2,886	A
	Paraíba		2,562	A
	Pernambuco		2,594	A
	Alagoas		2,652	A
	Sergipe		3,262	A
	Bahia		2,326	D
South East	Minas Gerais	3,056	2,668	D
	Espírito Santo		3,701	C
	Rio de Janeiro		2,652	D
	São Paulo		3,203	D
South	Paraná	3,078	2,829	D
	Santa Catarina		3,181	D
	Rio Grande do Sul		3,224	D

Table 3.4. Resources available per person (R$) - average 2018-2022 - by state

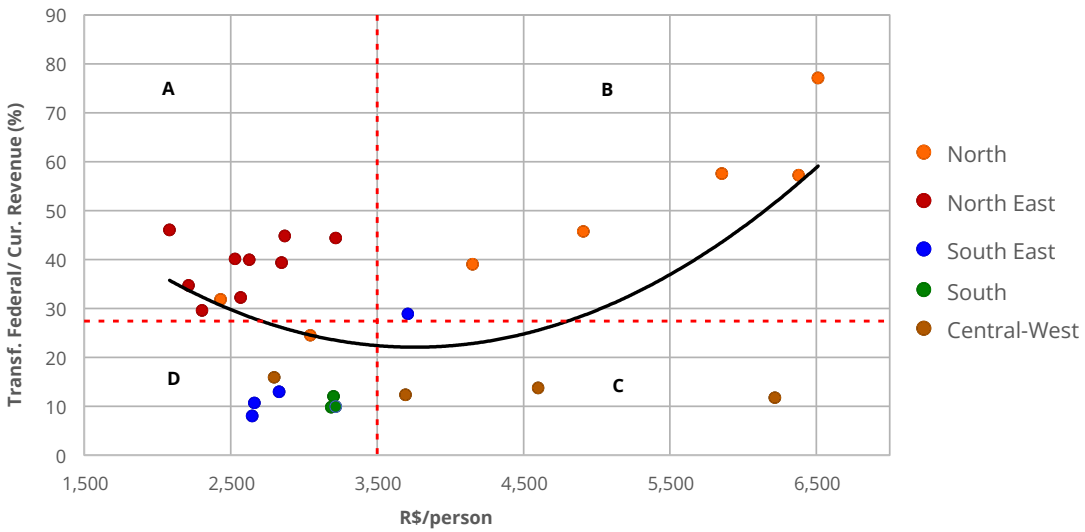
Region	State	R$/person*		Area
		Region	State	graph
Central-West	Mato Grosso do Sul	4,327	3,689	C
	Mato Grosso		4,557	C
	Goiás		2,797	D
	Distrito Federal		6,266	C
Brazil	Média	3,530	-	-
	Mínimo	2,082	-	Maranhão
	Máximo	6,511	-	Amapá

*** Real values (Jan/2023).**

Source: own elaboration based on Siops.

Graph 3.11 shows the relationship between the proportion of federal transfers to current revenue (%) and per capita resources (R$/person) in the states. The dashed lines indicate the national average values for these two measures in the 2018-2022 period.

Graph 3.11. Link to the federal government (%) and available resources per capita*(R$) - average 2018-2022 - real values (Jan./2023)



Source: own elaboration based on Siops.

Real values (Jan/2023).

Taking the averages of the link to the Union (%) and resources/person (R$) as a reference point, we can delimit four areas on the graph (A; B; C; D) according to whether each state is above/below these two averages (table 3.1).

Box 3.1. Link to the federal government (%) X Available resources per person (R$) - possible combinations

Area	Link to the Union	R$/person	Interpretation	Number State
A	Above the national average	Below the national average	Despite receiving above-average transfers, the amount of own resources is not capable of transpose the value of resources/person of the national average.	9
B	Above the national average	Above the national average	It receives above-average transfers and has resources/person also above the national average.	5
C	Below the national average	Above the national average	It receives below-average transfers, but the amount of its own resources is able to exceed the amount of resources/person of the national average.	4
D	Below the national average	Below the national average	It receives below-average transfers, but the amount of its own resources is not able to increase the amount of resources/person to the level of the national average.	9

Source: own elaboration

It can be seen that the majority of states[XIV] are below the average value of resources per capita (areas A and D). As for the distribution of states according to their position in relation to the national average for the share of federal transfers in current revenue (%), we have a more homogeneous composition, with 13 states below the national average (48.1% in areas D and C) and 14 above (51.9% in areas A and B).

For the majority of states in the Northe region (5 out of a total of 7 are in area B), federal transfers help to ensure that the amount available to these states is above the national average. However, the two most populous states in the region do not fit into this context[XV], because for both, the amount of resources per capita is below the national average (Amazonas in area D; and Pará in area A). In the case of Amazonas (area D),

XIV 18 states or 66.7% of all states.

XV Amazonas with approximately 4.1 million; and Pará with 8.5 million inhabitants.

whose links to the federal government are below the national average, it can be seen that the amount of own resources is not enough to increase the amount of resources per capita to the level of the national average. Even the state of Pará, whose proportion of federal transfers in relation to current revenue is slightly above average (31.8%), has an amount of resources per person below and further away from the national average[XVI].

In the Northeast region, all states have per capita resources below the national average, with the vast majority of states in area A in graph 3.11. The exception is the state of Bahia, whose proportion of federal transfers to current revenue is below, but still close to, the national average (29.6% against an average of 30.8% for Brazil). In general, we can conclude that although the states in the North region receive transfers above the national average, the total amount of resources (own and federal transfers) is far from the national average amount of resources/person. Thus, the situation is practically the opposite of that of the states in the North.

All states in the Southeast, South and Central-West regions have a share of federal transfers in relation to current revenue below the national average. Therefore, what differentiates the situation of these states is whether or not their own resources are sufficient to reach the available revenue per inhabitant in relation to the national average (areas C and D). In this context, all states in the South and most states in the Southeast share the same situation as the vast majority of Northeastern states: the amount of own resources is not capable of increasing the value of R$/person to the level of the national average (area D). Among them, the only state with R$/hab. above the average is Espírito Santo.

In the Central-West region, the opposite is true: most states have R$/person above the national average, with Goiás being the exception. It is worth mentioning that the Federal District is the third state with the most R$/person available, behind only the states of Amapá and Roraima. If we were to calculate the national average of resources available per person, excluding the states with per capita amounts above R$ 6,000, only four states in areas A or D of the graph would have resources above the average[XVII]. However, the situation of most northeastern states would remain unchanged. In other words, even if we exclude the states with high per capita resources (positive extremes) from the calculation, there would still be little change in the distance from the national average.

This description of state revenues serves to provide a general overview of the resources available for the execution of PHAS spending by the states. In this chapter, we pointed out how unequal the distribution of resources is, whether due to differences in

XVI R$ 1,099 below the national average of R$ 3,530.

XVII They are: Sergipe, São Paulo, Santa Catarina and Rio Grande do Sul.

revenue generation capacity, or because federal transfers are directed to less populous states and therefore do not reach the majority of the Brazilian population. Next, we'll analyze the spending profile of these funds.

3.2 STATE EXPENSES

We now turn to an analysis of the states' PHAS spending profile using the subfunction and source of funding. From 2018 onwards, Siops started collecting information integrating the functional and expenditure group perspectives, making it possible to analyze spending by subfunction/source of funds. The breakdown by subfunctions provides information on the purpose of expenditure on PHAS, thus helping to diagnose spending in specific areas. The origin of the resource, on the other hand, makes it possible to assess the weight of each entity in health financing at the state level. In the context of expanding public health demands (an ageing population, an increase in chronic diseases, a rise in vector-borne diseases, etc.) and limited resources, knowledge of this intersection helps us to draw up a framework for allocating resources on PHAS.

In Brazil, between 2018 and 2022, the annual average of total state spending on PHAS was R$111.5 billion (in nominal values[XVIII]). In real terms[XIX], this amount is equivalent to R$ 125.9 billion. Tables 3.5 and 3.6 show the states' average spending on PHAS, by subfunction, in nominal and real values (Jan./23 values) respectively; the share of each subfunctionand the variation between 2018 and 2022. As this is average spending, this data gives an overview of the allocation of resources by the states.

Table 3.5. Average state spending on PHAS - in R$ million (nominal)

						2018-2022	
Subfunction*	2018	2019	2020	2021	2022	Average	Share (%)
PC - Primary Care	84	129	128	161	171	135	3.3
HOC - Hosp. Outp. Care	2,027	2,237	2,472	3,019	3,405	2,632	63.8
PTS - Proph. Thera. Supp.	188	205	227	211	235	213	5.2
HEA - Health Surveillance	4	4	6	9	8	6	0.2
EPI - Epi. Surveillance	27	19	106	110	49	62	1.5

XVIII See table A1 in the Appendix.

XIX Deflated by the IPCA at Jan-2023 values, see table A2 in the Appendix.

Table 3.5. Average state spending on PHAS - in R$ million (nominal)

Subfunction*	2018	2019	2020	2021	2022	2018-2022	
						Average	Share (%)
F&N - Food and Nutrition	14	15	13	11	9	13	0.3
ADM - Administrative	869	849	907	1,041	1,133	960	23.3
Complementary Information	82	85	143	109	122	108	2.6
Brazil - State average	3,296	3,542	4,001	4,671	5,132	4,129	100

Source: own elaboration based on Siops. * Liquidated expenditure

Table 3.5 shows that the average annual spending by the states at national level was R$4.129 billion (nominal values), corresponding to R$4.664 in real terms. Among the subfunctions, Hospital and Outpatient Care (HOC) represents more than half of the state's expenditure on PHAS (approximately 64%), and the second most relevant is the administrative function, which represented almost a fifth of the total expenditure on PHAS in the period from 2018 to 2022. With the exception of the epidemiological surveillance subfunction, whose share of total spending on PHAS increased considerably during the period of the COVID-19 pandemic (2020-2021), it can be seen that, in general, the proportion of spending by subfunctions remained practically stable during this period.

Table 3.6 shows that over these five years, state spending on PHAS grew by 22% in real terms, with an average of 5.1% per year. The only subfunctions that saw a reduction in real value over the period were Prophylactic and Therapeutic Support (PTS) and Food and Nutrition (F&N), with reductions of 2.1% and 49.4% respectively.

Table 3.6. Average state spending on PHAS - in R$ million (real values: Jan./2023)

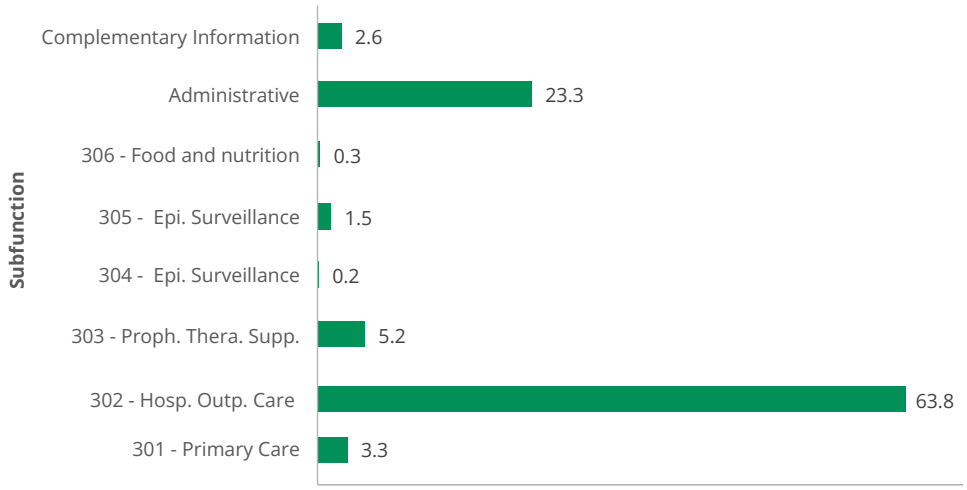
Subfunction*	2018	2019	2020	2021	2022	2018-2022	
						Average	Variation (%)
PC - Primary Care	107	158	150	172	171	151	60.4
HOC - Hosp. Outp. Care	2,586	2,737	2,893	3,211	3,405	2,966	31.7
PTS - Proph. Thera. Supp.	240	250	265	224	235	243	-2.1
HEA - Health Surveillance	5	5	7	10	8	7	42.6
EPI - Epi. Surveillance	35	23	124	117	49	70	39.9
F&N - Food and Nutrition	18	18	15	12	9	15	-49.4
ADM - Administrative	1,109	1,038	1,062	1,107	1,133	1,090	2.2
Complementary Information	105	104	167	115	122	123	16.1
Brazil - State average	4,205	4,333	4,683	4,968	5,132	4,664	22.0

Source: own elaboration based on Siops.

*** Expenses paid.**

Among the other subfunctions, the highest growth rates occurred in those with the smallest share in the states' PHAS structure (Graph 3.12): Health and Epidemiological Surveillance, which grew by approximately 43% and 40% respectively (but together accounted for less than 2% of expenditure); and Primary Care (PC), whose real expenditure grew by 60.4%, but accounted for 3.3% of total average expenditure in the period. In the end, the two subfunctions that account for 87.1% of PHAS expenditure - HOC (63.8%) and Administrative (23.3%) - increased by 31.7% and 2.2% respectively. The low growth in administrative expenses points to a context of cost containment in the *face of* the considerable increase in HOC, which is probably also being influenced by the covid-19 pandemic.

Graph 3.12. Share of PHAS spending by subfunction - state average (2018-2022, in %)



Source: own elaboration based on Siops.

In real terms, the average annual expenditure by the states on PHAS from 2018 to 2022 was R$4,664 million (table 3.6). Only the states in the South and Southeast have real spending above the national average for most subfunctions[XX]. The exception is HOC for the southern states (2% lower), and Administrative spending for the states of the Southeast (0.84% lower). The states of the North ern region, on the other hand, have expenditures below the national average in all subfunctions. In the case of the Northeast, the states spent 5.5% more on Epidemiological Surveillance than the national average; and in the Center-West, it was Administrative and A&N expenses that were in this situation (57.4% and 140.7% respectively).

The evolution of spending on PHAS shows that, between 2018 and 2020, the greatest growth occurred precisely in the regions with spending below the national average. Thus, while average real spending at national level grew by 22%, in the North, North-East and Central-West regions this increase was 31.7%, 28.6% and 31%. There was also a 19.3% increase in real expenditure on PHAS in the Southeast and a 5.2% increase in the South. It is worth mentioning that the "Complementary Information" subfunction refers to expenditure that is not linked to any of the indicated subfunctions or administrative

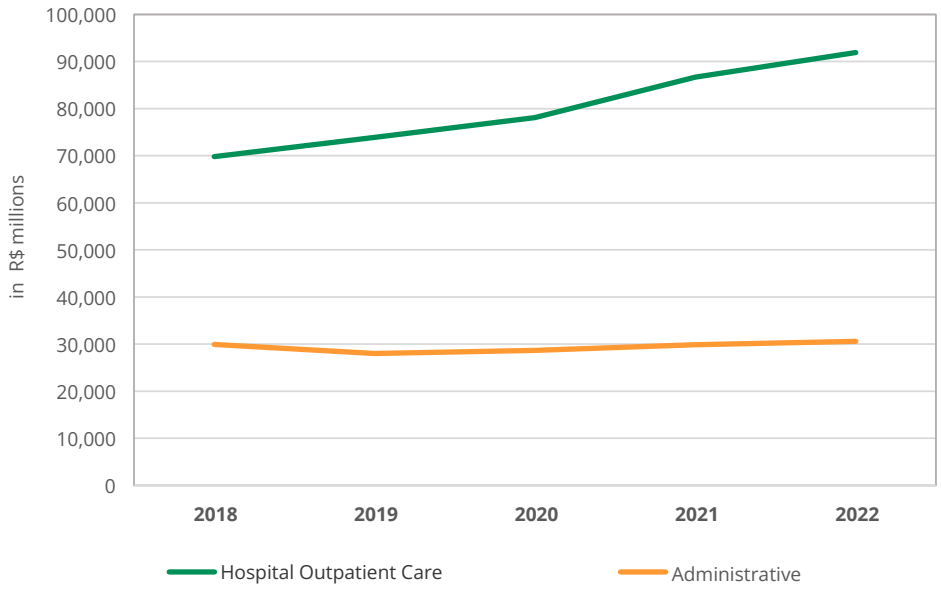
XX The southern states spend approximately 26% more than the national average, while the southeastern states spend 163% more than the national average. Table A4 in the Appendix provides information on the states' average spending on PHAS by region.

functions[XXI]. In the period analyzed, spending under this heading represented an average of 2.6% of state spending on PHAS.

2.2.1 EXPENDITURE BY PHAS SUBFUNCTION

Graphs 3.13 A, B and C show the trajectory of total real spending at national level according to subfunctions. The most relevant point is that the two main trajectories of increase in spending concern the Primary Care (PC) and Hospital and Outpatient Care (HOC) subfunctions, which grew continuously by 60.4% and 31.7% respectively.

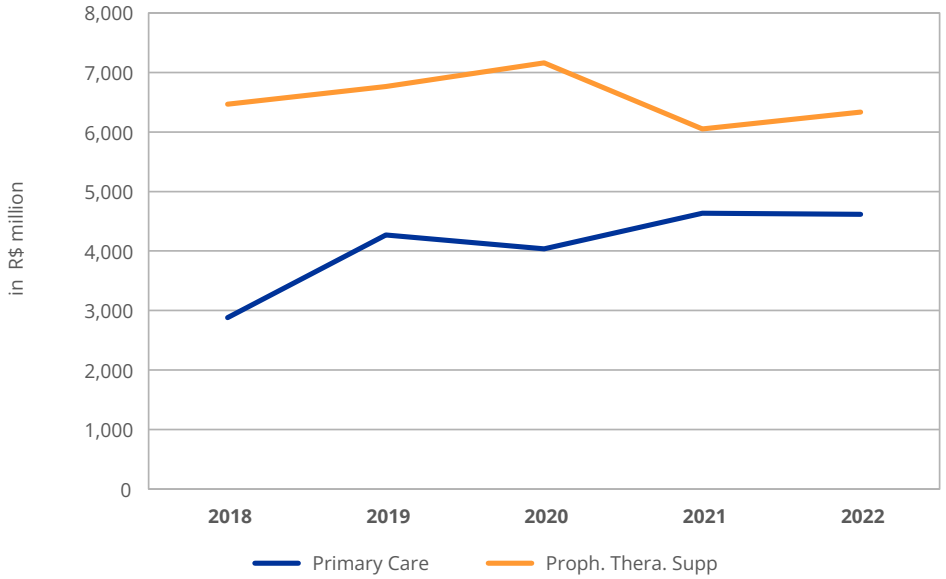
Graph 3.13 A. Average real spending for the main subfunctions: HOC and Administrative - (real values Jan./23)



Source: own elaboration based on Siops.

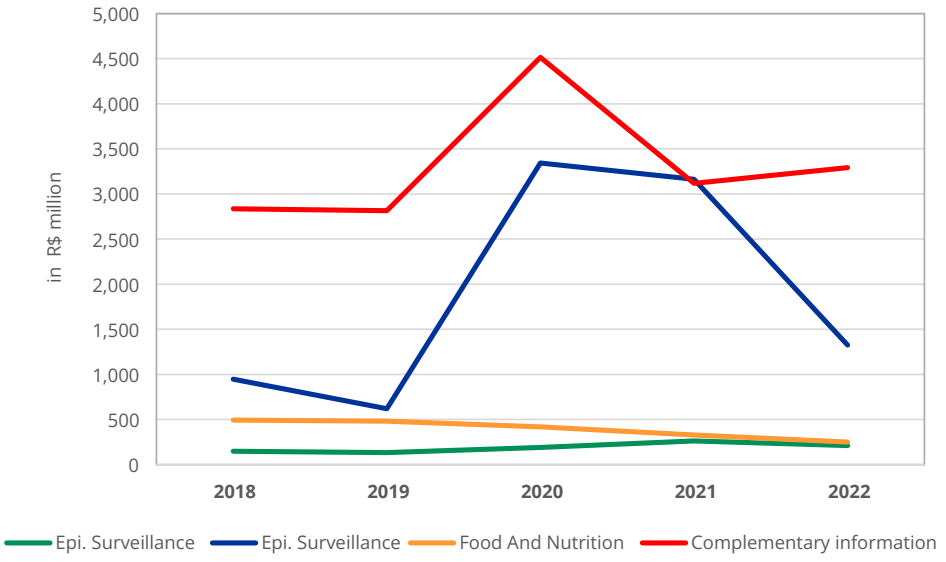
XXI Examples of expenditure under this heading are: social security, scientific, technological and engineering development, debt refinancing (internal/external).

Graph 3.13 B. Average real spending for the main subfunctions: PC and PTS (real values Jan./23)



Source: own elaboration based on Siops.

Graph 3.13 C. Average real spending for the main subfunctions: Health Surv..; Epid. Surv.; Food & Nutr, e Compl. Information - (real values Jan./23)



Source: own elaboration based on Siops.

The data in table 3.7 shows how the variation in spending by subfunction differed between the regions. In the case of PC, there was growth in all regions, with the Northeast and Southeast expanding above average. As for HOC spending, apart from the South, which saw a reduction (-1.1%), there was an increase in all the other regions, especially the Central-West (107.6%).

Table 3.7. Change in real average spending between 2018 and 2022, by region - main PHAS subfunctions (%)*

Region	PC	HOC	PST	ADM	PHAS
North	13,50	16,41	1,12	63,98	31,70
North East	126,25	39,93	28,12	-1,67	28,64
South East	80,65	31,08	-1,85	-49,63	19,31
South	24,45	-1,13	-3,76	24,75	5,23
Central-West	12,21	107,59	-37,79	-2,73	30,99
Brazil	60,40	31,70	-2,11	2,20	22,03

Source: own elaboration based on Siops.

Average state spending.

As for other expenses, the administrative function saw an average increase of 2.2%. In this case, continued growth began in 2020, since total real spending in 2019 was lower than the corresponding amount in 2018 (-6.40%). This expenditure shows a large discrepancy between the regions, with decreases in the Northeast, Southeast and Central-West, and a significant increase in the North.

PTS spending expanded by 10.7% between 2018 and 2020, only to fall back to levels lower than those seen in 2018, accounting for a 2.1% drop over the entire period. The only regions not to see a reduction in spending on this subfunction were the North and Northeast, where there was an increase of 1.1% and 28.1% respectively.

In addition to the main subfunctions shown in table 3.7, we also have Health and Epidemiological Surveillance, which together have a share of less than 2% in the profile of state spending on PHAS - 0.15% for the former and 1.50% for the latter. Graph 3.13 C shows that the maximum expenditure for Epidemiological Surveillance occurred in

2020, and for Health, in 2021 (the period of the pandemic), but that the subsequent drop limited the variation of both to approximately 40% over the period.

3.2.1B EXPENDITURE BY REVENUE SOURCE

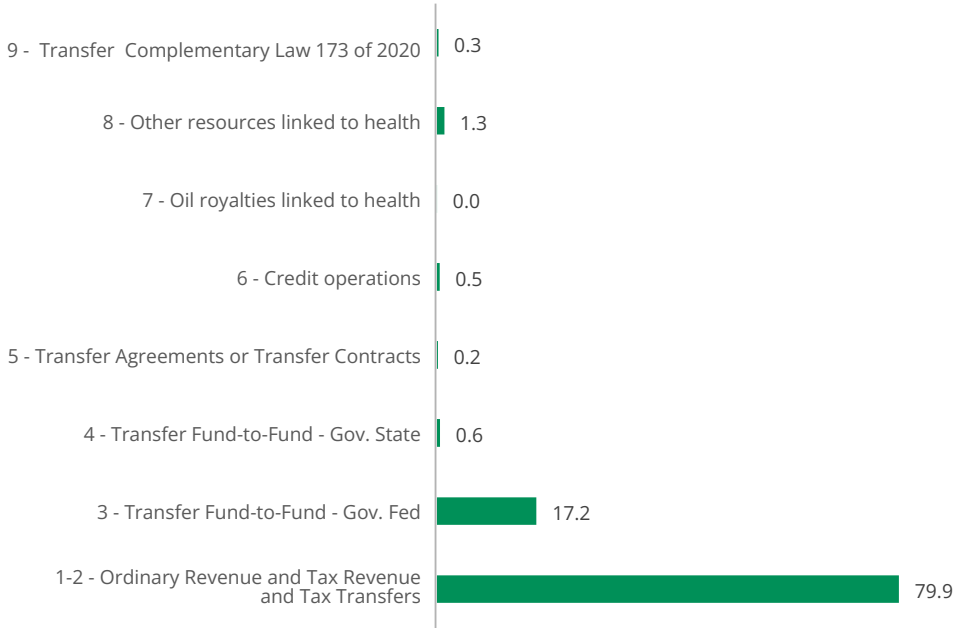
Siops identifies nine sources of revenue that make resources available for spending on PHAS, in the subfunctions indicated above:

1. Free source (ordinary income);
2. Tax revenues and transfers; FAF transfers:
3. Federal government; or
4. State government;
5. Agreements or Transfer Contracts;
6. Credit operations;
7. Oil Royalties ;
8. Other linked resources;
9. LC No. 173 of 2020.

Graph 3.14 shows the average share of revenue sources in spending on PHAS between 2018 and 2022. It can be seen that 80% of the funds come from sources 1 and 2, with less than 3% coming from free sources. This shows the importance of tax revenue (local governments or the federal government) in financing the PHAS. In addition, as ordinary revenues are not linked to any health program or body, it can be seen that a large part of the resources are used to comply with the constitutional limit[XXII] (with control of linkage at the origin or at the time of execution).

XXII Revenues earmarked for health in compliance with the provisions of art. 198, § 2 of CF/88 and Chapter III of LC 141/2012

Graph 3.14. Share of revenue sources in health spending (2018-2022)* - in %



Source: own elaboration based on Siops.

*** Average state spending.**

The second most important source is FAF transfers, with an average share of 17.2% over the period analyzed. These transfers from the Union are governed by specific laws, which refer to the mechanism for decentralizing the use of resources on PHAS. Since 2018, the financing blocks that receive FAF transfers have been reduced from six[XXIII] to two, namely: PHAS Maintenance Block, and Structuring Block in the Public Health Services Network[XXIV]. Source 8, on the other hand, refers to SUS revenues that do not fall under its own specifications, which are used to consolidate other SUS revenues that do not fall under the previous items. It is worth mentioning that source 9, referring to LC no. 173, accounted for resources during the covid-19[XXV] pandemic.

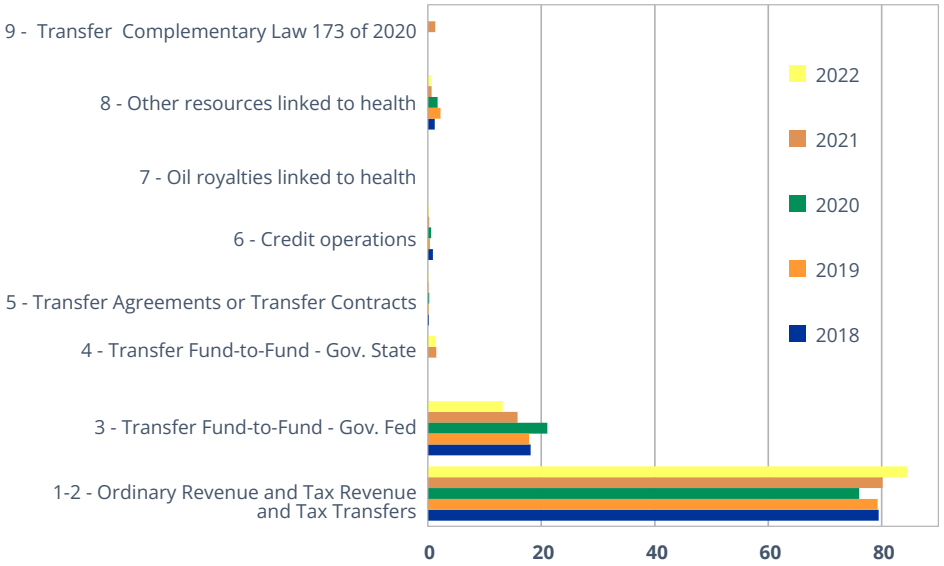
XXIII Until the end of 2017, the six blocks were: primary care, medium and high complexity outpatient and hospital care, health surveillance, pharmaceutical care, SUS management and investments in the health services network.

XXIV This change took place in two stages, the first being Ministerial Order GM/MSNo. 3.992 of December 28th, 2017, which reduced the number of blocks from 6 to 2, which were initially: the PHAS *Costing* Block and the *Investment* Block in the Public Health Services Network. Ordinance GM/MSNo. 828 , of April 17th, 2020, changed the nomenclature of the blocks in the previous ordinance, replacing "Costing" with Maintenance and "Investment" with Structuring.

XXV LC No. 173, of May 27th, 2020, establishes the Federal Program to Combat the SARS-CoV-2 Coronavirus (Covid-19). The participation shown in graph 3.3 refers to the average for the whole period, but if we calculate the proportion average will only be 0.45% of total spending once the law comes into force (2020-2022).

Graph 3.15 shows the trajectory of the share of funding sources over these five years. It can be seen that the year of the pandemic (2020) represents a cut in the distributive framework of the sources of funds, since, as of 2021, there has been a considerable increase in the share of ordinary revenue, taxes and tax transfers (sources 1 and 2) and a reduction in the weight of FAF transfers from the Union (source 3). The data show that the peak in the Union's FAF share of health spending was in 2020, when it exceeded 20%. However, in the following years, the relevance of this source fell to levels lower than those observed before the pandemic: 15% in 2021 and 12.6% in 2022[XXVI]. In addition, graph 3.15 shows that the resources transferred via LC 173/2020 were concentrated in 2021 and probably affected the reduction in the share of "Other resources linked to health" (source 8) in the states' total spending.

Graph 3.15. Share of revenue sources in health spending, state average - in %



Source: own elaboration based on Siops.

Table 3.8 shows the separate participation of sources 1 and 2, making it possible to verify the origin of this inversion in the participation of the main sources of funds that occurred after 2020. It should be noted that the reduction in the relative importance of resources from the FAF - the federal government - only occurred in the states of the Southern region. As for the other regions, the average share of FAF resources after 2020 is lower than the average before 2020, with the greatest reductions occurring in the

XXVI Below from around 17% before 2020.

Southeast and Central-West regions. Given the reduction in transfers from the federal government via the FAF, the states began to use a greater proportion of Ordinary Revenues to finance their spending on PHAS.

Table 3.8. Evolution of the share of the main sources of funds, average share of sources in the states, by region - in %

Region	Sources	2018	2019	2020	2021	2022	Average period		
							Pre 2020	Post 2020	2018 -2022
North	1 - Ordinary Revenue - Free Source	2.0	3.4	*7.3*	3.5	2.9	2.7	3.2	3.6
	2 - Tax Revenue and Tax Transfers	78.4	79.7	*70.6*	71.7	79.0	79.0	75.3	75.9
	3 - Transfer FAF - fed. gov.	17.0	16.4	*21.1*	16.5	15.9	16.7	16.2	17.4
North East	1 - Ordinary Revenue - Free Source	0.0	0.0	*0.0*	0.1	0.2	0.0	0.2	0.1
	2 - Tax Revenue and Tax Transfers	74.7	74.8	*73.0*	78.0	83.7	74.8	80.9	76.9
	3 - Transfer FAF - fed. gov.	21.9	22.8	*24.4*	20.1	15.1	22.4	17.6	20.9
South East	1 - Ordinary Revenue - Free Source	1.9	0.0	*1.9*	9.5	8.7	0.9	9.1	4.6
	2 - Tax Revenue and Tax Transfers	81.3	84.4	*78.9*	74.8	74.8	82.9	74.8	78.8
	3 - Transfer FAF - fed. gov.	15.3	14.2	*17.6*	9.4	7.6	14.8	8.5	12.8
South	1 - Ordinary Revenue - Free Source	0.0	0.0	*0.0*	0.9	0.0	0.0	0.5	0.2
	2 - Tax Revenue and Tax Transfers	77.4	79.2	*71.7*	76.4	80.4	78.3	78.4	77.0
	3 - Transfer FAF - fed. gov.	19.8	17.9	*25.7*	21.5	18.6	18.9	20.1	20.7
Central-West	1 - Ordinary Revenue - Free Source	0.9	0.0	*6.8*	8.3	8.1	0.5	8.2	4.7
	2 - Tax Revenue and Tax Transfers	85.7	77.7	*73.0*	83.3	85.9	81.7	84.6	81.1
	3 - Transfer FAF - fed. gov.	13.1	12.9	*13.7*	7.4	5.9	13.0	6.6	10.6
Brazil	1 - Ordinary Revenue - Free Source	1.0	0.7	*3.2*	4.5	4.0	0.8	4.2	2.6
	2 - Tax Revenue and Tax Transfers	79.5	79.1	*73.5*	76.8	80.8	79.3	78.8	77.9
	3 - Transfer FAF - fed. gov.	17.4	16.8	*20.5*	15.0	12.6	17.1	13.8	16.5

Source: own elaboration based on Siops.

*** Average state spending**

The data shows that, for all regions, the proportion of resources coming from ordinary revenue after 2020 is higher than before. However, there are three distinct situations:

a. states that did not make use of ordinary revenues and started to do so (Northeast and South);

b. states in which less than 1% of spending on PHAS came from budget revenues, but considerably increased the use of these resources after 2020 (Southeast and Central-West);

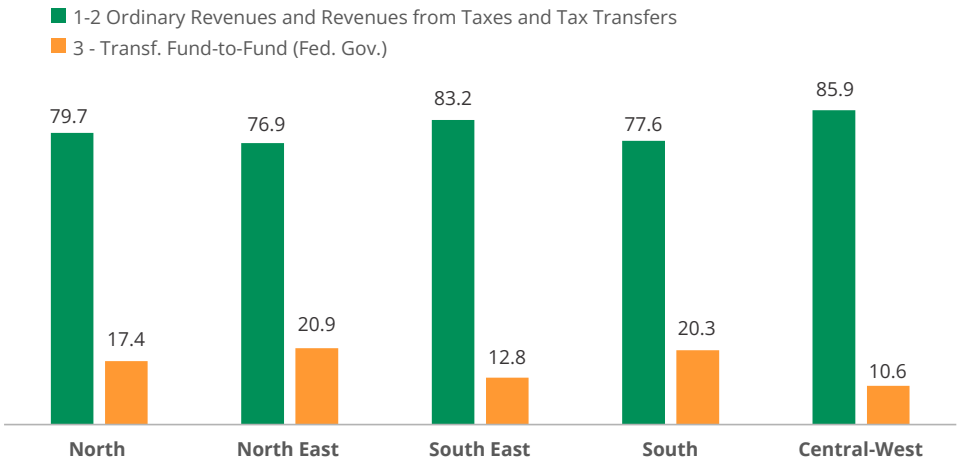
c. North region, where there was already more than 2% of spending on PHAS financed with ordinary revenues before 2020 and accounted for a marginal increase after 2020.

When comparing the share of revenues and constitutional transfers in financing spending on PHAS before/after 2020, we see that the reductions were concentrated in the North and Southeast regions[XXVII]. In the South, the relevance of this resource remained practically stable; in the Central-West, there was an increase of 3 pp; and in the Northeast, there was an exception with an increase in the share of these resources of approximately 6 pp.

Graph 3.16 summarizes the share of own revenues (sources 1 and 2) and FAF transfers from the federal government by region. The data reaffirms what was previously indicated: the states in the Central-West and Southeast regions have the lowest shares of FAF transfer resources from the federal government, and the states in the Northeast and South regions use the least of their own revenues to finance spending on PHAS.

XXVII With 3.7 and 8.0 pp respectively.

Graph 3.16. Share of own revenue and federal government transfers by region - 2018-2022* - in %



Source: own elaboration based on Siops.

* Average state spending

Due to the integration of the functional and group perspectives of expenditure from 2018 onwards, cross-referencing expenditure by subfunction with the sources of funds used gives us an overall picture of the allocation of resources.

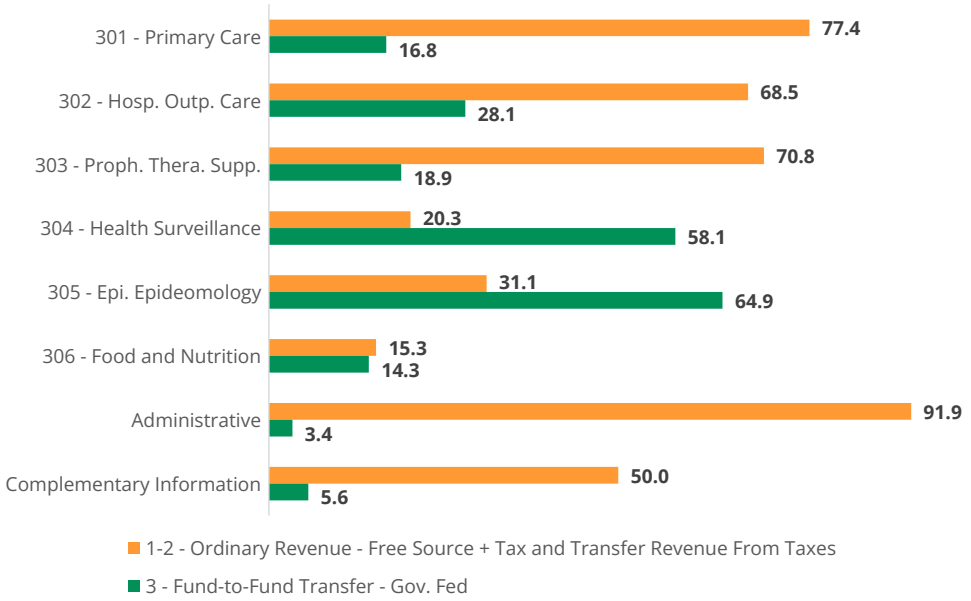
Table 3.9. Average share of spending on PHAS and proportion of resources from sources 1-3 by subfunction - in %

	Participation	Proportion of resources			
Subfunction	Average	Sources 1-2	Source 3	Sources 1-3	Other sources
PC - Primary Care	3.3	77.36	16.77	94.1	4.39
HOC - Hosp. Outp. Care	63.8	68.55	28.11	96.7	3.79
PTS - Proph. Thera. Supp.	5.2	70.82	18.93	89.7	0.65
HEA - Health Surveillance	0.2	20.26	58.14	78.4	7.52
EPI - Epi. Surveillance	1.5	31.15	64.90	96.1	2.47
F&N - Food and Nutrition	0.3	15.34	14.29	29.6	2.22
ADM - Administrative	23.3	91.88	3.36	95.2	2.21
Complementary Information	2.6	49.99	5.64	55.6	3.14

Source: own elaboration based on Siops.

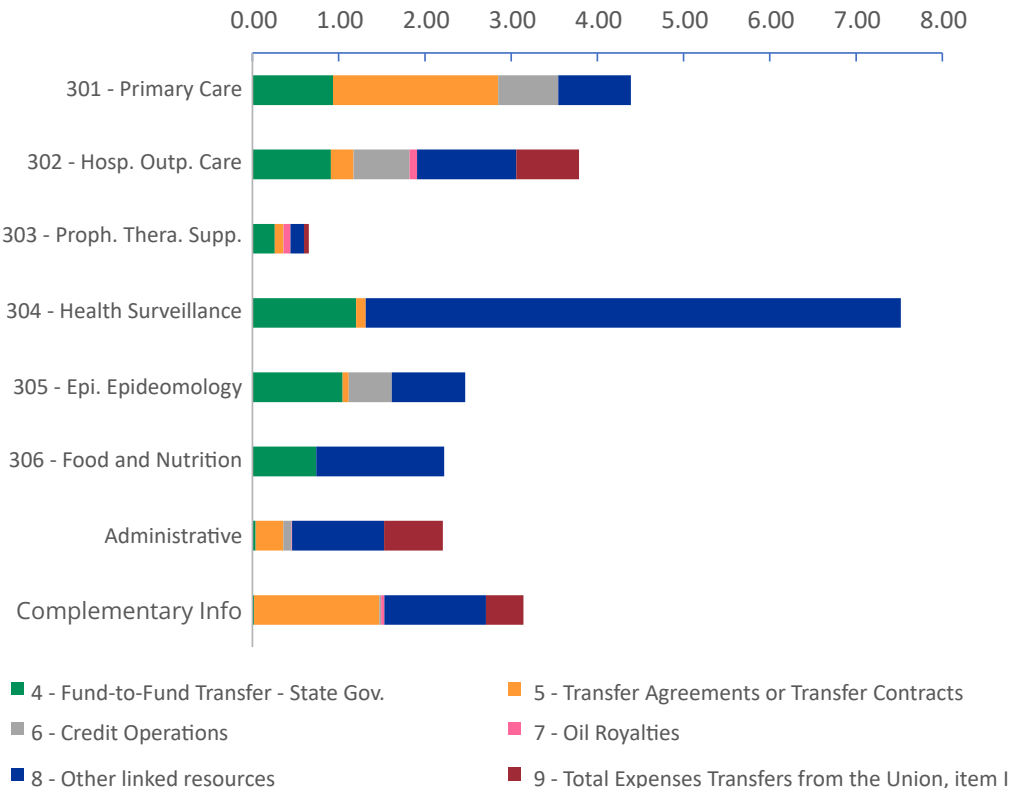
Table 3.9 shows the average share of each subfunction on PHAS spending between 2018 and 2022, as well as the proportion of spending that is maintained with the three main sources of funds *vis-à-vis* the other sources. This information can be seen in graphs 3.17 A and B, which show the share of revenue sources according to expenditure by subfunction. In the first, we have the three most relevant sources for the analysis, and in the second, the others.

Graph 3.17 A. Share of revenue sources according to expenditure by subfunction - state average (2018-2022, in %)



Source: own elaboration based on Siops.

Graph 3.17 B. Share of revenue sources according to expenditure by subfunction (continued) - state average (2018-2022, in %)



Source: own elaboration based on Siops.

It can be seen that the most relevant subfunctions for spending on PHAS in the states (HOC and ADM) are maintained with their own resources and/or FAF transfers from the Union. Between 2018 and 2022, 28% of the costs of HOC services were maintained with funds from the federal government's FAF. Graph 3.17 A shows that, only in the subfunctions relating to surveillance (HEA and EPI), FAF transfers from the Union are more relevant than the states' own resources (58% and 65% respectively). However, these subfunctions together do not represent even 2% of the average expenditure on PHAS (table 3.9).

The less relevant subfunctions at state level (PC and PTS) also rely predominantly on own resources (around 70%). Even so, graph 3.17 B shows a marginal share of transfers from agreements or transfer contracts (2%) for PC services. It should also be noted that Health Surveillance is the subfunction in which the financing of expenditure is more widely spread among sources, with the participation of transfers from agreements and

transfer contracts (0.11%), the state FAF (1.20%), and "other linked resources" (6.20%); this subfunction allocates resources to specific health actions[XXVIII].

Graph 3.17 B shows that the funds from LC 173/2020 were allocated to HOC services, the Administrative function and Complementary Information. Furthermore, it is worth mentioning that not every subfunction reaches 100% with the sum of the average share of the sources. This is because not all states spend on all subfunctions, and since the average includes all states, the proportion drops when spending is one-off or limited to a small group of entities. This is the case for the Food and Nutrition (F&N)[XXIX]subfunction, which has an average of only 10 states spending on this subfunction; and for expenditure on "Complementary Information", which is accounted for by 15 states[XXX].

These data refer to the average expenditure of the states according to subfunction and source of funds during the period 2018-2022, but there are significant differences according to the region and/or population profile of the state. Graph 3.7 A shows the breakdown of expenditure by subfunction and source of funds by region. It can be seen that the Central-West is the region with the highest proportion of own resources in the financing of HOC services (80%), and the South the lowest (58%). As a result, it is the South region that most uses the federal government's FAF resources as a source of funds for spending on HOC. The increasing order of the regions according to the proportion of HOC spending that is financed from their own resources (sources 1-2) is: South (58%); North and Northeast (69%); Southeast (77%) and Central-West (80%).

XXVIII This subfunction includes actions that guarantee the quality, efficacy and safety of products that interfere (directly or indirectly) with human health, such as drugs, medicines, foodstuffs, cosmetics, etc. - as well as monitoring the sanitary conditions of health establishments and the entry of products into the country (preventing the entry of agents harmful to the health of the population).

XXIX This subfunction refers to nutritional surveillance actions, control of nutritional deficiencies, food guidance and food safety promoted within the scope of the SUS

XXX In the case of spending on F&N, only four states had spending in all the years from 2018 to 2022: Rio Grande do Norte, São Paulo, Goiás and the Federal District.

Graph 3.18 A. Share of revenue sources according to expenditure by subfunction by region - state average (2018-2022, in %)

Source: own elaboration based on Siops.

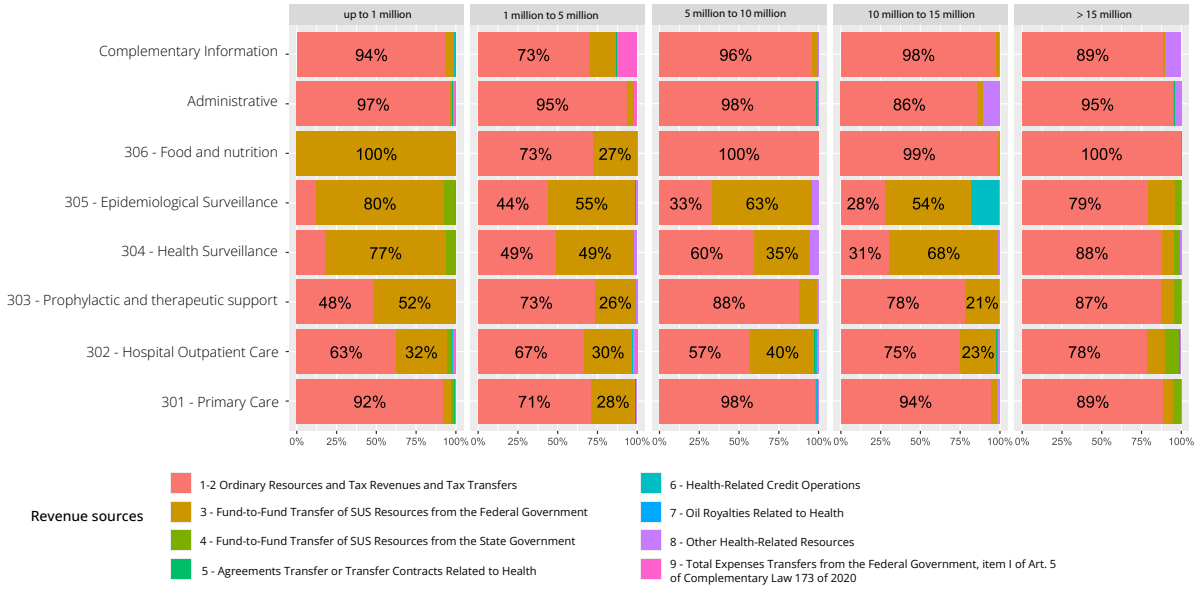
The second most important expenditure for the states is the administrative function. In this case, the use of own resources is even more prominent, reaching 99% in the South and 85% in the Central-West. To summarize, in all regions of the country, a large proportion of spending on both the HOC and the Administrative function is financed from the states own resources (sources 1-2).

As we have seen at the aggregate level, the subfunctions in which the majority of spending is financed with FAF transfers from the Union are the ones that have the least share on PHAS spending in the states: Health and Epidemiological Surveillance. However, graph 3.18 A shows that the proportion in which this occurs is very different between regions. In the case of Epidemiological Surveillance, the share of this source of funding varies from 78% in the North to 18.6% in the Southeast. As for health surveillance, the federal government's FAF funds account for 94% of spending in the North and 7.5% in the Southeast. For the other two subfunctions with a share of more than 3% in state PHAS spending (PC and PTS), the concentration of funding in own resources remains, but some diversification of sources is seen in the Northeast and Southeast regions.

Graph 3.18 B shows this same breakdown, but according to the population size of the states. In this case, only the three states with a population of between 10 and 15

million inhabitants[XXXI] have a better balance between the sources of funding, with 57% of HOC expenditure for this group coming from their own income and 40% from the federal government's FAF. For the group of states with a population of between 1 and 5 million inhabitants[XXXII], approximately 67% of the resources that fund spending on HOC come from their own resources. However, the highest proportion of use of own revenue for this purpose (78%) occurs in the three states with populations greater than 15 million[XXXIII].

Graph 3.18 B. Share of revenue sources according to expenditure by subfunction by population group - state average (2018-2022, in %)



Source: own elaboration based on Siops.

Likewise, states that receive funds via FAF from the federal government also transfer funds to other entities, either states, municipalities or private institutions. Graph 3.19 A shows that between 2018 and 2022, states spent an average of 18.20% of current expendi ture on transfers to other entities. Among these transfers, a large part of which went to municipalities (80.5%), and a smaller part (18.5%) to private institutions[XXXIV].

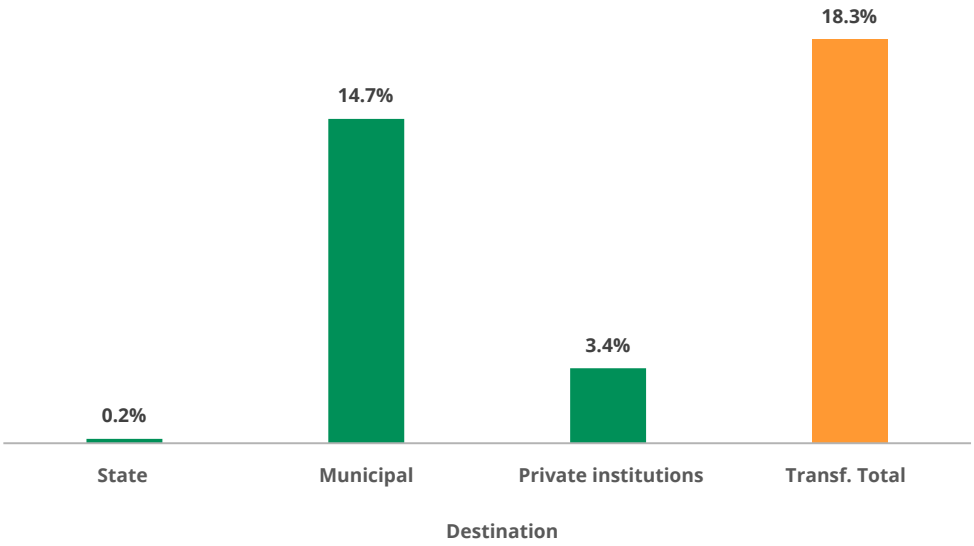
XXXI Bahia, Paraná and Rio Grande do Sul.

XXXII There are 12 states in this group: Alagoas, Amazonas, Distrito Federal, Espírito Santo, Mato Grosso, Mato Grosso do Sul, Paraíba, Piauí, Rio Grande do Norte, Rondônia, Sergipe and Tocantins.

XXXIII They are: Minas Gerais, Rio de Janeiro and São Paulo.

XXXIV The proportion of other states is just 1%

Graph 3.19 A. Transfer spending by destination, in relation to total current expenditure - state average (2018-2022)



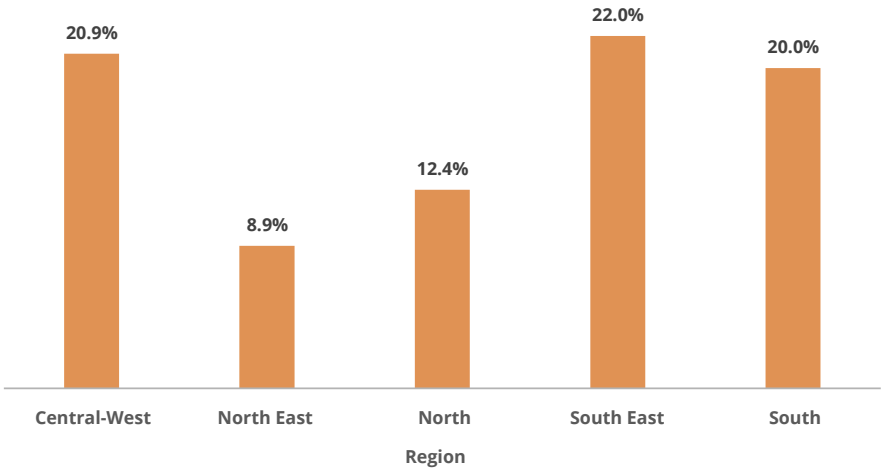
Source: own elaboration based on Siops.

Transfers from the states to the municipalities are concentrated on FAF transfers from the SUS, the constitutional or legal distribution of revenue (12% of tax collection) and resources for consumables[XXXV]. Thus, from this 14.7% of current expenditure, approximately 11.5% refers to the funds earmarked for the FAF, and the other 3.2% to the other two destinations. On the other hand, the average 3.4% of current expenditure that was spent on private non-profit institutions relates to the payment of outsourced services - Legal Entities (PJ) and social contributions/subsidies relating to health care services.

At a regional level, graph 3.19 B shows that between 2018 and 2022, only in the North and Northeast regions was the proportion of current expenditure allocated to transfers to municipalities lower than the national average. The Northeast is the region with the lowest proportion of resource transfers to municipalities.

XXXV Purchase of medicines and other consumables.

Graph 3.19 B. Spending on transfers to municipalities in relation to total current expenditure by region - state average (2018-2022)



Source: own elaboration based on Siops.

Table 3.10 shows that the Northeast region concentrates almost a third of the country's municipalities (32.2%), but with the average number of municipalities per state (199) and fewer inhabitants per municipality (30.5 thousand) than the national average[XXXVI].

Table 3.10. Number of municipalities and average number of inhabitants - by region

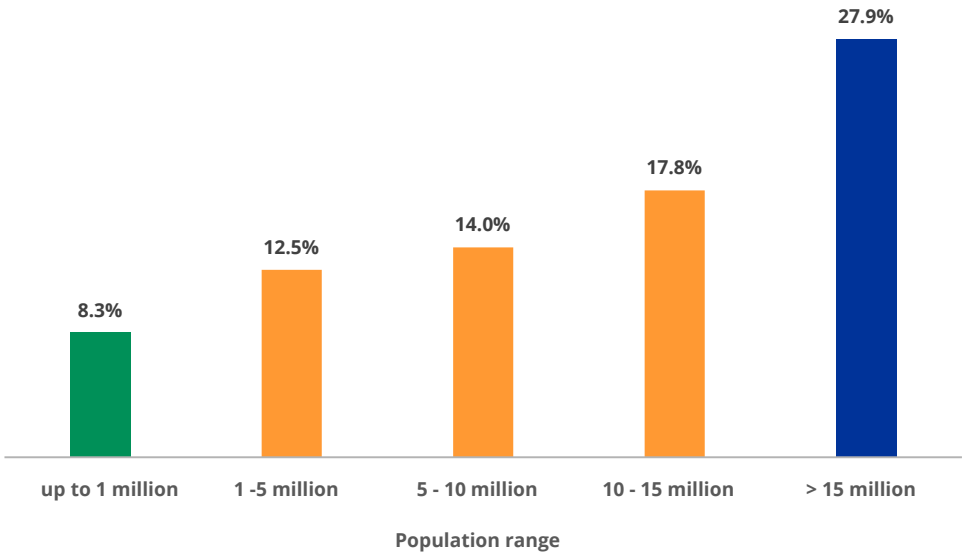
Region	Number		Average		
	State	Municipalities	Average of municipalities/ state	Inhab./state	Inhab. /mun.
North	7	450	64	2,479,269	41,040
North East	9	1,793	199	6,073,168	30,501
South East	4	1,668	417	21,210,028	79,149
South	3	1,191	397	9,979,235	25,459
Central-West	3	467	156	4,072,385	29,783
Brazil	**26**	**5,570**	**214**	**7,521,509**	**40,158**

Source: IBGE.

XXXVI The national average is that each state has an average of 214 municipalities, in which the average number of inhabitants is approximately 40,000 people. This calculation does not include the Federal District as a state since it has no municipalities.

Just below the Northeast, the Southeast has the second largest number of municipalities in the country (1,668), with an average number of municipalities per state (417) and an average number of inhabitants per municipality and per state above the national average (79,000 and 21 million respectively). Consequently, in line with the region's population concentration, the Southeast has the highest proportion of current expenditure transfers to municipalities. Graph 3.19 C shows how the proportion of transfers in relation to current expenditure increases as the size of the state increases.

Graph 3.19 C. Spending on transfers to municipalities in relation to total current expenditure by population group - state average (2018-2022)



Source: own elaboration based on Siops.

Data from table 3.11 indicates that, with the exception of the group of municipalities located in states with up to 1 million inhabitants[XXXVII], the other classes show very close participation, particularly the three intermediate classes, for which the average number of inhabitants per municipality is between 28 and 39 thousand.

XXXVII They total 53 municipalities and represent less than 1% of the total.

Table 3.11. Number of municipalities, state and average number of inhabitants - by size of municipality

Population group State	Number		Participation No. of mun.	Total	Average	
	Municipalities	State		Inhabitants	Inhab./state	Inhab. / mun.
Up to 1 million	53	3	0.95%	2,200,484	733,495	42,012
From 1 to 5 million	1,344	12	24.1%	35,987,326	2,998,944	29,728
From 5 to 10 million	1,270	6	22.8%	47,417,574	7,902,929	39,856
From 10 to 15 million	1,313	3	23.6%	36,468,971	12,156,324	28,164
More than 15 million	1,590	3	28.6 %	81,006,401	27,002,134	89,149
Brazil	**5,570**	**27**	**100%**	**203,080,756**	**7,521,509**	**36,460**

Source: IBGE.

In these three cases, despite increasing, the difference in the share of transfers to municipalities in current expenditure is not discrepant. The biggest difference occurs precisely for the group of municipalities that are located in states with a population of over 15 million inhabitants, in this case, all of them in the Southeast region. The average amount transferred to municipalities in these states corresponds to 28% of current expenditure and reaches almost 40% of the national population.

The analysis carried out so far has focused on current expenditure, but capital expenditure is fundamental to expanding coverage of the population. The next section focuses on the behavior of spending on PHAS according to economic category.

3.2.2 EXPENSES BY ECONOMIC CATEGORY

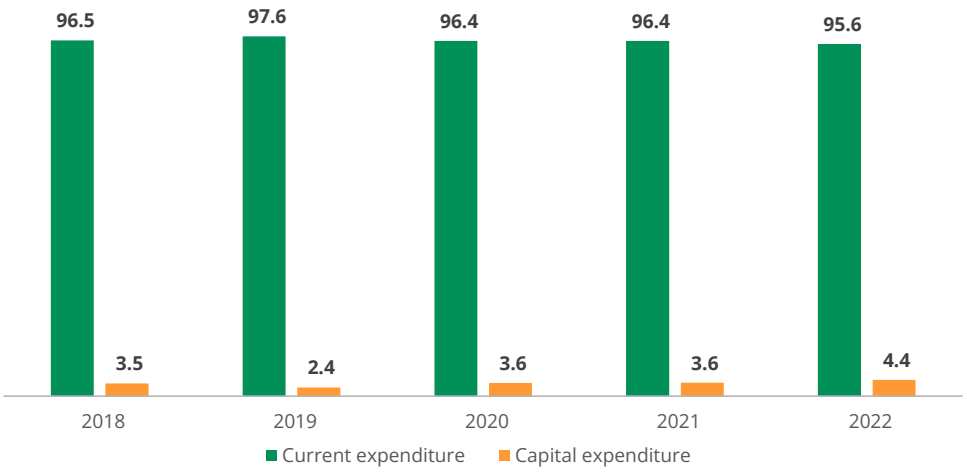
The analysis by economic category makes it possible to distinguish between current and capital expenditure on PHAS. This differentiation is important because it shows how much of the expenditure on PHAS is committed to financing the current structure, thus showing the system's effective capacity for expansion.

In the public sector, investment decisions do not depend exclusively on economic circumstances, but also reflect public choices. Capital expenditure covers a wide range of investments, from construction projects (such as hospitals and healthcare facilities), equipment (e.g. medical equipment, and Information and Communication Technologies

(ICT), as well as intellectual property (including databases and software). Consequently, low levels of capital expenditure can lead to an accumulation of problems, because once equipment and facilities deteriorate, we can expect higher costs in the future.

At the state level, capital expenditure corresponds fundamentally to the expansion of HOC services, which was evident at the time of the system's stress during the covid-19 pandemic. Although the pandemic has drawn attention to the need for investment, defining **the optimum level of capital expenditure** is no simple matter, especially given the numerous current spending demands. Taking the average of the OECD countries as a benchmark, current expenditure is equivalent to 93.2% of total spending, which means that 6.8% of total spending is investment (approximately 0.6% of GDP). However, it's worth remembering that these countries have a very different age structure and disease burden from those that prevail in developed countries.

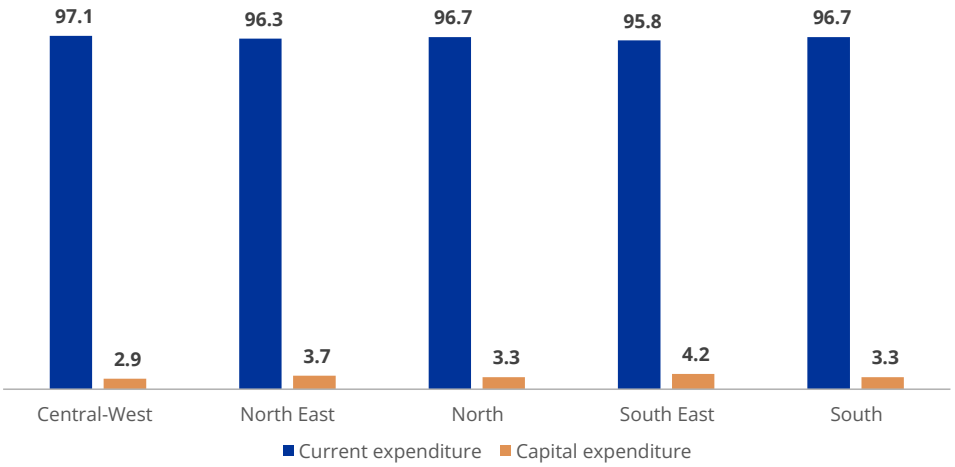
Graph 3.20 A. Distribution of current and capital expenditure - state average (in%)



Source: own elaboration based on Siops.

Graph 3.20 A shows that, on average, 96.5% of state spending on PHAS was allocated to current expenditure, leaving little room for investment spending. We draw attention to the difference in spending levels before, during and after the pandemic. Before 2020, the proportion of investment spending was 2.9%; during the covid-19 crisis, this level increased to 3.6%; and in 2022, it was 1.3 pp higher than the average for the 2018-2021 period (an increase of 39.6%). It's still early days to say that the pandemic has changed the dynamics of resource allocation, but the average proportion of capital expenditure in 2022 is the highest since 2018.

Graph 3.20 B. Distribution of current and capital expenditure by region - state average (2018-2022, in %)



Source: own elaboration based on Siops.

It is worth noting that the highest level in this series is 2.2 pp considerably below the average for OECD countries, representing approximately an average of 0.10% of the GDP of each state[XXXVIII]. Not only is the pattern of investment low throughout the period, but it is also uneven between the states. Taking the entire period (2018-2022), graph 3.20 B shows that the Northeast and Southeast are the regions that have a proportion of capital expenditure above the Brazilian average.

Table 3.12, however, shows that the relative position changed in the post pandemic[XXXIX], when the proportion of capital expenditure fell in the Northeast, but the Southeast, South and Central-West regions were above the national average. The North region also increased the proportion of investment spending in the post-pandemic period, but this was below the national average.

XXXVIII Due to the fact that state GDPs have not yet been released, the proportion of capital expenditure in each state's GDP was calculated using each unit's share of the 2021 GDP.

XXXIX Ordinance GM/MS No. 913, of April 22nd, 2022, declared the closure of the Public Health Emergency of National Importance (ESPIN) and revoked Ordinance GM/MS No. 188, of February 3rd, 2020. So most of 2022 took place after the end of ESPIN. In this analysis, we refer to 2022 as a period "after" the pandemic.

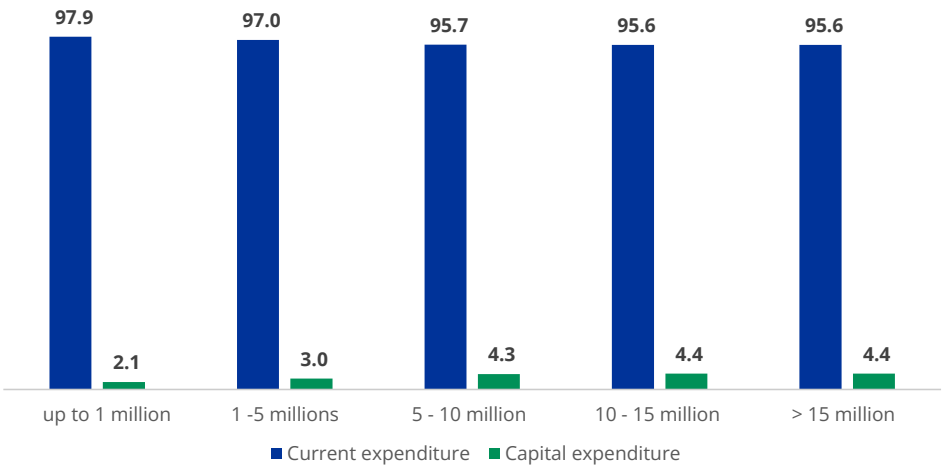
Table 3.12. Proportion of capital expenditure - by region - periods marked by the pandemic (in %)

Region	Pre-pandemic	Pandemic	Post-pandemic	2018-2022
North	3.0	3.0	4.2	3.3
North East	3.4	4.0	3.6	3.7
South East	3.4	4.4	5.5	4.2
South	2.3	3.2	5.6	3.3
Central-West	1.6	3.3	6.1	3.2
Brazil	**2.9**	**3.6**	**4.4**	**3.5**

Source: own elaboration based on Siops.

Graph 3.20 C shows that the share of current expenditure *versus* capital expenditure does not change according to the population size of the states. In other words, we can't assume that more populous states spend more on capital than others.

Graph 3.20 C. Distribution of current and capital expenditure by population group - state average (2018-2022, in %)

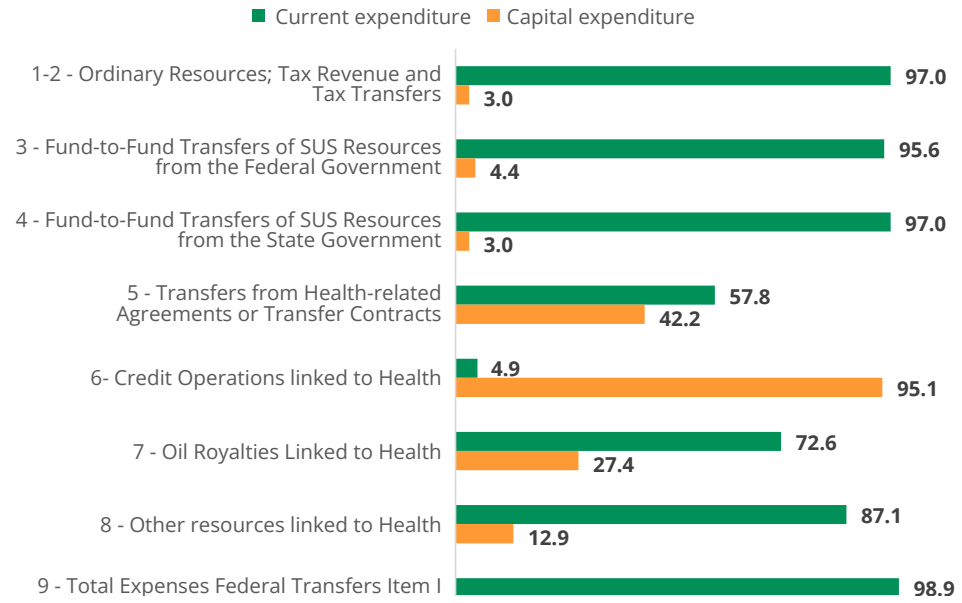


Source: own elaboration based on Siops.

Knowing that approximately 96.5% of PHAS expenditure is on current expenditure,

it is natural that resources from the system's main sources of funding are earmarked for this type of expenditure. It is therefore up to the sources with the lowest share to allocate resources to investment spending.

Graph 3.21. Distribution of current and capital expenditure by source of funds - state average (2018-2022, in %)



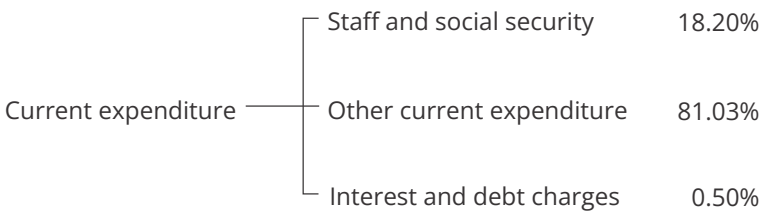
Source: own elaboration based on Siops.

Graph 3.21 highlights three sources of funds linked to Health with a considerable share of capital expenditure: Credit Operations, Transfers from Agreements or On-lending Contracts, and Oil *Royalties*[XL]. Next, we'll take a closer look at the composition of current and capital expenditure.

XL It is worth mentioning that Siops data indicate that resources from oil *royalties* were only recorded under this heading in three states: Amazonas, Rio Grande do Norte and Espírito Santo. We did not find any source entering for the state of Rio de Janeiro.

3.2.2A. CURRENT EXPENDITURE

When disaggregating current expenditure, it can be seen that the vast majority of resources are allocated to "other current expenditure", which, for the whole period, accounts for an average of 81.3% of total usual expenditure.

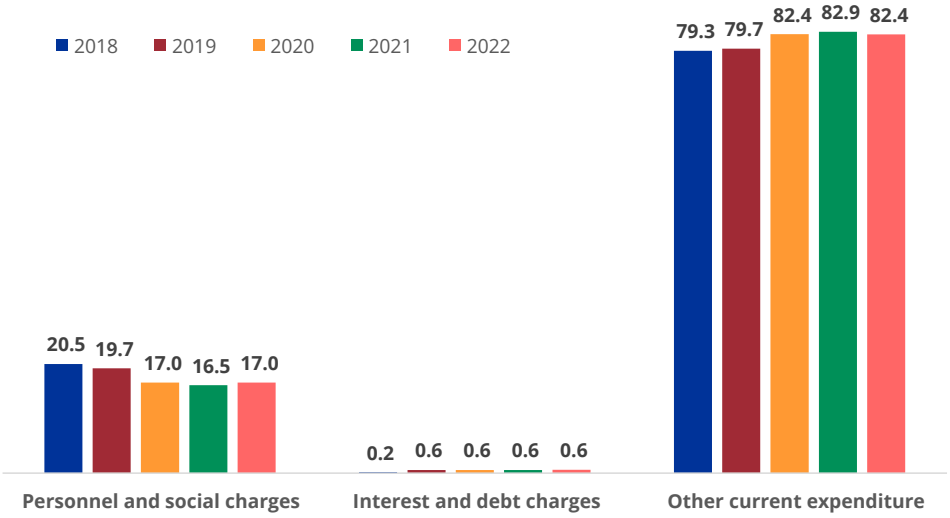


Box 3.2. Current expenditure - main headings - Siops State and Federal District accounts (in order of importance)

Staff and social security	
Direct Application	**Transfers**
– Fixed-term contract – Salary and fixed benefits - civilian staff	– Municipalities (constitutional and consumables) – States – Union
– Salary and fixed benefits - military personnel – Other variable expenses - personnel – Labor indemnities and restitutions – Court rulings	
Other current expenditure	
Direct Application	**Transfers**
- PJ Services - Consumable material (pharmaceutical; hospital medical) – Individual Services – Other personnel expenses - third-party contracts - Fixed-term contracts	- Private non-profit institutions - Municipalities (constitutional and consumables) – States – Union
- Court decisions	

Source: own elaboration based on Siops.

Graph 3.22. Distribution of current health expenditure by category - state average (in %)



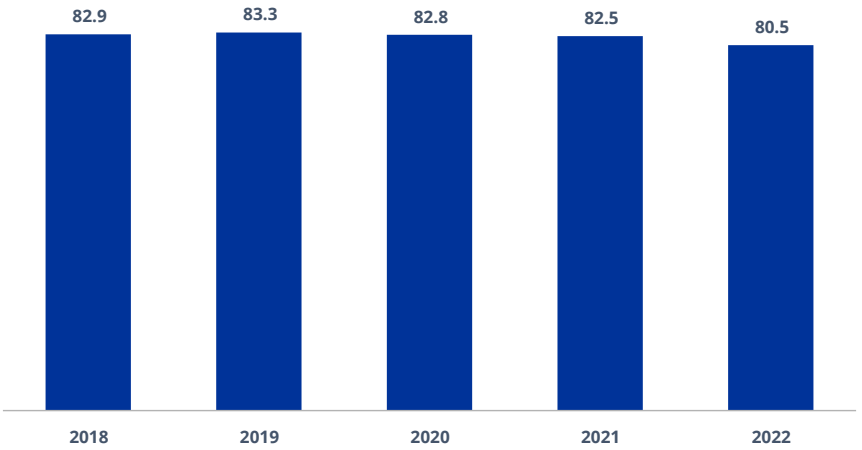
Source: own elaboration based on Siops.

Graph 3.22 shows that the pandemic represented a drop in the distribution of current spending, with a fall in the share of expenditure on "personnel and social charges" (by 16.7%) and an increase in "other current expenditure" (4%) and payments of "interest and debt charges" (57%). However, it is important to note that the reduction in spending on "personnel and social charges" reflects more the increase in the number of workers linked to the SUS in the PJ modality - a phenomenon that has become known as "pejotization" - than a real drop in spending on labor.

The analysis of **direct application** expenditure on "personnel and social charges" shows a drop in participation after the pandemic (graph 3.23 A) due to the relative increase in transfers to municipalities. Among direct expenditure on "personnel and social charges", more than half relates to "civilian salaries and benefits", while "fixed-term contracts" is a type of expenditure that has been growing over time. Together, these two types of expenditure represent, on average, 64% of the direct expenditure on "personnel and social charges" of the states[XLI].

XLI The other 36% is spread over the accounts for "salaries and fixed advantages of military personnel", "other variable personnel expenses", "indemnities and labor restrictions" and "court sentences".

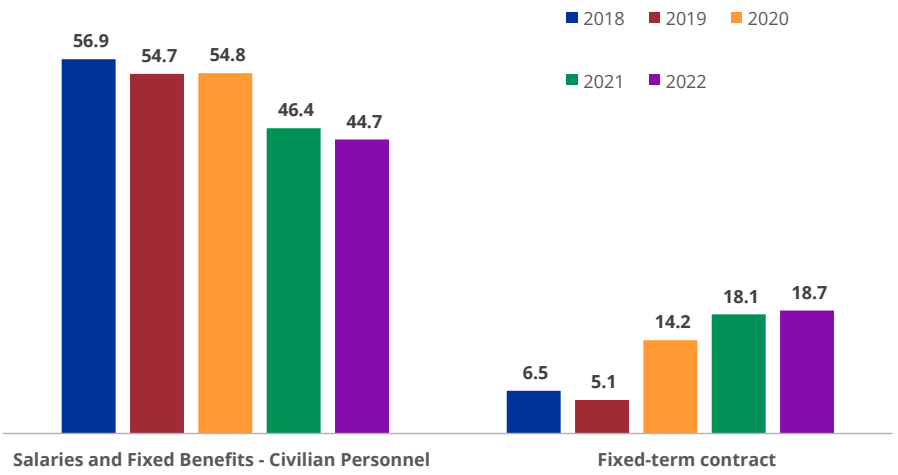
Graph 3.23 A. Percentage of Direct Appropriation in relation to Personnel Expenses and Social Charges - state average (in %)



Source: own elaboration based on Siops.

Graph 3.23 B shows that, once again, the pandemic seems to have been a watershed, since there was a drop in the share of expenditure on "salaries and fixed advantages for civilian staff" and practically a doubling in the share of expenditure on fixed-term contracts. It is worth mentioning that, even after the end of the pandemic, the share of fixed-term contracts increased by approximately 0.5 pp compared to the 2020-2021 biennium.

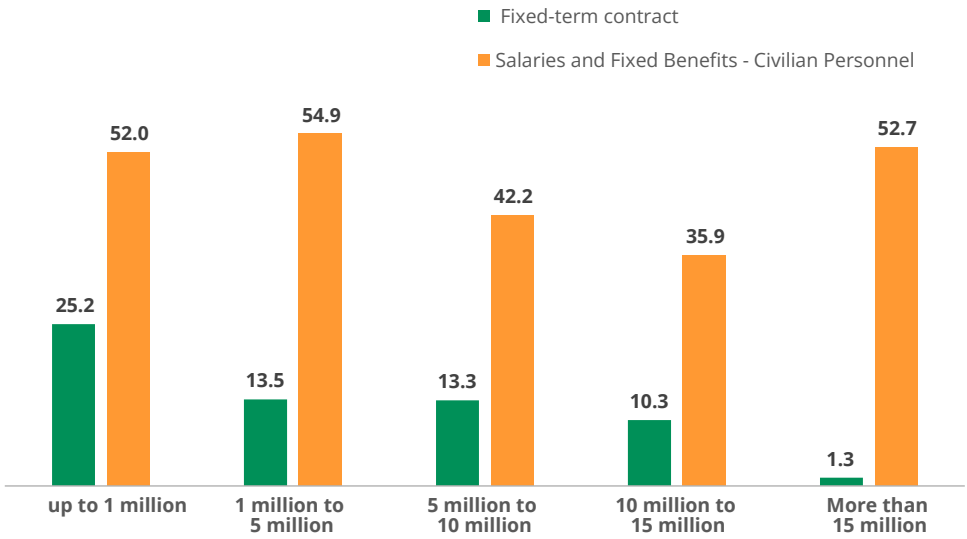
Graph 3.23 B. Composition of direct investments in personnel costs and social contributions - state average (in %)



Source: own elaboration based on Siops.

Graph 3.24 A shows that spending on fixed salaries is more than half of direct spending on "personnel and social charges" at the extremes of the population size of the states, occurring both in states with populations below 5 million and in those with more than 15 million inhabitants. On the other hand, the share of expenditure on temporary hires is higher in less populous states (25.2%), and is relatively stable in states with populations between 1 and 15 million (13.5% to 10.3%).

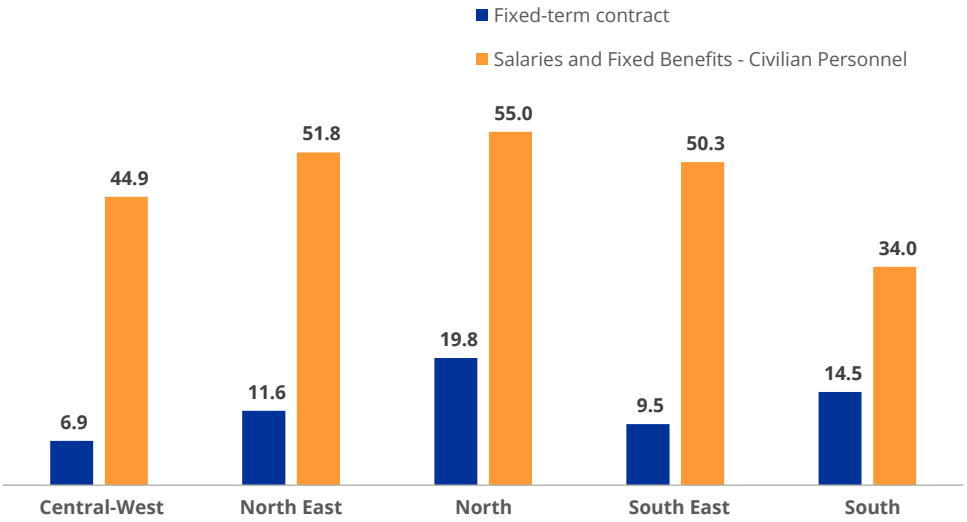
Graph 3.24 A. Selected accounts of the Direct Application of Expenditure on personnel and social charges by population group - average of the states (2018-2022, in %)



Source: own elaboration based on Siops.

As for regional behavior, graph 3.24 B shows that the share of spending on temporary hiring is highest in the North (19.8%) and lowest in the Central-West (6.9%).

Graph 3.24 B. Selected accounts of the Direct Application of Expenditure on personnel and social charges by region - average of the states (2018-2022, in %)



Source: own elaboration based on Siops.

The proportion below 50% for expenditure on fixed salaries in the South and Central-West is striking. This is due to a statistical effect in the calculation of regional averages. Due to the lack of standardization in the filling in of various headings, it is common for the declaration by the states of expenses in specific subfunctions and/or economic categories to be very heterogeneous, thus making it difficult to compare between entities and even over time.

The analysis of expenditure on "salaries and fixed benefits - civilian staff" showed that some states had zero expenditure on this item, which means that the cost of this type of expenditure is probably being recorded in another accounting. Table 3.13 shows the states that did not enter figures for this type of expenditure and the period in which this occurred. It should be noted that four states had this account zeroed out for the entire period (Ceará, Maranhão, Rio Grande do Sul and Goiás); while for other states, the inaccuracy occurred in some specific years. This type of discrepancy affects the regional average, causing this high variation in the average proportion of the type of spending - in this case, 34% for Rio Grande do Sul, and 44.9% for the Central-West.

Table 3.13. Indication of states that have zero expenditure on "salaries and fixed advantages - civilian staff" - period 2018 to 2022

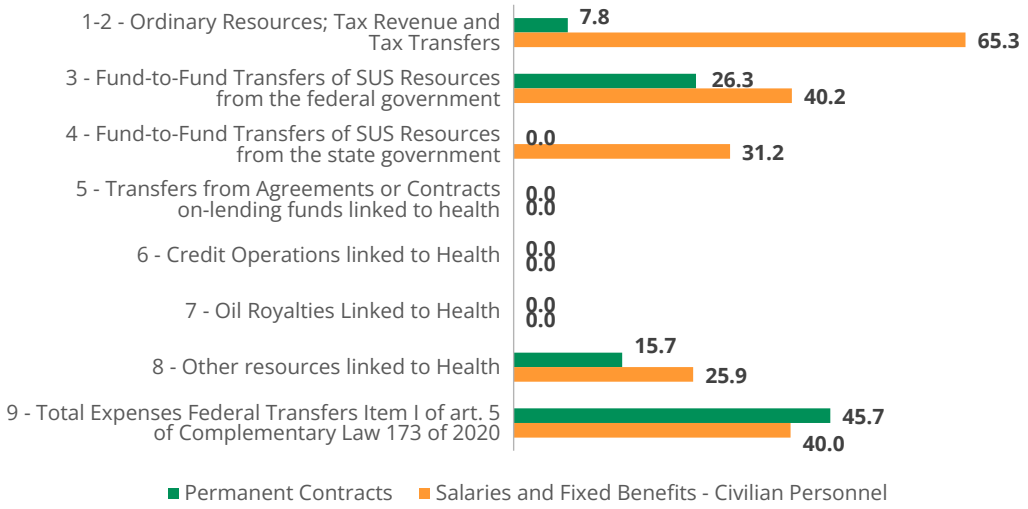
Region	No. of states in the region	State	2018	2019	2020	2021	2022
North	7	Amapá					X
North East	9	Maranhão	X	X	X	X	X
		Ceará	X	X	X	X	X
		Paraíba	X	X	X		
		Alagoas	X	X	X		
		Sergipe	X	X			
South East	4	Rio de Janeiro	X	X			X
		São Paulo		X	X	X	X
South	3	Rio Grande do Sul	X	X	X	X	X
entral-West	4	Goiás	X	X	X	X	X
		Distrito Federal		X			
Brazil	**27**		**8**	**10**	**7**	**5**	**7**

Source: Siops - own elaboration

One option would be to calculate the average only with the FUs that have non-zero values for the expenses of interest. However, this would mean that, for each year, we would obtain the average with a different number of FUs, thus making it impossible to compare over time[XLII].

XLII In this specific case, the proportion of average spending between 2018 and 2022 on "salaries and fixed advantages - civilian staff" in total spending on "staff and social charges" would be: 65.7% in the North; 75.3% in the Northeast; 57.7% in the Southeast; 50.2% in the South and 56% in the Central-West.

Graph 3.24 C. Selected accounts of the Direct Application of Expenditure on personnel and social charges by source of revenue - state average (2018-2022, in %)



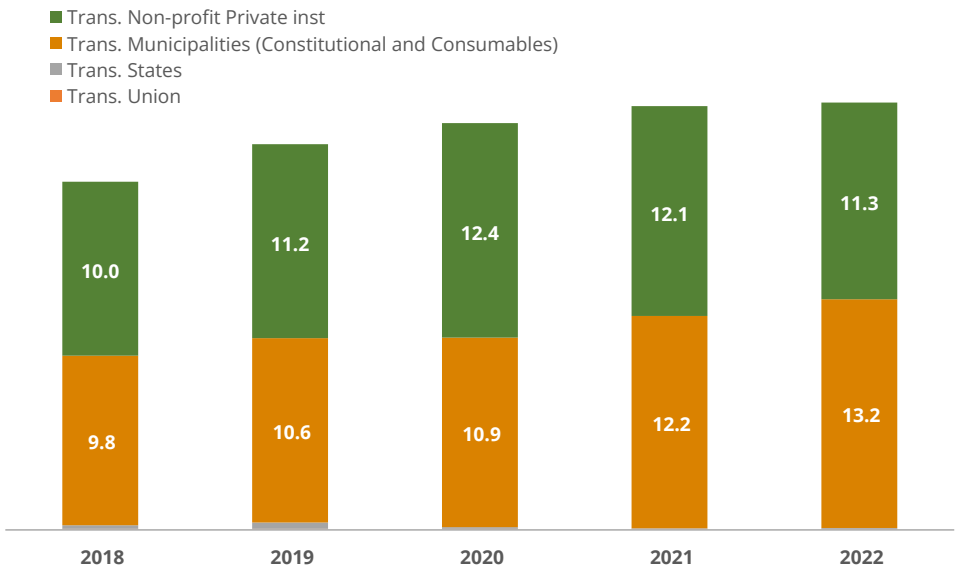
Source: own elaboration based on Siops.

Graph 3.24 C shows how the funds from each source of revenue are allocated to the costs of fixed salaries and temporary contracts relating to "staff and social charges". In addition to the three most important sources for financing PHAS (see graph 3.15), resources linked to health (source 8) and Federal Transfers related to LC 173/2020 (source 9) are also used to finance these two expenses.

However, since own revenues (sources 1 and 2) account for practically 80% of the funds earmarked for PHAS, the proportion of 7.8% from this source for temporary employment is much higher than the 45.7% from source 9 (LC 173/2020). In other words, in addition to the fact that the majority of spending on staff and social security costs is provided from own resources, approximately 73% of this revenue is allocated to direct spending on "staff and social security costs".

As for spending on "other current expenditure", as indicated above, at state level it represents the vast majority of current expenditure on PHAS (81%). This expenditure is quite heterogeneous and includes consumables (pharmaceuticals, medical and hospital supplies, fuel, etc.), outsourced services (medical and hospital services, dental services, laboratory services (Outpatient Information System/Hospital Information System - SIA/SIH), maintenance of equipment, etc.), expenditure on third-party contracts, among others. Approximately 74% of this expenditure is spent directly, and around 20% is transferred to municipalities, private non-profit institutions and other states.

Graph 3.25. Share of transfers in total other current expenditure - state average (in %)



Source: own elaboration based on Siops.

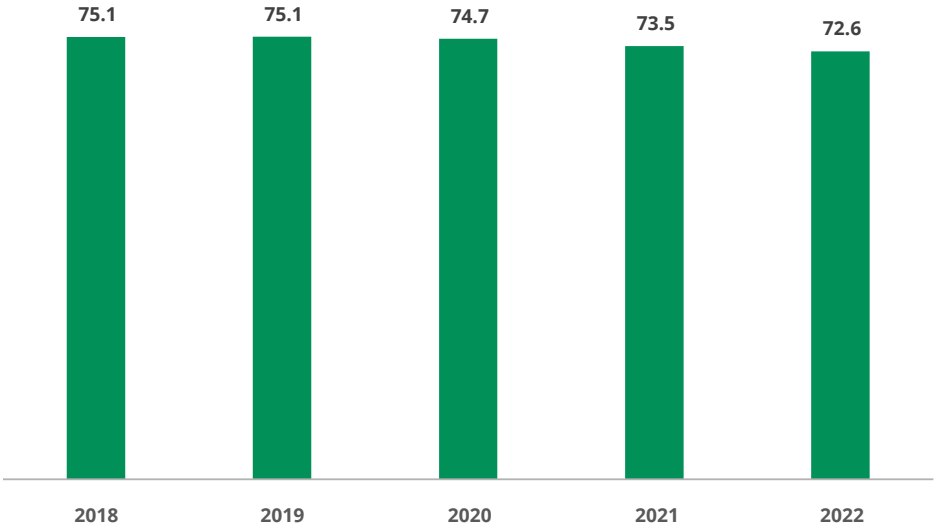
Graph 3.25 shows the evolution of the share of transfers in total spending on "other current expenditure". We can see that, during the pandemic (2020-2021), the share of resources earmarked for transfers increased by approximately 13.2%. This level was maintained in 2022, when total transfers accounted for 24.6% of total "other current expenditure".

When we look at the whole period, we see that, despite the transfers, private non-profit institutions grew in the 2020-2021 biennium at almost the same rate as transfers to municipalities; in 2022, their share was equivalent to that seen a year before the pandemic (11.2%). Among the regions, there was a decrease in the share of transfers to private institutions in the total of resources in the "other current expenditure" account only in the Southeast. Transfers to municipalities increased by almost 3 pp between 2022 and the 2018-2019 biennium. Most of these refer to FAF transfers, which account for approximately 78% of the total. In regional terms, the biggest increase was in the South, and once again the Southeast showed a downturn.

As for direct applications relating to "other current expenditure", graph 3.26 A shows that the share of this expenditure remained practically stable over the course of the period. The most representative expenses in this account, in order of importance, are: "other services - PJ", "consumables" (concentrated in pharmaceuticals and medical

and hospital supplies), “third-party contract expenses” and “other outsourced services - PF”; these account for approximately 55.7% of total expenses.

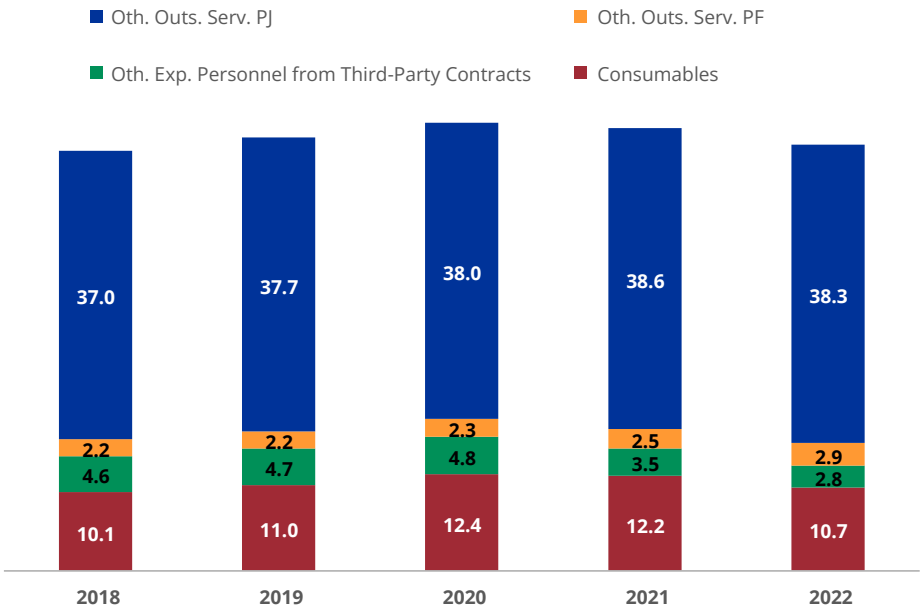
Graph 3.26 A. Share of direct investments in total other current expenditure - state average (in %)



Source: own elaboration based on Siops.

Graph 3.26 B shows that, between the pre-pandemic period and 2022, the only expense that had a reduced share was “third-party contracts” (-1.9 pp; or a negative variation of 40.2%). This reduction was almost equally spread among outsourced services, with an increase of 0.8 pp for Individuals and 0.9 pp for Professionals, while the share of spending on consumables grew only slightly (0.2 pp).

Graph 3.26 B. Composition of Direct Applications of total other current expenditure - state average (in %)

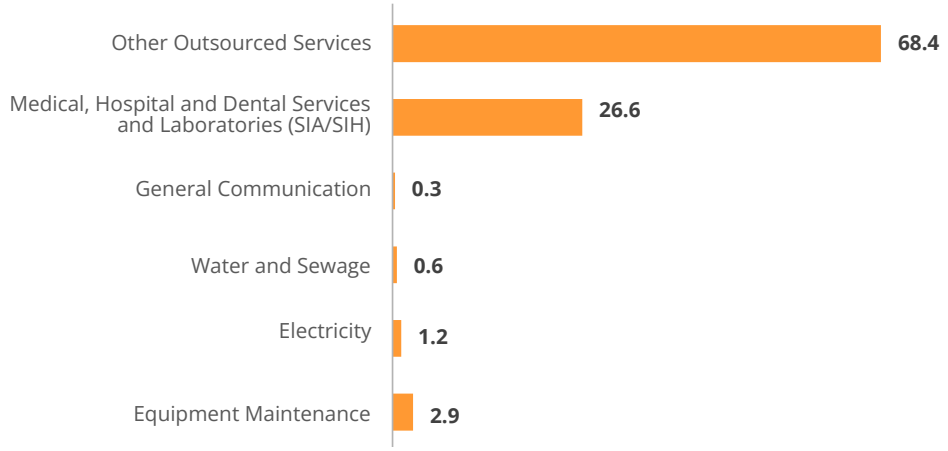


Source: own elaboration based on Siops.

It should also be noted that the expenditure with the greatest weight is that spent on "other outsourced services - PJ", which represents more than 35% of total expenditure on other current expenditure. Graph 3.27 A shows that the main items under this heading relate to medical and hospital services, equipment maintenance, electricity, water and sewage, as well as the cost of outsourced services. This last type of expenditure has the largest share of resources going to contracted providers (68%), which includes everything from hiring companies for clinical analysis to the trend of "pejotization" of clinical staff (doctors and nurses).

It is worth mentioning that the practice of hiring clinical staff by health service providers through third parties is not new in the country, but it was the 2017 Labor Reform that liberalized outsourcing in an unrestricted manner. As we analyze a period after its approval, it is not possible to capture the change before/after its implementation.

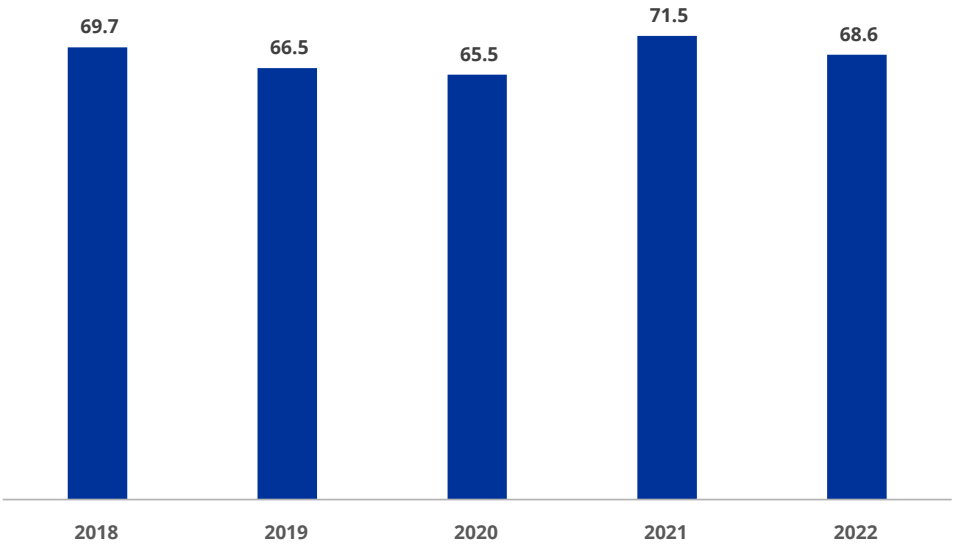
Graph 3.27 A. Composition of Other Outsourced Services - PJ - state average (2018-2022, in %)



Source: own elaboration based on Siops.

Graph 3.27 B shows that, despite the increase in the share of expenditure on "other outsourced services - PJ" in total other current expenditure that occurred in 2021, overall this proportion remained stable over the period analyzed.

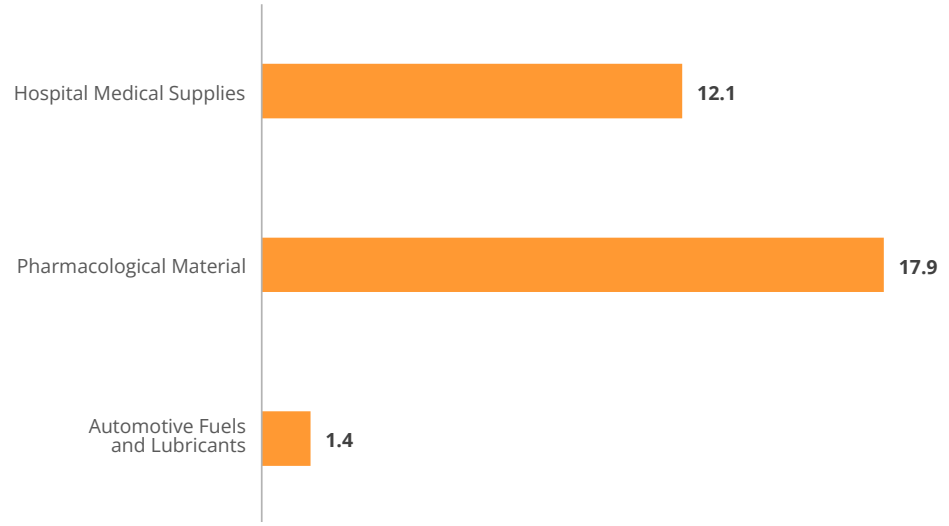
Graph 3.27 B. Evolution of the participation of Other Third Party Services - PJ - average of the states (in %)



Source: own elaboration based on Siops.

The second component with the largest share of direct application expenditure is spending on consumables. This account heading includes many items[XLIII], here we will focus on three of them: fuels, pharmaceutical supplies (this is limited to medicines[XLIV]) and medical and hospital supplies - OPME[XLV]. Together, they account for approximately 31.5% of total expenditure and consumables (graph 3.28 A). Graph 3.28 B, however, shows that these three items have lost ground, falling from 36.9% in 2018 to 27.5% in 2022.

Graph 3.28 A. Composition of consumables - state average (2018-2022, in %)



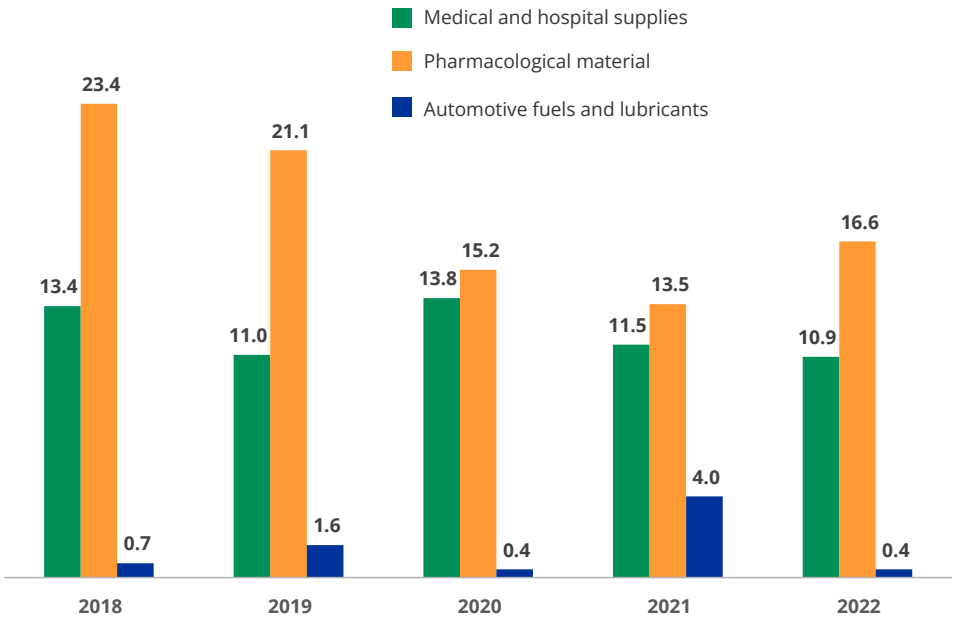
Source: own elaboration based on Siops.

XLIII In addition to the above, we also have the following materials: laboratory, dental, chemical, office, bed, etc. -tableware, cleaning and sanitizing, uniforms, fabrics and trims, safety and security and data processing.

XLIV This refers to medicines both used in healthcare facilities and those distributed for home use.

XLV Orthoses, Prostheses and Special Materials.

Graph 3.28 B. Composition of consumables in relation to total other current expenditure) - state average (2018-2022, in %)



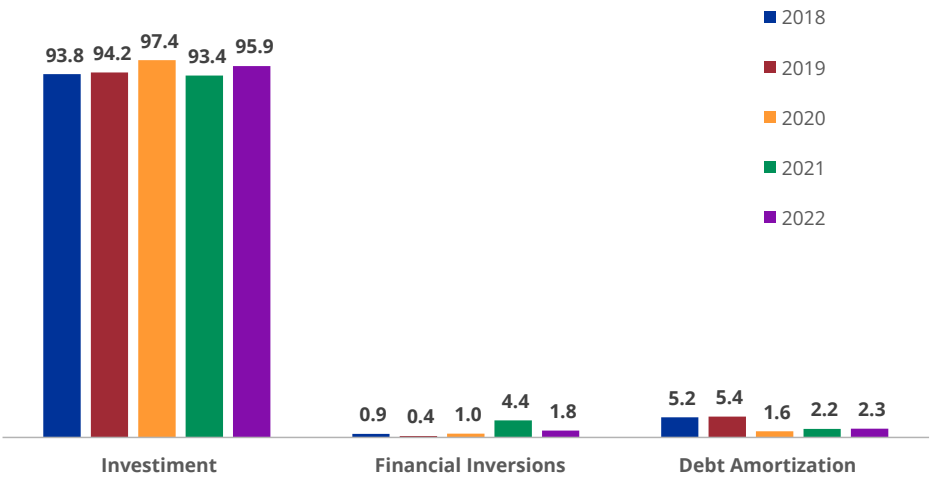
Source: own elaboration based on Siops

3.2.2B. CAPITAL EXPENDITURE ON SOCIAL SECURITY

As we have seen, between 2018 and 2022, capital expenditure accounted for an average of only 3.5% of PHAS spending, and within this economic category, the allocation of resources is still allocated to investment (94.9%), financial investment (1.95%) and debt amortization (3.14%).

Graph 3.29 shows that the highest proportion of investment spending occurred precisely in 2020, when it reached 97.4% of total capital expenditure on PHAS. Although this share has not been maintained, we reached 2022 at a higher level than before the pandemic. In addition, the proportion of capital expenditure in relation to the total on PHAS in 2022 was the highest observed in the period analyzed (4.4%), bringing investment expenditure to R$6.3 billion.

Graph 3.29. Distribution of health capital expenditure by category - state average (in %)

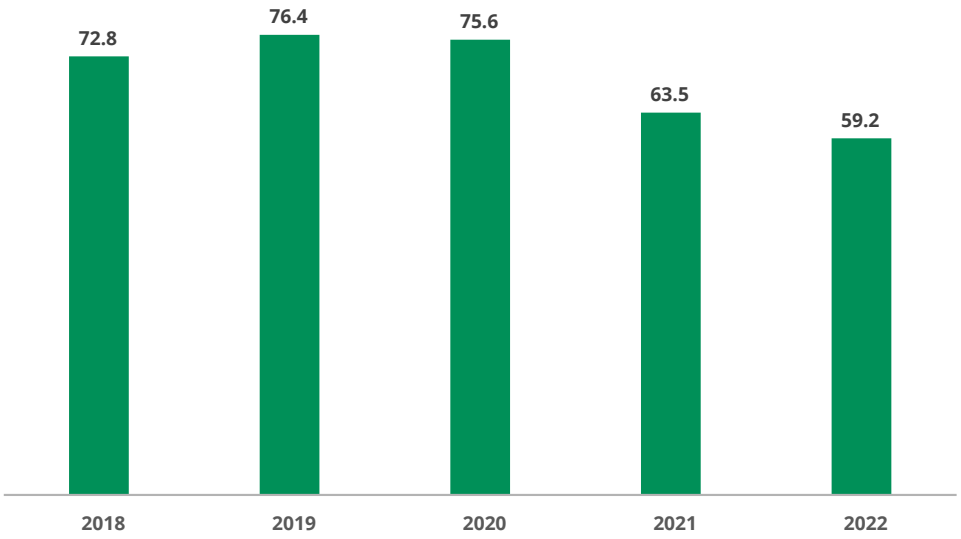


Source: own elaboration based on Siops.

Between 2018 and 2022, the North was the region with the highest share of investments in capital expenditure (99%), and the Northeast the lowest (92.1%). As with the specific current expenditure accounts, the investment item is also calculated according to the amounts earmarked for transfers and direct investments. In the period analyzed, direct investments accounted for approximately 70% of the total amount earmarked for investments.

Graph 3.30 A shows an important change in pattern after the pandemic, with a reduction in the share of spending on direct applications in total investments. This reduction occurred in all regions, but was most intense in the Southeast, where this proportion fell from 61.7% in 2018 to 31.5% in 2022.

Graph 3.30 A. Percentage of direct investment in relation to investment expenditure - state average (in %)

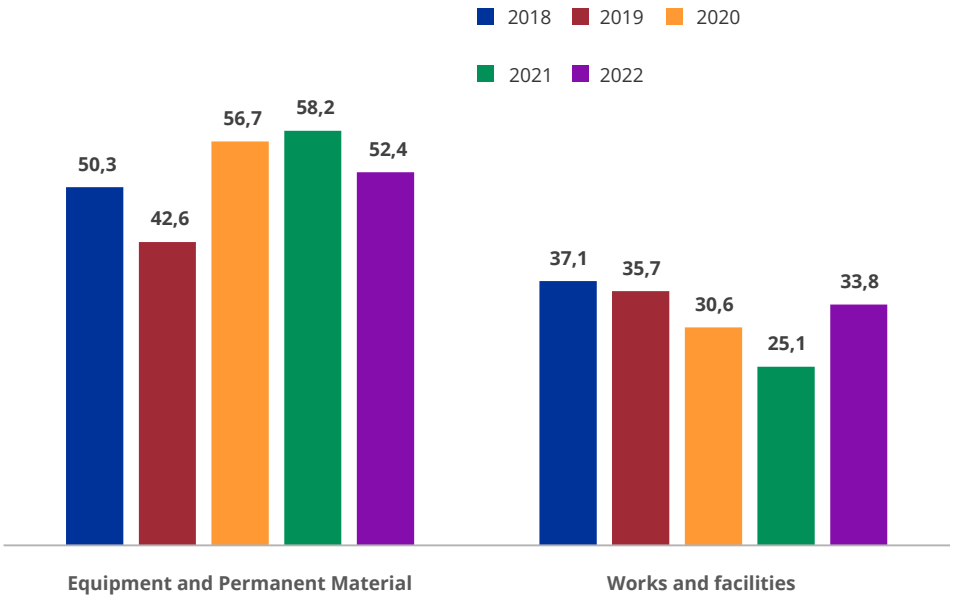


Source: own elaboration based on Siops.

Graph 3.30 A shows the two most important types of direct spending on capital investments: i) equipment and permanent material; and ii) works and facilities. These two items together account for almost 75% of the total spent on investment through direct investment. The first item refers to expenditure on "laboratory and hospital dental apparatus, equipment and utensils", which in the period analyzed accounted for more than half of total investment spending (52.7% on average).

The information in graph 3.30 B shows that the share of spending on equipment and permanent material after the pandemic was 5.9 pp higher than the average for the 2018-2019 biennium (pre-pandemic). Moreover, as was to be expected, it was during the period of the pandemic (2020-2021) that these expenses reached the highest share of investment spending (on average 57.5%).

Graph 3.30 B. Composition of direct investment expenditure - state average (in %)



Source: own elaboration based on Siops.

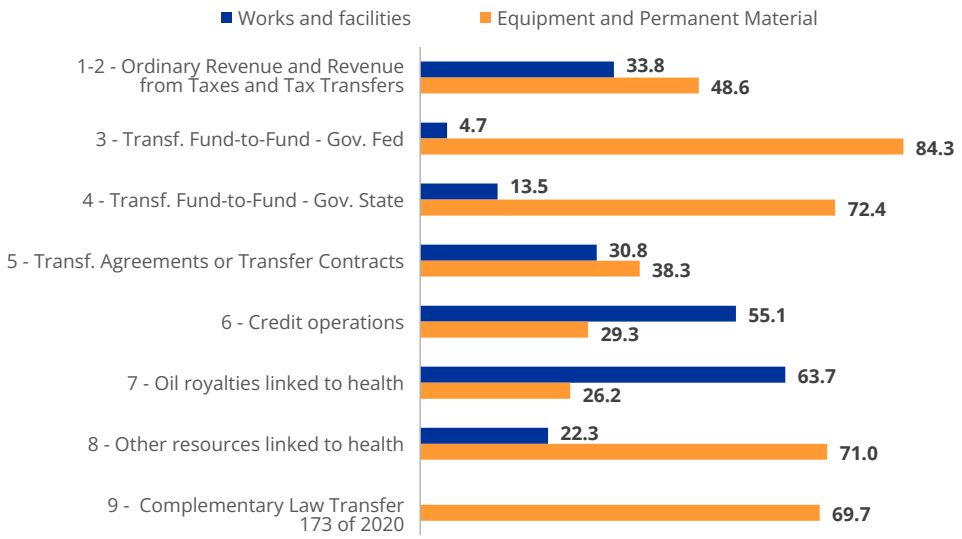
This increase in the proportion of capital expenditure directed towards equipment and permanent material came at the cost of a reduction in the share of expenditure on works and facilities. As a result, this last item of expenditure in direct application reduced its share by approximately 8.6 pp between 2020 and 2021 compared to 2018 and 2019, only to grow again in 2022. However, it can be seen that the share of spending on works and facilities in 2022 had not yet returned to the pre-pandemic levels.

It is common for the dynamics between these two types of investment spending to be the same: the share of spending on equipment and permanent material is greater than that on works and facilities. However, in the Brazilian case, we see a very large discrepancy. OECD data shows that, for this group of countries, investment spending is distributed as follows: 46% on equipment and permanent material, 40% on works and facilities and 14% on intellectual property. In this case, spending on equipment is only 15% (or 6 pp) of spending on works and facilities. In Brazil, the same difference is approximately 60% (or 19.6 pp). This discrepancy suggests that not only is the level of spending on PHAS capital low, but also that the allocation of a large part of the investment resources is concentrated on maintaining the current structure, rather than expanding it.

Graph 3.31 shows that the sources of funds that help increase spending on works and facilities are: the states' own revenues (sources 1-2), transfers from agreements/

contracts, credit operations and oil *royalties* . At the same time, the vast majority of FAF funds from the federal government (84%) are earmarked for expenditure on equipment and permanent material. The state government's FAF resources are less relevant in general terms, but they are still mostly earmarked for expenditure on equipment and permanent material (72.4%)

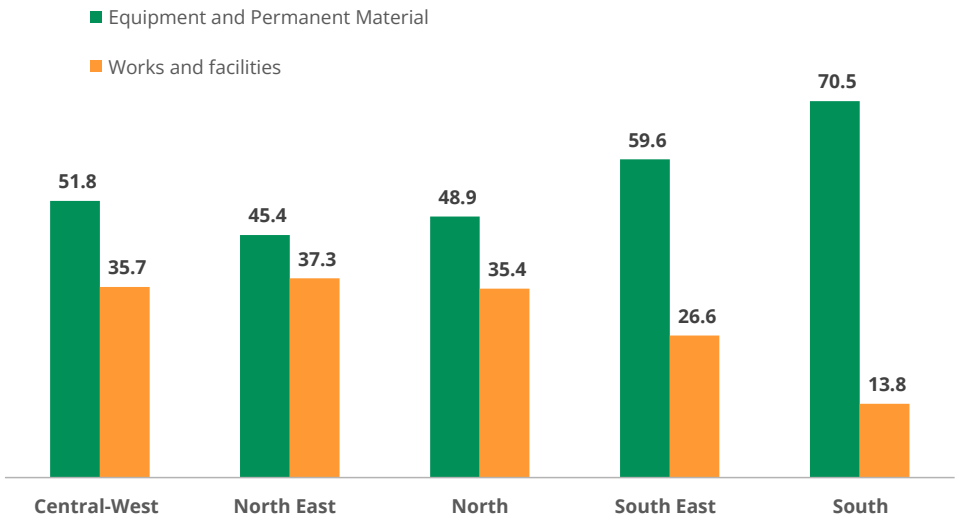
Graph 3.31. Selected accounts of the Direct Application of investment expenditure by source of revenue - state average (2018-2022, in %)



Source: own elaboration based on Siops.

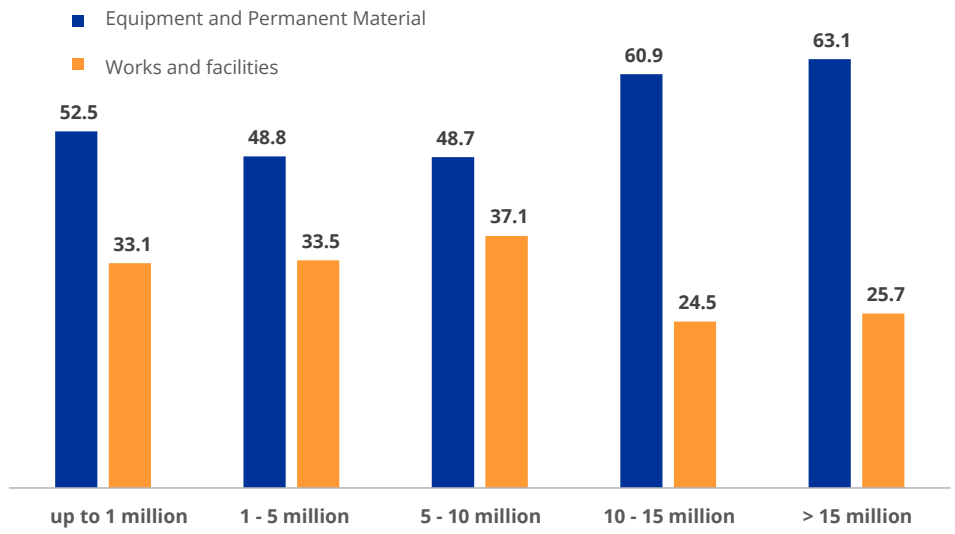
Still on the dynamics of the allocation of capital resources for investments on PHAS, graphs 3.32 A and B show the regions and the size of the FUs (in population terms) that allocate a greater proportion of capital expenditure to works and facilities.

Graph 3.32 A. Selected accounts of Direct Investment expenditure by region - state average (2018-2022, in %)



Source: own elaboration based on Siops.

Graph 3.32 B. Selected accounts of direct investment expenditure by population group - state average (2018-2022, in %)



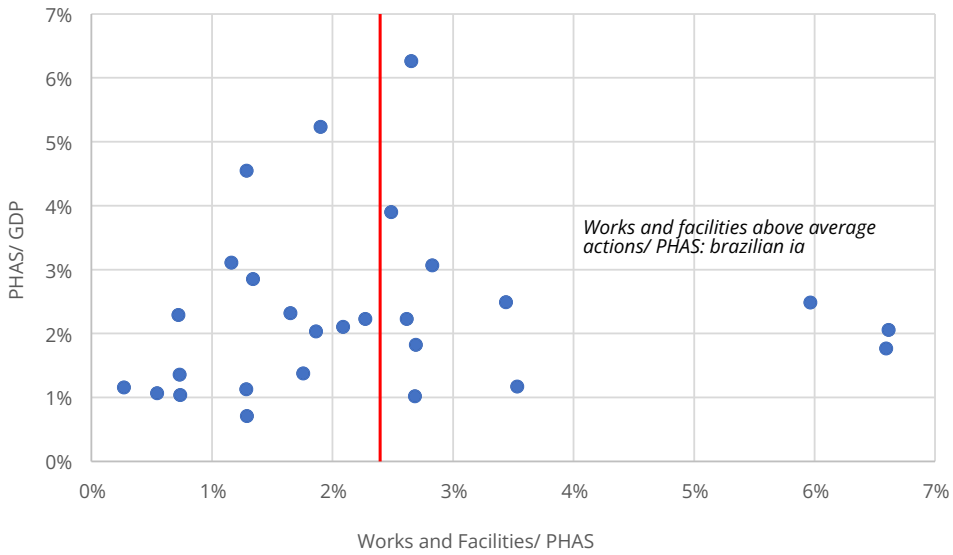
Source: own elaboration based on Siops.

The data shows that it is the states in the North, Northeast and Center-West regions that maintain, on average, a 35% share of expenditure on works and facilities of direct

capital expenditure on PHAS, as the South and Southeast regions are below 30%. In addition, contrary to popular belief, the most populous states (at least 10 million inhabitants) have a lower share of expenditure on works and facilities. On the other hand, FUs with up to 5 million inhabitants spend approximately 33% of direct application expenditure on works and facilities, and the highest proportional capital expenditure (37%) is made by 6 FUs with populations between 5 and 10 million inhabitants[XLVI].

Graph 3.33 shows the relationship between the share of expenditure on works and facilities in spending on PHAS and the proportion of state GDP allocated to PHAS. Between 2018 and 2019, the states spent an average of 2.33% of their expenditure on PHAS on works and facilities (red vertical line in the graph). We have 11 states above the average, among which the minimum proportion of works and facilities/PHAS is 2.50%, and the maximum 6.60%. The graphic visualization does not allow us to identify any correlation (positive or negative) between spending on PHAS/GDP and the share of investments in works and facilities over total spending on PHAS. It can be seen that the state with the highest proportion of SPS/GDP has a slightly higher ratio of spending on works and facilities to SPS than the national average (2.65%); or the state with the highest share of spending on works and facilities to SPS (6.60%) allocates only 2% of its GDP to PHAS.

Graph 3.33. Ratio between the share of expenditure on Works and Facilities in total PHAS expenditure and the PHAS proportion of GDP - state average (2018-2022)



Source: own elaboration based on Siops.

XLVI They are: Ceará, Goiás, Maranhão, Pará, Pernambuco and Santa Catarina.

The lack of a direct relationship between spending on works and facilities and the proportion of the state's GDP that is allocated to PHAS does not allow us to identify an PHAS spending profile that favors investment in the expansion/replacement of the state health network. Although the high proportion of spending on equipment and permanent material (to the detriment of spending on works and facilities) is higher in the Southeast and South regions, it is generalized in terms of the population size of the state. In other words, regardless of local characteristics in terms of the need for health services and/or the complexity of the supply and management of the network, the low expenditure on works and facilities indicates that the risk of health structures being scrapped is a possible reality.

3.3 ONLINE SURVEY WITH STATE HEALTH DEPARTMENTS

The management of health expenditure is particularly complex. Each state has its own peculiarities and faces specific demands in terms of command, control and supervision of the PHAS services offered. For this reason, there are difficulties in defining a common categorization of expenses that are entered under one account heading or another.

Moreover, we understand that the constant changes in the aggregation of Siops accounts also make it difficult to create an organizational culture in which decisions on resource allocation are based on common evidence. This situation hinders the exchange of experiences between health managers.

In order to better understand how the Health Secretariats feed and use Siops, we administered an *online* questionnaire to managers. This survey was made up of four specific parts:

I. Current and capital expenditure;

II. Sources of revenue available for PHAS;

III. Expenditure by typical health subfunctions; and

IV. Producing the data and sending the information to Siops.

Table 3.14. Main results of the Conass survey of Health Secretaries

Region	Difficulty in execution		Own monitoring system for spending on PHAS	Revenue forecast for health is stable
	Current Expenditure	Capital Expenditure		
North	33.3%	50.0%	16.7%	16.7%
North East	28.6%	42.9%	57.1%	50.0%
South East	25.0%	75.0%	100%	50.0%
South	0.0%	0.0%	66.7%	16.7&
Central-West	0.0%	0.0%	33.3%	50.0%
Brazil	**21.7%**	**39.1%**	**47.8%**	**47.8%**

Source: own elaboration.

The health secretaries had a period of three months over the second half of 2023 to submit their answers. In the end, we had 85.2% adherence (23 Health Secretariats).

In summary, the answers to the *online* questionnaire indicated that:

- There is difficulty in executing capital expenditure;
- With regard to the classification of expenses by Siops, 17.4% of the responding secretariats said they had doubts about the best way to record them;
- Less than half of the secretariats have their own monitoring system for spending on PHAS;
- The revenue forecast for health is stable for less than half of the responding departments (47.8%);

High perception that the state needs to allocate a large portion of its own resources to health;

Most secretariats use the data sent to Siops for planning;

Most secretariats would like to have a data dashboard.

In our view, this project is a first step towards the Health Secretariats having a broad and, at the same time, circumscribed view of the participation of the main sources

of income in health spending. By providing a regional portrait of the financing of PHAS, we want to encourage the exchange of local experiences and thus broaden the debate on the existing bottlenecks in the application and execution of resources dedicated to health actions and services at the state level.

3..4 CONCLUSION

This chapter provided details on the public health accounts of the states. Despite their reasonable fiscal autonomy, the states are still far from being able to equalize their financial management to the point of considerably increasing investment spending. Firstly, we show how fiscal autonomy is unequal not only between regions, but also within each region. This situation makes the equalization of resources proportional to the population between the different entities even more complex.

In addition, the differences in the degree of relevance of federal transfers in relation to current expenditure practically separate Brazil into two areas. On the one hand, we have the North and Northeast with the lowest collection capacity and a high share of federal transfers (FAF) in current revenues; on the other, the Southeast, South and Central-West, whose share of federal transfers represents well under half of the resources.

The second relevant point concerns the spending profile. It can be seen that the states' expenditure on PHAS is concentrated in the HOC and Administrative subfunctions. Among the others, PTS is the most significant, while Health and Epidemiological Surveillance have shown marginal participation. It's worth mentioning that both Surveillance Centers have shown growth during the pandemic, but that spending has been reduced since 2022. The cross-referencing between subfunction and source of funds shows that the vast majority of spending on HOC and the Administrative function comes from the states' own resources (sum of ordinary revenues, taxes and resources from constitutional tax transfers). The main source of expenditure for Health and Epidemiological Surveillance is the federal government's FAF.

Despite the fact that all regions have more than half of their HOC spending coming from their own revenues, there are still significant differences according to the region and/or population profile of the state. Expenditure data by subfunction and source of funds show that the North and Northeast regions are more diversified in terms of sources of funds. In this case, only the three states with a population of between 10 and 15 million inhabitants have a better balance between funding sources.

The last point concerns the distribution of resources between current and capital expenditure. The data reaffirms that the majority of resources are allocated to current

expenses. This shows that the heavy burden of maintaining existing services demands practically all the resources, thus jeopardizing investments in new structures that could expand access for the population. In other words, there is now a limit that narrows the space for state managers when it comes to allocating resources to infrastructure, particularly works and facilities. At the end of the study, it can be seen that, without a targeted effort, it will be difficult for the states on their own to increase capital expenditure to renew and expand health infrastructure.

Finally, we believe that this study shows the complex context of the financial management of health resources at state level. It is known that, although the capacity to generate revenue is unequal among the states, the need for investment is pressing for all of them. Given this situation, the regional inequality and the urgent need to diversify the sources of funds to increase investment in infrastructure (works and facilities) are striking.

Since the chances of increasing the share of federal resources in health financing seem limited, it is recommended that resources be increased through agreements or transfer contracts that do not come from the SUS. In addition, a detailed analysis of each health policy/program can't be postponed in order to check whether they are meeting their objectives. It will be up to each state to check whether or not there is room to reallocate spending, further optimizing the public budget in order to make room for capital expenditure.

From this perspective, it is essential that local specificities regarding epidemiological characteristics and the burden of disease are taken into account so that health spending is not only efficient, but also equitable and geared towards the needs of the population. We believe that the suggested recommendations will help to re-evaluate the financial management of health in the states, so that a better balance in spending can be achieved.

3.5 APPENDIX

STATE EXPENDITURES

Table A1. Total expenditure on PHAS in R$ million (nominal) - Brazil

Subfunction	2018	2019	2020	2021	2022	Average 2018-2022	Share 2018-2022 (%)
301 - Primary Care	2,256	3,489	3,450	4,359	4,616	3,634	3.26
302 - Hosp. Outp. Care	54,720	60,405	66,743	81,518	91,933	71,064	63.75
303 - Proph. Thera. Supp.	5,069	5,527	6,117	5,690	6,332	5,747	5.16
304 - Health Surveillance	115	109	162	247	210	169	0.15
305 - Epi. Surveillance	742	506	2,855	2,973	1,324	1,680	1.51
306 - Food and Nutrition	386	393	357	309	249	339	0.30
Administrative	23,472	22,914	24,497	28,100	30,602	25,917	23.25
Complementary Information	2,223	2,302	3,856	2,931	3,293	2,921	2.62
North	**88,983**	**95,644**	**108,037**	**126,126**	**138,560**	**111,470**	**100**

Source: own elaboration based on Siops.

*** Expenditure paid**

Table A2. Total state expenditure on PHAS in R$ million (real values: Jan./2023)

Subfunction*	2018	2019	2020	2021	2022	Average 2018-2022
PC - Primary Care	2.879	4.268	4.038	4.635	4.616	4.087
HOC - Hosp. Outp. Care	69.823	73.894	78.120	86.690	91.933	80.092
PTS - Proph. Thera. Supp.	6.468	6.761	7.159	6.051	6.332	6.554
HEA - Health Surveillance	147	133	189	263	210	188
EPI - Epi. Surveillance	946	619	3.342	3.162	1.324	1.879
F&N - Food and Nutrition	492	481	418	328	249	394
ADM - Administrative	29.950	28.031	28.673	29.883	30.602	29.428
Complementary Information	2.837	2.816	4.513	3.117	3.293	3.315
Brazil	**113.543**	**117.004**	**126.452**	**134.130**	**138.560**	**125.938**

Source: own elaboration based on Siops.

*** Expenditure paid**

Table A3. Total PHAS expenditure in R$ million (nominal) - by region

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022	Share 2018-2022 (%)
North	301 - Primary Care	156.8	266.3	105.1	165.2	227.2	184.1	1.37
	302 - Hosp. Outp. Care	6,196.0	6,219.1	6,390.5	7,525.4	9,203.5	7,106.9	52.81
	303 - Proph. Thera. Supp.	316.5	334.8	256.1	328.0	408.3	328.7	2.44
	304 - Health Surveillance	14.7	10.0	9.5	3.3	12.6	10.0	0.07
	305 - Epi. Surveillance	81.8	59.7	48.9	63.6	80.5	66.9	0.50
	306 - Food and Nutrition	1.8	7.1	0.0	0.0	0.0	1.8	0.01
	Administrative	3,574.0	3,584.8	4,979.4	7,057.4	7,478.0	5,334.7	39.64
	Complementary Information	113.8	35.5	1,420.5	386.4	159.5	423.1	3.14
	North	**10,455**	**10,517**	**13,210**	**15,529**	**17,570**	**13,456**	**100**
North East	301 - Primary Care	291.4	400.5	458.9	453.3	841.3	489.1	1.83
	302 - Hosp. Outp. Care	13,517.9	16,387.6	17,261.6	20,762.8	24,136.2	18,413.2	68.79
	303 - Proph. Thera. Supp.	598.8	604.0	720.4	793.9	979.0	739.2	2.76
	304 - Health Surveillance	39.7	52.1	7.0	8.8	10.9	23.7	0.09
	305 - Epi. Surveillance	137.9	125.5	1,007.3	1,236.7	480.7	597.6	2.23
	306 - Food and Nutrition	15.4	14.8	0.8	0.9	0.9	6.5	0.02
	Administrative	5,808.2	5,198.2	6,000.6	6,287.8	7,287.9	6,116.5	22.85
	Complementary Information	409.8	364.8	325.7	380.2	435.6	383.2	1.43
	North East	**20,819**	**23,148**	**25,782**	**29,924**	**34,172**	**26,769**	**100**
South East	301 - Primary Care	994.2	1,916.8	1,684.1	2,415.5	2,291.7	1,860.5	4.28
	302 - Hosp. Outp. Care	25,145.4	27,268.5	30,687.4	38,829.0	42,056.4	32,797.3	75.46
	303 - Proph. Thera. Supp.	2,463.1	2,660.3	2,836.1	2,699.5	3,084.8	2,748.7	6.32
	304 - Health Surveillance	45.4	32.8	108.3	186.5	128.6	100.3	0.23
	305 - Epi. Surveillance	436.6	221.7	1,303.9	903.9	521.8	677.6	1.56
	306 - Food and Nutrition	143.5	146.4	138.9	132.4	130.0	138.2	0.32
	Administrative	5,017.5	4,226.4	2,653.8	3,490.4	3,225.1	3,722.6	8.57
	Complementary Information	809.2	1,255.3	1,589.3	1,503.4	1,928.2	1,417.1	3.26
	South East	**35,055**	**37,728**	**41,002**	**50,161**	**53,367**	**43,462**	**100**

Table A3. Total PHAS expenditure in R$ million (nominal) - by region

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022	Share 2018-2022 (%)
South	301 - Primary Care	584.3	584.3	776.0	1,067.6	927.9	788.0	5.08
	302 - Hosp. Outp. Care	6,908.3	6,992.3	7,663.2	8,041.5	8,715.2	7,664.1	49.36
	303 - Proph. Thera. Supp.	1,192.2	1,351.3	1,774.6	1,426.7	1,464.0	1,441.8	9.29
	304 - Health Surveillance	7.2	6.6	30.8	44.9	52.1	28.3	0.18
	305 - Epi. Surveillance	55.9	55.3	278.7	633.2	135.5	231.7	1.49
	306 - Food and Nutrition	92.2	89.7	68.1	105.9	0.0	71.2	0.46
	Administrative	3,855.6	3,813.9	4,649.1	5,195.3	6,137.2	4,730.2	30.47
	Complementary Information	732.5	506.7	481.9	532.0	599.3	570.5	3.67
	South	**13,428**	**13,400**	**15,722**	**17,047**	**18,031**	**15,526**	**100**
Central-West	301 - Primary Care	229.2	321.2	425.9	257.2	328.2	312.3	2.55
	302 - Hosp. Outp. Care	2,952.8	3,537.1	4,740.5	6,359.0	7,821.6	5,082.2	41.46
	303 - Proph. Thera. Supp.	498.5	576.6	529.7	441.9	395.8	488.5	3.99
	304 - Health Surveillance	8.5	7.1	6.1	3.5	6.0	6.2	0.05
	305 - Epi. Surveillance	29.5	44.2	216.4	135.9	105.8	106.4	0.87
	306 - Food and Nutrition	132.7	135.2	149.4	69.4	118.3	121.0	0.99
	Administrative	5,216.2	6,090.3	6,214.6	6,068.8	6,474.0	6,012.8	49.06
	Complementary Information	158.2	139.6	38.7	129.5	170.6	127.3	1.04
	Central-West	**9,226**	**10,851**	**12,321**	**13,465**	**15,420**	**12,257**	**100**

Source: own elaboration based on Siops.

Table A4. Total PHAS expenditure in R$ million (real) - by region

* concept: paid

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022	Variation 2022/2018 (%)
North	301 - Primary Care	200	326	123	176	227	210	13.5
	302 - Hosp. Outp. Care	7,906	7,608	7,480	8,003	9,204	8,040	16.4
	303 - Proph. Thera. Supp.	404	410	300	349	408	374	1.1
	304 - Health Surveillance	19	12	11	3	13	12	-33.1
	305 - Epi. Surveillance	104	73	57	68	80	77	-22.8
	306 - Food and Nutrition	2	9	0	0	0	2	-99.4
	Administrative	4,560	4,385	5,828	7,505	7,478	5,951	64.0
	Complementary Information	145	43	1,663	411	159	484	9.9
	North	**13,341**	**12,866**	**15,462**	**16,515**	**17,570**	**15,151**	**31.7**
North East	301 - Primary Care	372	490	537	482	841	544	126.2
	302 - Hosp. Outp. Care	17,249	20,047	20,204	22,080	24,136	20,743	39.9
	303 - Proph. Thera. Supp.	764	739	843	844	979	834	28.1
	304 - Health Surveillance	51	64	8	9	11	29	-78.6
	305 - Epi. Surveillance	176	154	1,179	1,315	481	661	173.2
	306 - Food and Nutrition	20	18	1	1	1	8	-95.6
	Administrative	7,411	6,359	7,023	6,687	7,288	6,954	-1.7
	Complementary Information	523	446	381	404	436	438	-16.7
	North East	**26,565**	**28,317**	**30,177**	**31,823**	**34,172**	**30,211**	**28.6**
South East	301 - Primary Care	1,269	2,345	1,971	2,569	2,292	2,089	80.6
	302 - Hosp. Outp. Care	32,086	33,358	35,918	41,293	42,056	36,942	31.1
	303 - Proph. Thera. Supp.	3,143	3,254	3,319	2,871	3,085	3,134	-1.8
	304 - Health Surveillance	58	40	127	198	129	110	122.2
	305 - Epi. Surveillance	557	271	1,526	961	522	768	-6.3
	306 - Food and Nutrition	183	179	163	141	130	159	-29.0
	Administrative	6,402	5,170	3,106	3,712	3,225	4,323	-49.6
	Complementary Information	1,033	1,536	1,860	1,599	1,928	1,591	86.7
	South East	**44,730**	**46,154**	**47,991**	**53,344**	**53,367**	**49,117**	**19.3**

Table A4. Total PHAS expenditure in R$ million (real) - by region

* concept: paid

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022	Variation 2022/2018 (%)
South	301 - Primary Care	746	715	908	1,135	928	886	24.4
	302 - Hosp. Outp. Care	8,815	8,554	8,969	8,552	8,715	8,721	-1.1
	303 - Proph. Thera. Supp.	1,521	1,653	2,077	1,517	1,464	1,647	-3.8
	304 - Health Surveillance	9	8	36	48	52	31	468.7
	305 - Epi. Surveillance	71	68	326	673	135	255	89.9
	306 - Food and Nutrition	118	110	80	113	0	84	-100.0
	Administrative	4,920	4,666	5,441	5,525	6,137	5,338	24.7
	Complementary Information	935	620	564	566	599	657	-35.9
	South	**17,134**	**16,393**	**18,402**	**18,129**	**18,031**	**17,618**	**5.2**
Central-West	301 - Primary Care	292	393	498	273	328	357	12.2
	302 - Hosp. Outp. Care	3,768	4,327	5,548	6,763	7,822	5,645	107.6
	303 - Proph. Thera. Supp.	636	705	620	470	396	565	-37.8
	304 - Health Surveillance	11	9	7	4	6	7	-44.5
	305 - Epi. Surveillance	38	54	253	145	106	119	181.3
	306 - Food and Nutrition	169	165	175	74	118	140	-30.1
	Administrative	6,656	7,450	7,274	6,454	6,474	6,862	-2.7
	Complementary Information	202	171	45	138	171	145	-15.5
	Central-West	**11,772**	**13,275**	**14,422**	**14,320**	**15,420**	**13,842**	**31.0**

Fonte: elaboração própria com base no Siops.

Table A5. Average state spending on PHAS in R$ million (real values R$: Jan./23) - by region

* concept: paid

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022
North	301 - Primary Care	29	47	18	25	32	30
	302 - Hosp. Outp. Care	1,129	1,087	1,069	1,143	1,315	1,149
	303 - Proph. Thera. Supp.	58	59	43	50	58	53
	304 - Health Surveillance	3	2	2	0	2	2
	305 - Epi. Surveillance	15	10	8	10	11	11
	306 - Food and Nutrition	0	1	0	0	0	0
	Administrative	651	626	833	1,072	1,068	850
	Complementary Information	21	6	238	59	23	69
	North	**1,906**	**1,838**	**2,209**	**2,359**	**2,510**	**2,164**
North East	301 - Primary Care	41	54	60	54	93	60
	302 - Hosp. Outp. Care	1,917	2,227	2,245	2,453	2,682	2,305
	303 - Proph. Thera. Supp.	85	82	94	94	109	93
	304 - Health Surveillance	6	7	1	1	1	3
	305 - Epi. Surveillance	20	17	131	146	53	73
	306 - Food and Nutrition	2	2	0	0	0	1
	Administrative	823	707	780	743	810	773
	Complementary Information	58	50	42	45	48	49
	North East	**2,952**	**3,146**	**3,353**	**3,536**	**3,797**	**3,357**
South East	301 - Primary Care	317	586	493	642	573	522
	302 - Hosp. Outp. Care	8,021	8,340	8,980	10,323	10,514	9,236
	303 - Proph. Thera. Supp.	786	814	830	718	771	784
	304 - Health Surveillance	14	10	32	50	32	28
	305 - Epi. Surveillance	139	68	382	240	130	192
	306 - Food and Nutrition	46	45	41	35	33	40
	Administrative	1,601	1,293	777	928	806	1,081
	Complementary Information	258	384	465	400	482	398
	South East	**11,182**	**11,538**	**11,998**	**13,336**	**13,342**	**12,279**

Table A5. Average state spending on PHAS in R$ million (real values R$: Jan./23) - by region

* concept: paid

	Subfunction	2018	2019	2020	2021	2022	Average 2018-2022
South	301 - Primary Care	249	238	303	378	309	295
	302 - Hosp. Outp. Care	2,938	2,851	2,990	2,851	2,905	2,907
	303 - Proph. Thera. Supp.	507	551	692	506	488	549
	304 - Health Surveillance	3	3	12	16	17	10
	305 - Epi. Surveillance	24	23	109	224	45	85
	306 - Food and Nutrition	39	37	27	38	0	28
	Administrative	1,640	1,555	1,814	1,842	2,046	1,779
	Complementary Information	312	207	188	189	200	219
	South	**5,711**	**5,464**	**6,134**	**6,043**	**6,010**	**5,873**
Central-West	301 - Primary Care	73	98	125	68	82	89
	302 - Hosp. Outp. Care	942	1,082	1,387	1,691	1,955	1,411
	303 - Proph. Thera. Supp.	159	176	155	117	99	141
	304 - Health Surveillance	3	2	2	1	1	2
	305 - Epi. Surveillance	9	14	63	36	26	30
	306 - Food and Nutrition	42	41	44	18	30	35
	Administrative	1,664	1,863	1,818	1,613	1,618	1,715
	Complementary Information	50	43	11	34	43	36
	Central-West	**2,943**	**3,319**	**3,605**	**3,580**	**3,855**	**3,460**

Source: own elaboration based on Siops.

HEALTH ACCOUNTS FROM A MUNICIPAL PERSPECTIVE

4

This chapter presents an in-depth diagnosis of municipal spending on PHAS in Brazil, highlighting the significant fiscal effort made by municipalities to sustain the health system in the face of insufficient funding from the state and federal levels. The aim is to understand the sector's financing dynamics, analyzing the limited fiscal autonomy of local entities, the composition of intergovernmental revenues and the profile of expenditure, with an emphasis on subfunctions and the sources of funds mobilized.

The analysis, based on official data and validation workshops with municipal managers, reveals that although the average municipality still relies heavily on constitutional transfers from taxes collected at federal level, the aggregate volume of expenditure shows that the majority of health funding comes directly from municipal coffers. This scenario reflects not only the centralization of revenue in the Brazilian federal pact, but also the limited capacity of the other levels of government to provide resources compatible with the responsibilities decentralized to the municipalities.

This mismatch imposes a central role on local entities in sustaining the SUS, often forcing them to compensate for the instability and unpredictability of federal and state revenues with their own, even in the face of restricted and unequal tax bases. The effort is even more evident in the subfunctions with the highest demand, such as PC and HOC, in which municipalities fund most of the expenditure, in contrast to areas where state and federal support should be more significant, such as Epidemiological Surveillance, Health Surveillance and Food and Nutrition Surveillance.

In addition, the composition of expenditure by economic category shows a pattern of allocation heavily concentrated on current expenditure - which consumes an average of 95% of resources - to the detriment of capital investments, which compromises the ability to expand and modernize the health infrastructure over time.

The structure of the chapter is organized as follows: Section 4.1 discusses the composition of municipal revenues, highlighting the low fiscal autonomy and the lack of fiscal autonomy.

Section 4.2 details the profile of municipal expenditure, exploring expenditure by subfunction, by source of revenue; Section 4.3 analyzes the economic position of expenditure, distinguishing between costing and investment; finally, Section 4.4 presents the conclusions, with emphasis on the challenges to the sustainability of municipal health financing and the urgent need for policies that promote greater equity and stability in the federative arrangement.

4.1 MUNICIPAL REVENUES

4.1.1 FISCAL AUTONOMY OF MUNICIPALITIES

Budget revenues represent the available financial resources that enter the public coffers during the year. These revenues enable the implementation of public policies and are used by the state to finance programs and actions aimed at society's needs.

More specifically, taxes, fees and improvement contributions are classified as revenue in the budget structure. These are derived revenues, compulsorily collected by the state to fund its activities, as established in the National Tax Code (CTN). Taxes are levied on triggering events that are independent of any specific state provision, with no direct consideration to the taxpayer. Fees, on the other hand, are charged for exercising police powers or providing specific and divisible public services. The improvement contribution arises from the increase in value of real estate generated by public works, and is limited to the cost of the work and the individual benefit gained by the property.

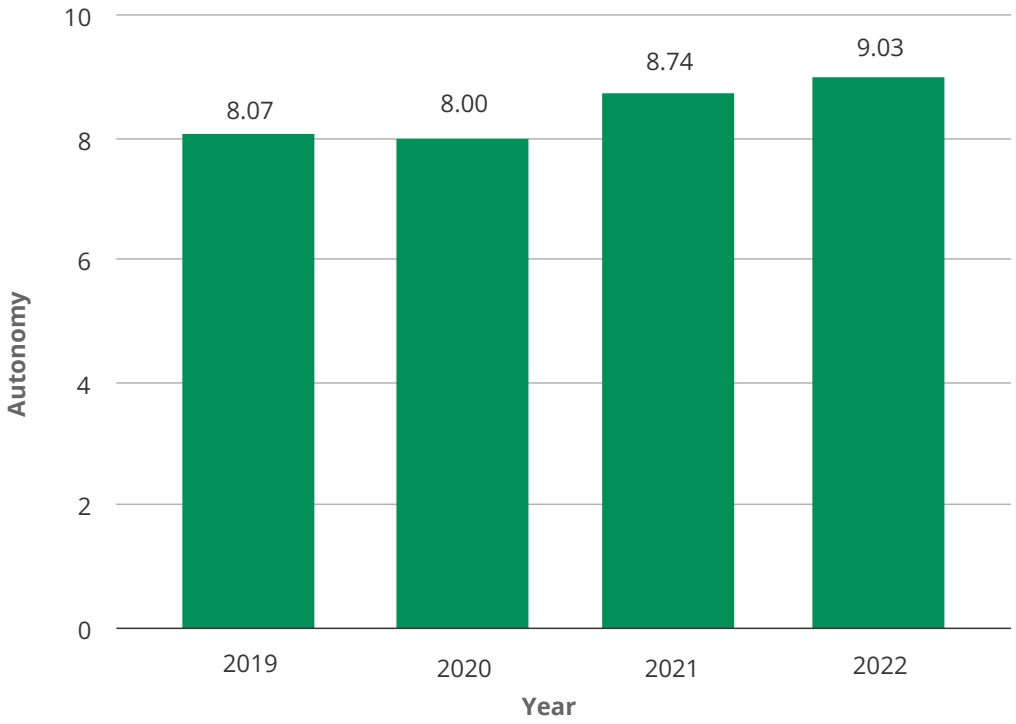
In the context of Brazilian municipalities, own revenue, made up of taxes, fees and contributions, represents a small portion of total revenue. Municipal fiscal autonomy, measured by the ratio between these own revenues and the total collected, is limited. This is mainly due to the Brazilian federative pact, which imposes a centralization of tax collection, with municipalities being responsible for collecting taxes with lower revenue potential, such as IPTU, ISS and ITBI.

In any case, during the period analyzed, there was a slight increase in the financial autonomy of municipalities, of approximately one percentage point. Even so, dependence on intergovernmental transfers remains significant: of every R$10.00 collected, only R$1.00 comes from own taxation, highlighting the central role of transfers of taxes collected by other federal entities in the municipal financial structure. It is important to

note that these taxes collected by other federal entities make up the municipal revenue base, as provided for in the legislation.

In this calculation, the FPM is considered a transfer, as the collection is outside the direct management of the municipality. In fact, the FPM is made up of 25.5% of Income Tax (IR), and the same percentage of IPI, both collected by the Union. Although it is technically an involuntary transfer, which is mandatory and therefore constitutes the revenue base for municipalities, this source is influenced by the federal government's decision on which rates to set for taxing income tax and IPI. This ends up reducing municipal autonomy, leading to volatility and uncertainty in revenue collection. The data is shown in graph 4.1

Graph 4.1. Evolution of municipal autonomy

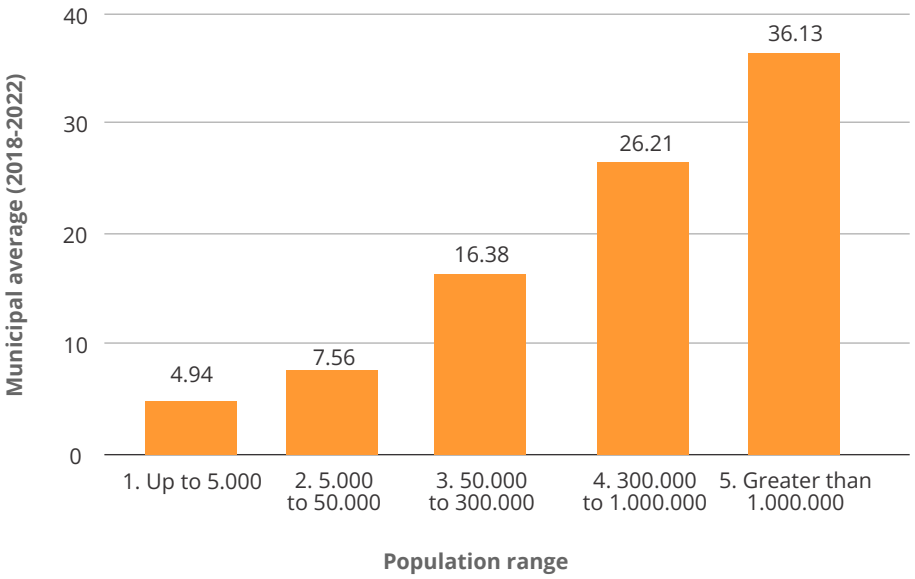


Source: own elaboration based on Siops.

Graph 4.1 shows the evolution of the fiscal autonomy of Brazilian municipalities over the years 2019 to 2022. There was a gradual increase in the fiscal autonomy index during this period. In 2019, the autonomy was 8.07%, rising to 8% in 2020, which indi-

cates a slight drop. However, in the following years, there was a significant increase, with autonomy reaching 8.74% in 2021 and 9.03% in 2022.

Graph 4.2. Evolution of autonomy by population size



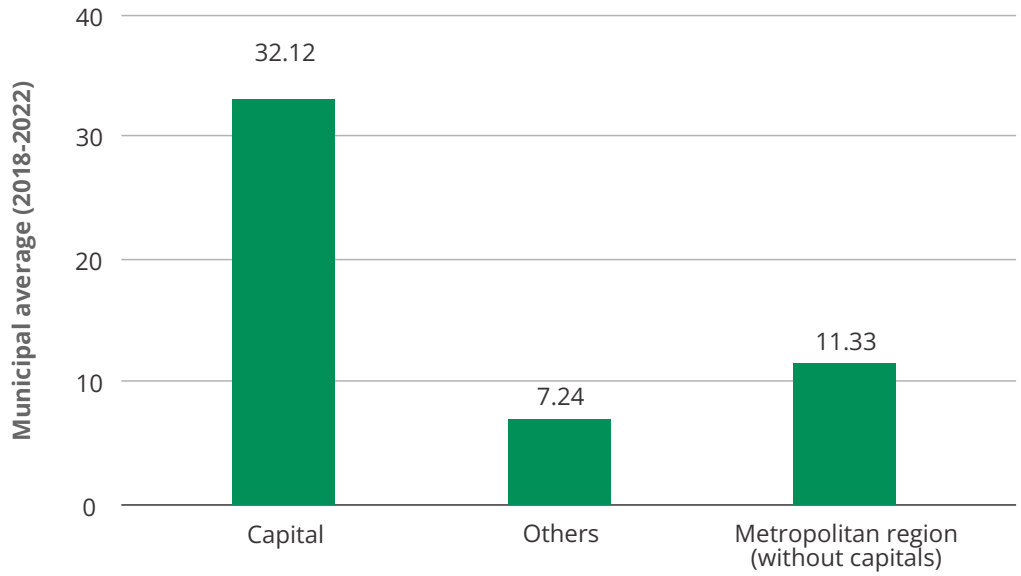
Source: own elaboration based on Siops.

We note, however, that autonomy is directly related to population size. Graph 4.2 illustrates the autonomy of Brazilian municipalities segregated by different population groups, with an average calculated for the period from 2018 to 2022. The analysis reveals a clear correlation between the size of the population and the level of fiscal autonomy of the municipalities.

For municipalities with up to 5,000 inhabitants, the average autonomy is the lowest, at 4.94%. As the population grows, so does fiscal autonomy. Municipalities with a population of between 5,000 and 50,000 inhabitants have an average autonomy rate of 7.56%. This autonomy increases significantly to 16.38% in municipalities with a population of between 50,000 and 300,000 inhabitants. Growth continues in municipalities with between 300,000 and 1 million inhabitants, where the average autonomy is 26.21%. The greatest fiscal autonomy is observed in municipalities with a population of more than 1 million inhabitants, with an average of 36.13%.

This pattern suggests that larger municipalities tend to have a greater capacity to generate their own revenue, possibly due to a broader and more diversified tax base, as well as a more developed infrastructure for collecting taxes, fees and contributions. In contrast, smaller municipalities face greater challenges in generating their own revenue and consequently rely more heavily on external transfers, this means revenues sharing collected by other federal entities to support the public policies they produce.

Graph 4.3. Evolution of autonomy - capitals



Source: own elaboration based on Siops.

Next, we analyzed the average fiscal autonomy of Brazilian municipalities, segmented into three categories: capitals, other municipalities and municipalities in the metropolitan region (excluding capitals), considering the period from 2018 to 2022. The data is shown in Graph 4.3. The capitals have the highest average fiscal autonomy, at 32.12%. This indicates that capital cities have a significant capacity to generate their own revenue, possibly due to a more diversified economy, a larger tax base and better collection mechanisms.

The other municipalities, which are neither capitals nor part of the metropolitan regions, had a much lower average level of fiscal autonomy, with only 7.24% of revenue coming from taxes, fees and improvement contributions. This relatively low average suggests a greater dependence on external transfers and less capacity to generate its own revenue. It is therefore a completely different reality, in which the FPM, in addition

to other government transfers, is the administration's main source of income. As has already been explained, this means dependence on resources collected by other federative entities, which, although it is mandatory, brings great volatility and uncertainty to municipal management. In the next section, this source of funds will be explored further.

Municipalities located in metropolitan regions, excluding capital cities, have an average fiscal autonomy of 11.33%. These municipalities, despite being close to large urban centers, still face challenges in terms of generating their own revenue, although they perform better than other non-metropolitan municipalities. In summary, the graph shows that fiscal autonomy is significantly higher in the capital cities, reflecting a greater capacity for financial management and collection of their own resources, while smaller and non-metropolitan municipalities face greater difficulties in achieving this autonomy.

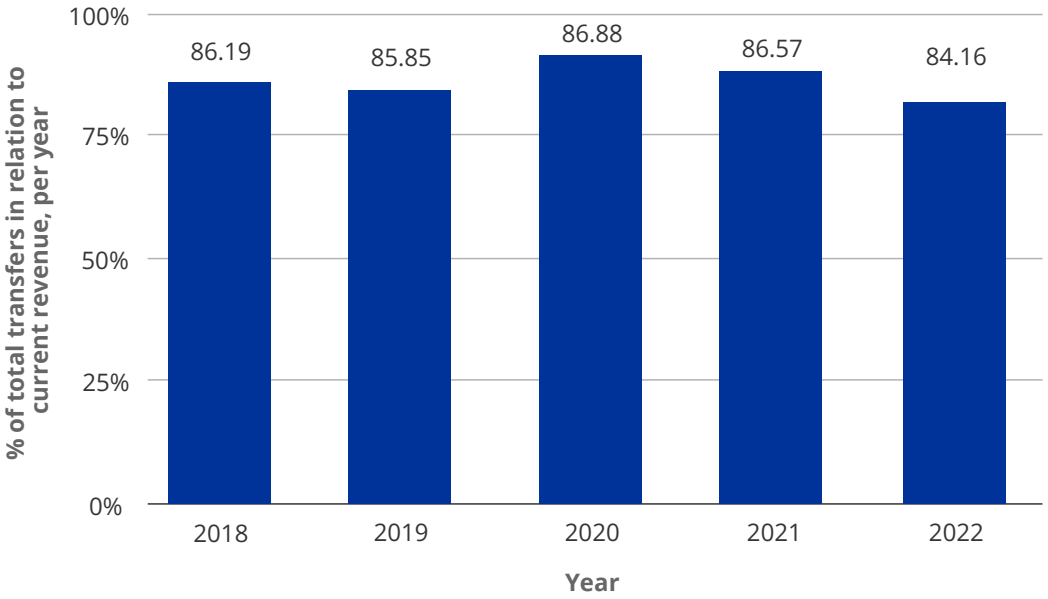
4.1.2 REVENUE WITH FPM, FPE AND OTHER MODALITIES

Involuntary transfers are the main sources of revenue for municipalities, i.e. financial resources received from other entities, whether public or private, to cover the costs of maintaining or operating activities in the public interest, without requiring direct consideration in goods or services from the transferor. These transfers can be constitutional, legal or voluntary, relevant examples being transfers from the Union to states and municipalities, such as the FPE and FPM . In this section, we analyze all the transfers received, both those directly destined for health and amounts that can also be applied in other areas.

During the period analyzed, there was a 2.03 pp drop in transfers, but they still remain above 80% in all years. However, the importance of the federal entities that support the municipalities is very different. For every R$1.00 passed on by the state governments, the federal government contributes R$2.40. State governments tend to transfer more resources to the capitals, with an average difference of 9.10 pp. On the other hand, transfers from the Federal Government through the FPM direct more resources to municipalities outside the metropolitan regions and to those that are not capital cities.

There is great heterogeneity in the patterns of state transfers. States in the Center-South pass on an average of 30% of the funds. In the North, this percentage is approximately 20%, while in the Northeast it is only 11%. These figures consider the FPM as an involuntary transfer, i.e. the obligatory sharing of the portions of IR and IPI that are the municipalities' right.

Graph 4.4. Relevance of transfers

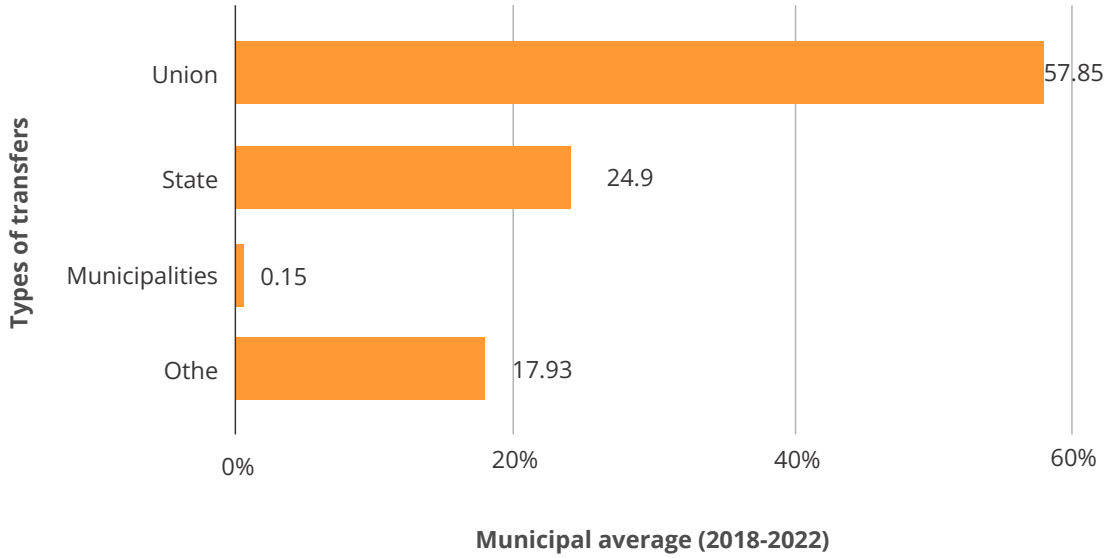


Source: own elaboration based on Siops.

Graph 4.4 shows the percentage of total transfers in relation to the current revenues of Brazilian municipalities, analyzed annually from 2018 to 2022. In 2018, the percentage of transfers in relation to current revenue was 86.19%. In 2019, there was a slight reduction to 85.85%, followed by an increase in 2020, when the percentage reached 86.88%, the highest value of the period analyzed. In 2021, the percentage of transfers fell slightly to 86.57%, and in 2022, there was a more significant reduction, reaching 84.16%.

In addition to the analysis in the previous section, this data indicates that, over the period, a large part of the current revenue of Brazilian municipalities comes from transfers, highlighting the significant dependence on external resources. Despite small annual variations, the percentage of transfers in relation to current revenue has remained quite high, always above 84%.

Graph 4.5. Type of transfers



Source: own elaboration based on Siops.

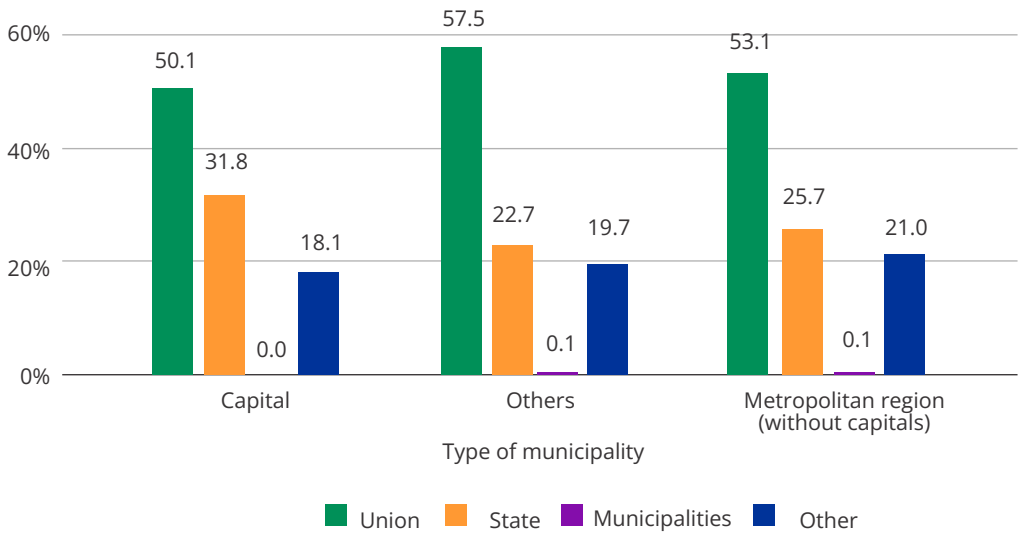
Graph 4.5 shows the profile of transfers by federative entity of origin in relation to the total government transfers received by Brazilian municipalities between 2018 and 2022.

Most government transfers come from the Federal Government, accounting for 57.85% of the total. This shows the significant dependence of municipalities on the federal government for financial resources, given that a substantial portion of the revenue that municipalities are entitled to is collected by the federal government and subsequently transferred. The detailed composition of these transfers will be presented and discussed in the following sections. Transfers from the states are the second largest source, accounting for 24.08% of the total. This reflects the important role assigned by the Federal Constitution to the centralization of resource collection in the Union and the concentration of service provision and expenditure in the state and federal governments.

Transfers between municipalities themselves are practically insignificant, accounting for just 0.15% of the total. Other sources of transfers, which can include non-governmental organizations, international donations and other forms of financial support, account for 17.93% of total government transfers.

The high level of dependence on tax transfers which are the right of municipalities, but which are collected by the federal and state governments, means that many municipalities find themselves in a fragile situation. They depend on a limited capacity to generate their own revenue and need constant support to maintain their accounts and implement their public policies. This is due to multiple reasons, resulting from the centralization of tax collection. Firstly, the tax base of municipalities, made up of IPTU, ISS, ITB, Fees and Improvement Contributions, has a more limited collection potential compared to state and municipal taxes. On the other hand, taxes from other federal entities that are guaranteed to be passed on to municipalities are not administered by municipal managers. In this way, IPI exemption policies, for example, end up hitting municipal coffers hard.

Graph 4.6. Type of transfers by type of municipality



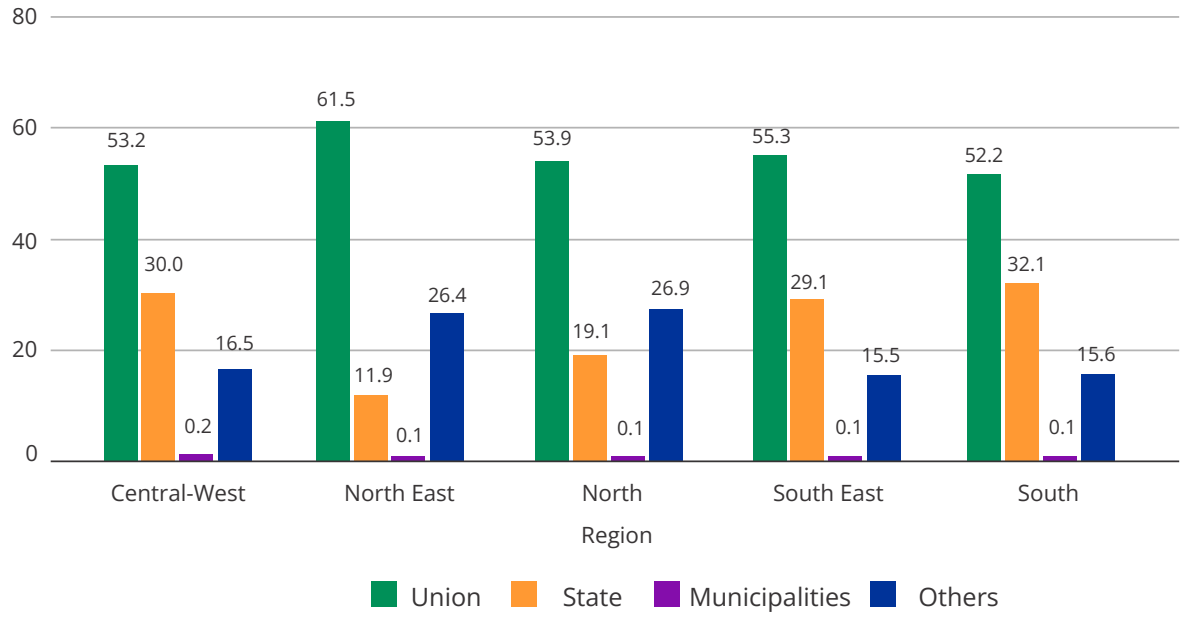
Source: own elaboration based on Siops.

Graph 4.6 shows the percentage of transfer types in relation to total government transfers, segmented by type of municipality: capitals, other municipalities and municipalities in the metropolitan region (excluding capitals), considering the average for the years 2018 to 2022. For the capitals, 50.1% of government transfers come from the federal government, 31.8% from the states and 18.1% from other sources. There are no transfers between municipalities noted in this category.

In the other municipalities, dependence on federal transfers is even higher, accounting for 57.5% of the total. State transfers account for 22.7%, while 19.7% come from other sources. As in the capitals, transfers between municipalities are practically non-existent, at just 0.1%.

In the municipalities of the metropolitan region, excluding the capitals, the Federal Government is the main source of transfers, with 53.1% of the total. State transfers account for 25.7%, and other sources contribute 21.1%. Transfers between municipalities are also negligible, at just 0.1%. Although the capitals have a more balanced contribution from the Union and the states, the other municipalities and those in the metropolitan region depend more heavily on federal tax transfers. Transfers from other sources also play an important role, especially outside the capitals. The absence of transfers between municipalities indicates that this form of financing is little explored or insignificant in the context of Brazilian municipal accounts.

Graph 4.7. Type of Transfers by Type of Municipality



Source: own elaboration based on Siops.

Graph 4.7 shows the percentage of the types of transfer in relation to total government transfers, broken down by Brazilian region: Central-West, Northeast, North, Southeast and South. The analysis covers the average years from 2018 to 2022. In the Central-West region, the Union is the main source of transfers, accounting for 53.2% of the total, followed by the states with 30% and other sources with 16.5%. Transfers between municipalities are practically insignificant, at 0.2%.

In the Northeast, dependence on the Union is even more pronounced, with 61.5% of transfers coming from the federal government. State transfers account for 11.9%, while other sources contribute 26.4%. Transfers between municipalities are negligible, at 0.1%. In the North, transfers from the Union account for 53.9% of the total, followed by the states with 19.1% and other sources with 26.9%. Transfers between municipalities account for just 0.1%.

The Southeast has a significant dependence on federal transfers, with 55.3% of the total. State transfers account for 29.1% while other sources contribute 15.5%. Transfers between municipalities are minimal, at 0.1%. In the South, the Union is responsible for 52.2% of transfers, followed by the states with 32.1% and other sources with 15.6%. Transfers between municipalities are insignificant, at 0.1%.

As expected, this data shows that, in all regions, the Union is the main source of government transfers, as established by the Federal Constitution. As already explained, this is the essence of the Brazilian tax collection model, which is centralized. Out of these, the main one is the FPM, as already explained. Other additional sources are FAF transfers, etc. which have been covered in depth in previous sections.

On the other hand, as far as the states are concerned, the variation in the size of state transfers suggests regional differences in the financing structure. In the Northeast, for example, there is a greater contribution from other sources, such as specific transfers from the SUS, while in the South, state transfers play a more prominent role. The almost insignificant presence of transfers between municipalities is a constant pattern in all regions, indicating that this source is irrelevant in the context of Brazilian municipal accounts.

It is important to note that this section analyzed all sources of transfers. Analyzing the collection profile and, with it, fiscal autonomy is extremely important, as it establishes the limits that municipalities can use to make their health expenditures, by their own decision, within their budgets.

4.2 MUNICIPAL EXPENSES PROFILE

4.2.1 EXPENDITURE BY SUBFUNCTION

In this section, we analyze the total expenditure figures by subfunction, as defined in Ordinance No. 42/1999 of the then Ministry of State for Budget and Management and currently used by the National Treasury Secretariat. The data is presented without yet breaking it down by funding source, which will be done below. It is important to note that the results of the workshops indicate that the municipalities have difficulties in understanding the macro logic of the budget function, since, in the case of health, it would always be Function 10 - Health, and then freely use the subfunction that fits. This is evidenced by the incorrect application of the administration subfunctions, for example, and the low spending on Health Surveillance. On the other hand, however, we were able to verify that the health subfunctions are used consistently, as investigated in the two workshops held in the states of Rio Grande do Sul (RS) and Rio Grande do Norte (RN).

Table 4.1. Nominal values by expenditure subfunction (in millions of R$) - average per municipality

Function	2018	2019	2020	2021	2022
301 - Primary Care	10.02	10.59	11.92	12.99	16.00
302 - Hospital Outpatient Care	11.04	12.28	14.65	16.44	18.72
303 - Prophylactic and Therapeutic Support	0.50	0.56	0.62	0.74	0.92
304 - Health Surveillance	0.25	0.27	0.31	0.35	0.43
305 - Epidemiological Surveillance	0.44	0.52	0.77	0.84	0.94
306 - Food and Nutrition	0.01	0.01	0.01	0.01	0.02
Administrative	4.28	4.28	5.48	5.71	5.74
Complementary Information	0.23	0.23	0.29	0.38	0.41

Source: own elaboration based on Siops.

Analysis of the data shows a significant and continuous increase in investment in primary care. Table 4.1 shows the nominal amounts spent on average by spending sub-

function in millions of reais for the years 2018 to 2022, detailing the resources allocated to different areas of health in Brazilian municipalities. This is the average expenditure per municipality, including current and capital expenditure. In relation to PC, spending was R$10.02 million in 2018, progressively increasing until it reached R$6 million in 2022. In the HOC, spending started at R$1.04 million in 2018 and increased to R$18.72 million in 2022, indicating the expansion of hospital and outpatient services to meet the demands of the population.

For the PTS, the amounts went from R$500,000 in 2018 to R$920,000 in 2022, showing constant growth although on a smaller scale compared to other subfunctions. Health Surveillance had its expenses increased from R$250,000 in 2018 to R$430,000 in 2022. Epidemiological Surveillance also saw an increase in expenditure, from R$440,000 in 2018 to R$940,000 in 2022. Moving on, the F&N subfunction showed stable figures of R$10,000 until 2021, with a small increase to R$20,000 in 2022. It is important to note that these figures are low given the importance of these subfunctions, indicating the immediate need for greater spending.

Average administrative expenses, in turn, increased from R$4.28 million in 2018 to R$5.74 million in 2022, reflecting the need to support the administrative structure for the operation of health services. Finally, investments in Complementary Information grew from R$230,000 in 2018 to R$410,000 in 2022, indicating the value placed on collecting and managing information for public health.

To sum up, the table shows a general trend of increased investment in various subfunctions of health spending, with emphasis on primary care and HOC. The growth in the areas of epidemiological and health surveillance suggests a response to the growing need for public health monitoring and control, even if it falls far short of what is needed. On the other hand, areas such as F&N show low and stable investments, suggesting the need for greater attention.

Table 4.2. Real values per spending subfunction (average in millions of R$) - average per municipality

Function	2018	2019	2020	2021	2022	Var 18-22%
301 - Primary Care	12.66	12.95	13.98	13.76	16.00	26%
302 - Hospital Outpatient Care	13.95	15.03	17.18	17.41	18.72	34%
303 - Prophylactic and Therapeutic Support	0.63	0.69	0.73	0.78	0.92	45%
304 - Health Surveillance	0.31	0.33	0.36	0.37	0.43	38%

Table 4.2. Real values per spending subfunction (average in millions of R$) - average per municipality

Function	2018	2019	2020	2021	2022	Var 18-22%
305 - Epidemiological Surveillance	0.56	0.63	0.90	0.89	0.94	68%
306 - Food and Nutrition	0.01	0.01	0.02	0.01	0.02	59%
Administrative	5.40	5.24	6.43	6.05	5.74	6%
Complementary Information	0.29	0.28	0.34	0.40	0.41	44%

Source: own elaboration based on Siops.

Table 4.2 shows the real amounts spent on average by subfunction at December 2022 prices, in millions of reais, for the years 2018 to 2022, with the percentage change over the period 2018 to 2022. The data is analyzed by spending subfunction, providing a detailed view of the changes in investments over the years. This is the average expenditure per municipality.

In relation to PC, spending increased from R$12.66 million in 2018 to R$16 million in 2022, representing a growth of 26%. The HOC also saw a significant increase, from R$13.95 million in 2018 to R$18.72 million in 2022, a variation of 34%.

The PTS recorded an increase from R$630,000 in 2018 to R$920,000 in 2022, a variation of 45%. Health Surveillance grew by 38%, from R$310,000 in 2018 to R$430,000 in 2022. Epidemiological Surveillance showed the biggest percentage increase, with a variation of 68%, from R$560,000 in 2018 to R$940,000 in 2022.

Investments in F&N, although low, increased from R$10,000 in 2018 to R$20,000 in 2022, reflecting a variation of 59%. Administrative expenses increased from R$5.40 million in 2018 to R$5.74 million in 2022, with a variation of 6%, while investments in Complementary Information grew from R$290,000 in 2018 to R$410,000 in 2022, representing a variation of 44%

In short, the table shows a general upward trend in various subfunctions of health spending, even if there are marked differences in the impact of each of them. The significant growth in Epidemiological Surveillance and PTS stands out, reflecting the growing importance of these areas in public health. On the other hand, areas such as F&N, despite showing high percentage growth, still represent a very small share of total investments. Administrative expenses showed more modest growth, suggesting a stabilization in management costs.

Table 4.3 below shows the total expenditure by all municipalities by subfunction, at December 2022 prices, in billions of reais, for the years 2018 to 2022. The data provides a comprehensive overview of total investments in different areas of health over these years. While the previous analysis looked at the averages per municipality, the totals spent by all municipalities are now explored.

Table 4.3. Total spending by spending subfunction at Dec./2022 prices (in billions of R$)

Function	2018	2019	2020	2021	2022
301 - Primary Care	70.5	72.1	77.9	76.6	89.1
302 - Hospital Outpatient Care	77.7	83.7	95.7	96.9	104.2
303 - Prophylactic and Therapeutic Support	3.5	3.8	4.1	4.4	5.1
304 - Health Surveillance	1.7	1.8	2.0	2.1	2.4
305 - Epidemiological Surveillance	3.1	3.5	5.0	4.9	5.2
306 - Food and Nutrition	0.08	0.07	0.09	0.06	0.13
Administrative	30.1	29.2	35.8	33.7	32.0
Complementary Information	1.6	1.6	1.9	2.2	2.3
Total	**188.3**	**195.8**	**222.5**	**220.9**	**240.4**

Source: own elaboration based on Siops.

For PC, spending increased from R$70.5 billion in 2018 to R$89.1 billion in 2022, indicating substantial growth. The HOC also recorded a significant increase, rising from R$77.7 billion in 2018 to R$104.2 billion in 2022.

At PTS, spending grew from R$3.5 billion in 2018 to R$5.1 billion in 2022. Health Surveillance grew from R$1.7 billion in 2018 to R$2.4 billion in 2022. Epidemiological Surveillance showed an increase from R$3.1 billion in 2018 to R$5.2 billion in 2022.

Expenditure in the F&N subfunction, although low, grew from R$79.2 million in 2018 to R$125.7 million in 2022. Administrative expenses increased from R$30.1 billion in 2018 to R$32.0 billion in 2022. Finally, investments in Complementary Information grew from R$1.6 billion in 2018 to R$2.3 billion in 2022.

Total health spending increased from R$188.3 billion in 2018 to R$240.4 billion in 2022, reflecting significant growth in overall health investments over these years. In summary, the data shows a continuous and significant increase in municipal investment in various areas of health, especially primary care and HOC. The growth in the areas of Health and Epidemiological Surveillance also suggests a response to the growing need to monitor and control public health. On the other hand, areas such as AF&N, despite high percentage growth, still represent a small share of total investments. Administrative expenses, on the other hand, showed more modest growth, indicating a possible stabilization in management costs.

Table 4.4. Distribution of spending by subfunction at Dec./2022 prices (in millions of R$) - average per municipality

Function	Média Período em %	Valor em 2022 em %
301 - Primary Care	36.16%	37.05%
302 - Hospital Outpatient Care	42.90%	43.35%
303 - Prophylactic and Therapeutic Support	1.96%	2.12%
304 - Health Surveillance	0.94%	0.99%
305 - Epidemiological Surveillance	2.05%	2.18%
306 - Food and Nutrition	0.04%	0.05%
Administrative	15.05%	13.29%
Complementary Information	0.90%	0.96%

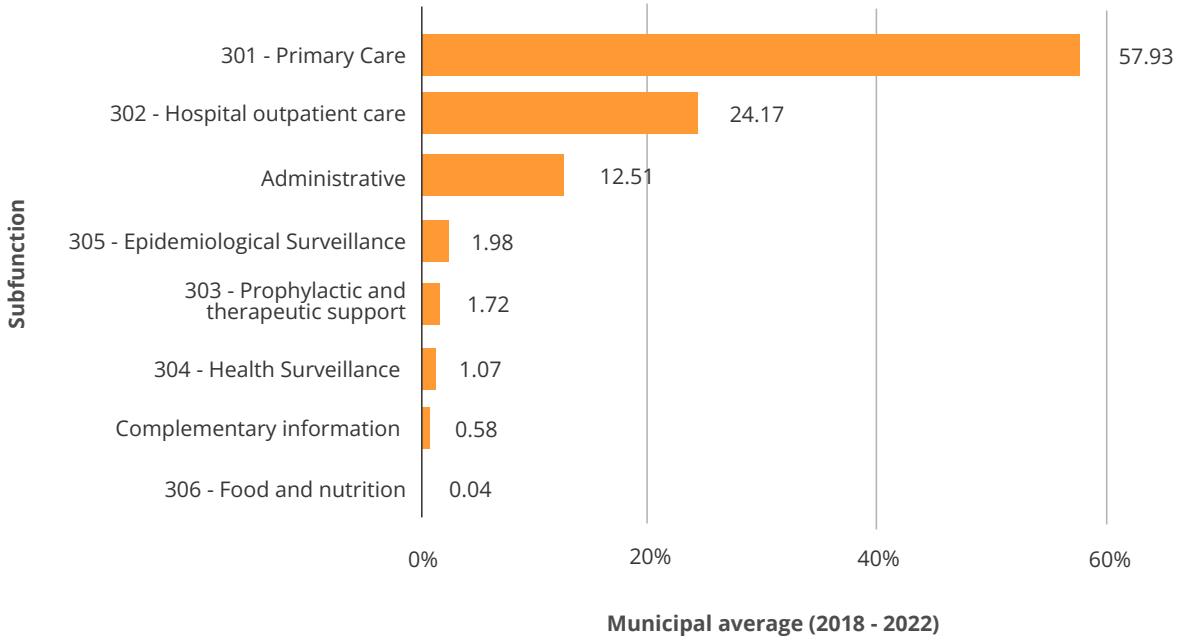
Source: own elaboration based on Siops.

Table 4.4 shows the distribution of expenditure by subfunction at December 2022 prices, highlighting the distribution in percentages for the period and in 2022. PC accounted for an average of 36.16% of total spending in the period analyzed, reaching 37.05% in 2022. In the HOC, the average participation was 42.90%, rising to 43.35% in the last year of the series. The PTS had an average share of 1.96%, rising to 2.12% in 2022. Health Surveillance, which accounted for 0.94% of spending over the period, reached 0.99% last year. Epidemiological Surveillance had an average of 2.05%, rising to 2.18% in 2022. In turn, A&N's share remained low, at 0.04% on average for the period and 0.05%

in 2022. Administrative expenses, which represented 15.05% of the total on average, showed a slight reduction, reaching 13.29% in 2022. Finally, spending on Complementary Information went from an average of 0.90% to 0.96% in the last year of the series.

Graph 4.8 shows the average percentage of spending by subfunction for Brazilian municipalities for the period from 2018 to 2022. The subfunction with the highest average share of spending is PC, accounting for 57.93% of the total. The HOC average then took up 24.17% of spending. Average administrative expenses account for 12.51% of the total. Other subfunctions have lower average shares, such as Epidemiological Surveillance (1.98%), PTS (1.72%), Health Surveillance (1.07%), Complementary Information (0.58%) and A&N (0.04%).

Graph 4.8. % of average spending by subfunction in municipalities



Source: own elaboration based on Siops.

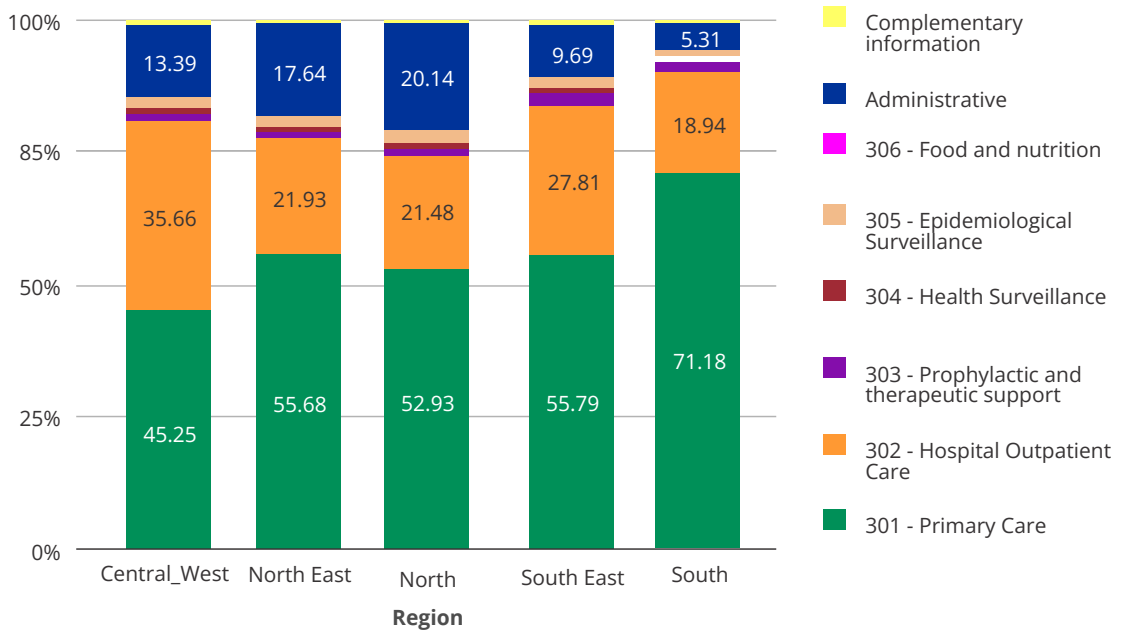
This pattern of expenditure distribution shows the priority given to PC and HOC in the allocation of resources by municipalities, reflecting the importance of these areas in the provision of public health services. Administrative expenses also make up a significant part of the budget while the other subfunctions, although essential, receive a smaller share of the resources. This expenditure under the Administrative heading can encompass the

purposes of the subfunctions. However, it is important to highlight the difficulty in recording these expenses and the tendency to mistakenly centralize them as administrative, which can impact transparency and efficiency in the allocation of resources

The following graphs show an analysis of expenditure on the various subfunctions. Graph 4.9 shows the percentage of expenditure by subfunction in the different regions of Brazil, based on the average of the municipalities for the period from 2018 to 2022. The analysis highlights significant variations in the spending profile between regions.

In the Central-West region, PC accounts for 45.25% of expenses, followed by HOC with 35.66% and Administrative expenses with 13.89%. In the Northeast, PC accounts for 55.68% of spending, while HOC occupies 21.93%, and Administrative expenses 17.64%.

Graph 4.9. % of expenditure by subfunction by region



Source: own elaboration based on Siops.

In the North, PC accounts for 52.93% of expenditure, HOC for 21.48% and administrative expenditure for 20.14%. In the Southeast, PC is responsible for 55.79% of spending; HOC, 27.81%; and Administrative expenses, 9.69%. Finally, in the South, PC accounts for 71.18% of spending; HOC, 18.94%; and administrative expenses, 5.31%. Other subfunctions, such as Epidemiological Surveillance, PTS, Health Surveillance, A&N, and

Complementary Information, show smaller variations in all regions, with percentages generally below 5%. This data shows that the profile of spending by subfunction is not homogeneous between the regions. There is a wide variation in administrative costs and spending in the PC and HOC subfunctions. While some regions, such as the South, largely prioritize PC, others, such as the Central-West, distribute spending more evenly between different subfunctions.

The data shows that most of the resources were directed to PC and HOC, which have continued to grow over the years. Other subfunctions, such as PTS and Epidemiological Surveillance, showed relative increases although they still represent a much smaller share of the total. Administrative expenses remained stable, while investments in F&N continued to fall.

4.2.2 EXPENDITURE BY REVENUE SOURCE

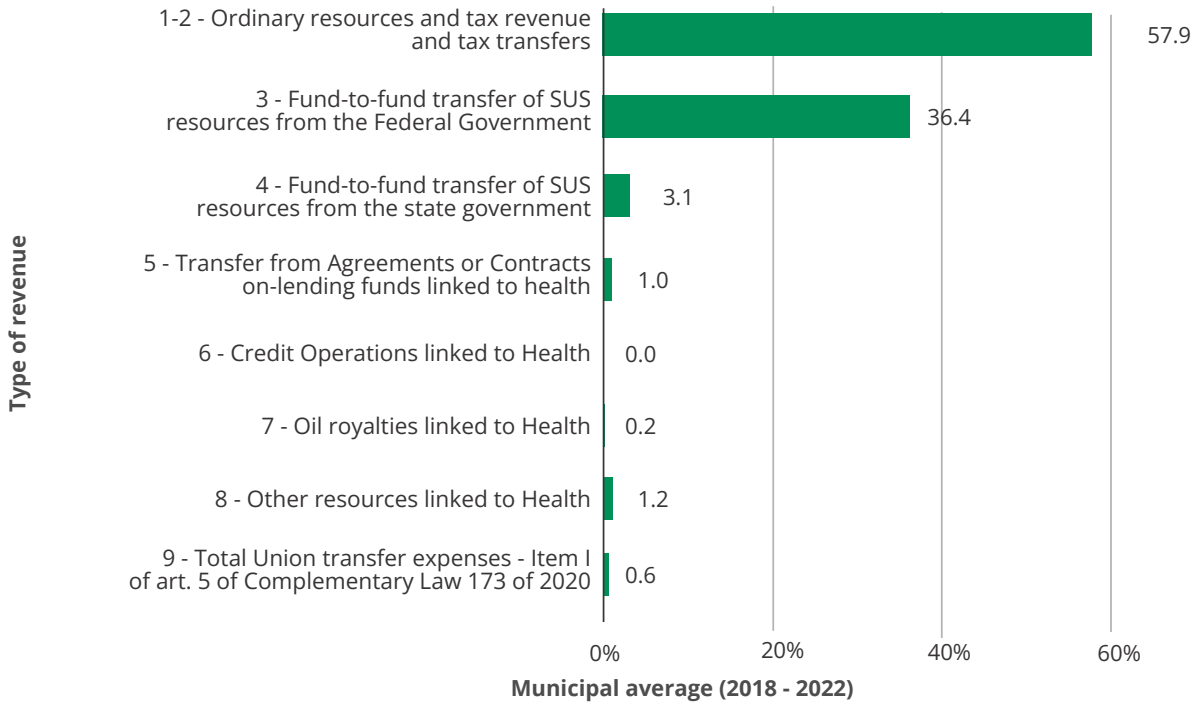
In the analysis of health expenditure by source of revenue, we incorporated FPM resources, in addition to the ICMS and IPVA share, into the total collection of taxes, fees and contributions. This is the total amount available to municipalities according to their local taxation and their share of federal and state tax collection (IR and IPI, plus ICMS and IPVA). It is important to note that these taxes are part of the base linked to EC No. 29.

In the period analyzed, it was found that for every R$1.00 that the federal government transferred to the FAF, the municipalities spent an average of R$1.59 on health. Similarly, for every R$1.00 that the state government transferred to the FAF, the municipalities spent an average of R$18.67 on health.

Graph 4.10 shows the share of revenue in health spending, by type of revenue, based on the average of municipalities in the period from 2018 to 2022. The data show that “Ordinary Resources and Revenue from Taxes and Tax Transfers” account for the largest share of revenue, at 57.9%. Next, “Fund-to-Fund Transfers of SUS Resources from the Federal Government” account for 36.4% of revenues. “Fund-to-Fund Transfers of SUS Resources from the State Government” account for 3.1%, while “Transfers from Agreements or Transfer Contracts linked to Health” contribute 1%.

Other categories, such as “Credit Operations Linked to Health” and “Oil *Royalties* Linked to Health”, have smaller shares, of 0.2% each. “Other Resources Linked to Health” account for 1.2%, and “Total Expenses Federal Transfers - item I of art. 5 of LC No. 173 of 2020” account for 0.6%.

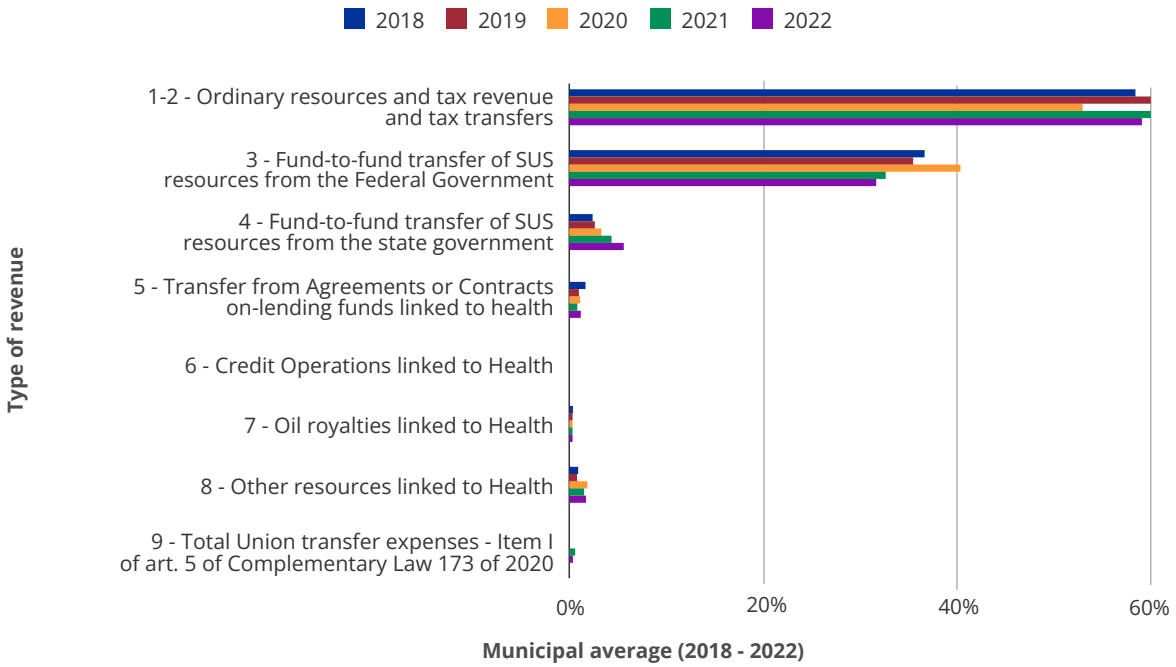
Graph 4.10. Share of revenue in expenditure by type of revenue



Source: own elaboration based on Siops.

Graph 4.11, in turn, shows the share of revenue in health expenditure by type of revenue and year, broken down year by year for the period from 2018 to 2022. Once again, "Ordinary Resources and Revenue from Taxes and Tax Transfers" remained the largest source of funding over the years, varying little and remaining above 50%. In 2020, there was a significant increase in the "Fund-to-Fund Transfer of SUS Resources from the Federal Government", reflecting greater participation by the federal government in response to the COVID-19 pandemic. However, in 2021, this trend returned to the levels seen earlier in the period, with a slight decrease in 2022.

Graph 4.11. Share of revenue in expenditure by type of revenue and by year



Source: own elaboration based on Siops.

The "Fund-to-Fund Transfers of SUS Resources from the State Government" show a smaller and relatively constant share, varying from 2% to 4% over the years. "Transfers from Agreements or Transfer Contracts linked to Health" and other sources such as "Credit Operations linked to Health", "Oil *Royalties* linked to Health" and "Other Resources linked to Health" had smaller and more stable shares, generally below 2%.

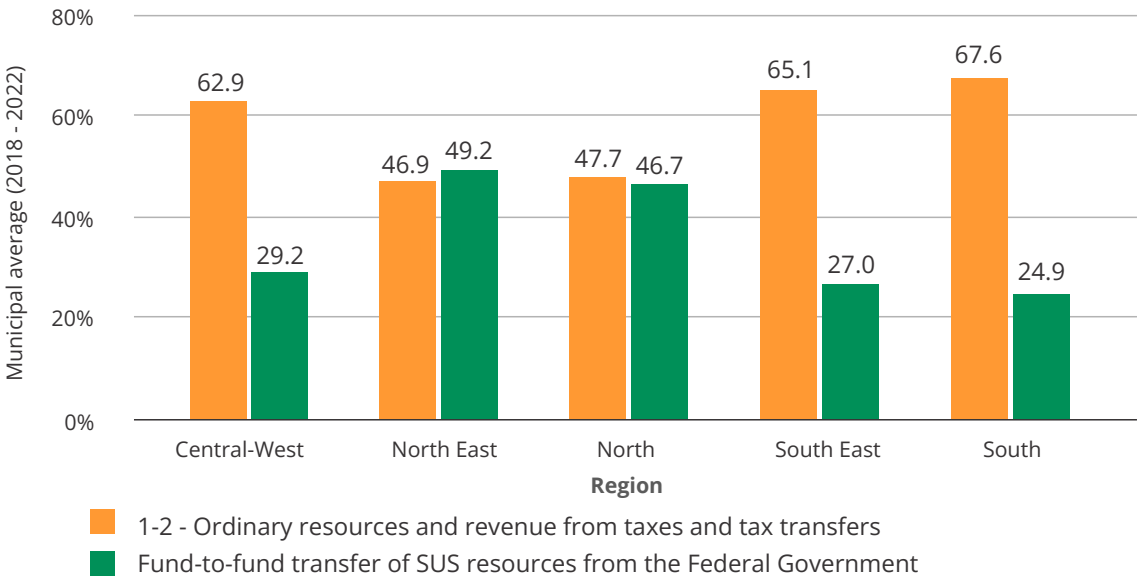
The line "Total Expenses Federal Transfers - item I of article 5 of Complementary Law No. 173 of 2020" is notable in 2020, but almost non-existent in the other years. LC No. 173, of May 27th, 2020, established the Federative Program to Combat the SARS-CoV-2 Coronavirus (Covid-19) and amended the Fiscal Responsibility Law (LC No. 101, of May 4, 2000). The main objective of this law was to provide financial aid to states, the Federal District and municipalities to mitigate the economic and social impacts of the pandemic.

In summary, the graph shows that, although there are annual variations, "Ordinary Resources and Tax Revenue and Tax Transfers" and "Fund-to-Fund Transfers of SUS Resources from the Federal Government" are the main sources of funding for municipal health spending. The greater participation of the federal government in 2020 highlights a

specific response to the emergency needs of that year, i.e. due to the pandemic, returning soon after to a more typical distribution in subsequent years.

This data shows the predominance of own resources in municipal health financing, with complementary contributions from other sources. This configuration underscores the importance of predictability in federal and state transfers, a recurring challenge due to their frequent irregularity. In the following paragraphs, this scenario will be presented in more detail.

Graph 4.12. Share of own revenue and federal transfers by region



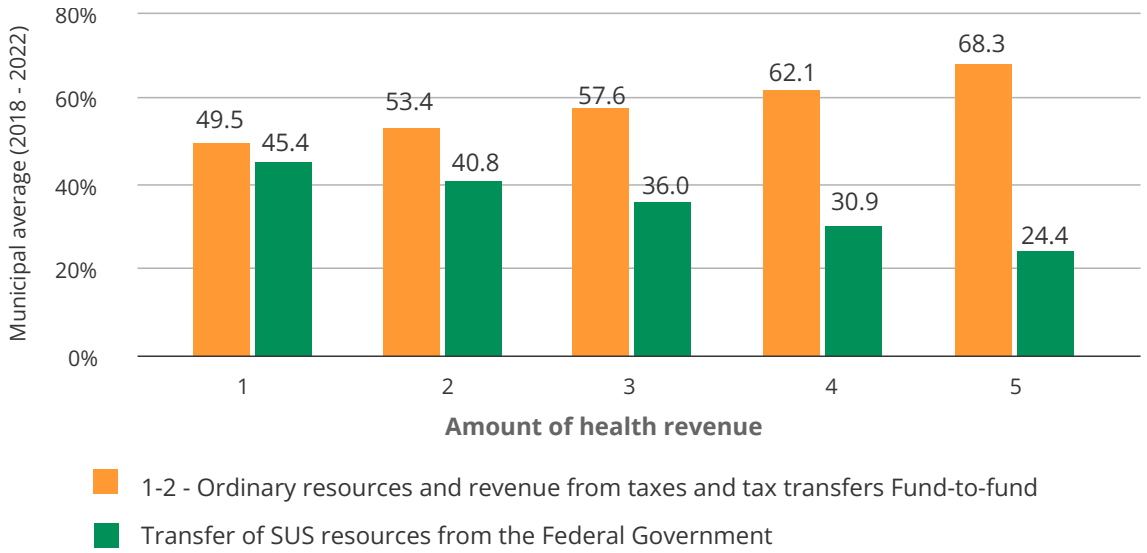
Source: own elaboration based on Siops.

Graph 4.12 shows the share of own revenues and federal government transfers in health spending by Brazilian region, based on the average of the municipalities for the period from 2018 to 2022. State transfers, which are much less relevant, will be discussed below. For the Central-West region, own revenues and tax transfers (in blue) account for 62.9% of resources, while FAF transfers of SUS resources from the federal government (in red) account for 29.2%. In the Northeast, own revenues account for 49.2% and federal transfers for 46.9%.

In the North region, own revenues and tax transfers account for 47.7%, while federal transfers account for 46.7%. In the Southeast, the largest share of own revenues is observed, at 65.1%, and federal transfers account for 27%. In the South, own revenues account for 67.6%, and federal transfers account for 24.9%.

These data show that the South and Southeast regions use more of their own revenues and local tax transfers to finance health spending, while the North and Northeast regions are more dependent on federal transfers. The Central-West region has an intermediate dependence between its own revenues and federal transfers.

Graph 4.13. Share of own revenue and government transfers by decile



Source: own elaboration based on Siops.

Note: municipalities were grouped into five quantiles based on per capita health revenue. The first quantile includes those with values between R$ 0 and R$ 646.02 while the second quantile covers R$ 646.02 to R$ 782.17. In the third quantile, income varies from R$782.17 to R$944.96, and in the fourth quantile, from R$944.96 to R$1,212.67. Finally, the fifth quantile comprises the municipalities with the highest revenue, between R$1,212.67 and R$4,578.59.

Graph 4.13 shows the share of own revenue and federal government transfers in health spending by quantile of health revenue, based on the average of municipalities for the period from 2018 to 2022. For municipalities in the first quantile (R$ 0 - R$ 646.02), own revenues and tax transfers account for 49.5% of resources, while FAF transfers from SUS, which come from the federal government, account for 45.4%.

In the second quantile (R$ 646.02 - R$ 782.17), the share of own revenues increases to 53.4% while federal transfers fall to 40.8%. In the third quantile (R$ 782.17 - R$ 944.96),

own revenues and tax transfers account for 57.6%, and federal transfers fall to 36%. In the fourth quantile (R$944.96 - R$1,212.67), this trend continues, with own revenues reaching 62.1% and federal transfers falling to 30.9%. In the fifth quantile (R$1,212.67 - R$4,578.59), which groups together the municipalities with the highest per capita spending, own revenues reach 68.3% while the share of federal transfers drops to 24.4%.

The data shows that municipalities with greater availability of their own resources tend to have higher average spending on health. As municipalities increase in revenue amounts, their dependence on federal transfers decreases, indicating a greater capacity to finance health services themselves.

Table 4.5. Distribution of spending by subfunction by source in % 2018 to 2022

Year	Subfunction	Own resources	Transfers from the federal government	Transfers from the state government	Others
2018	Primary Care	59.67%	36.72%	2.11%	1.50%
2019		59.58%	36.95%	1.95%	1.52%
2020		54.81%	40.13%	2.50%	2.56%
2021		49.16%	47.32%	1.70%	1.83%
2022		57.82%	34.37%	4.86%	2.96%
2018	Hospital Outpatient Care	46.57%	47.58%	3.76%	2.08%
2019		46.89%	46.83%	4.36%	1.92%
2020		42.96%	48.52%	5.10%	3.42%
2021		48.20%	42.14%	6.13%	3.53%
2022		48,95%	37.23%	8.72%	5.10%
2018	Prophylactic and Therapeutic Support	47.74%	44.11%	6.48%	1.67%
2019		51.10%	41.25%	6.52%	1.13%
2020		51.56%	38.70%	8.01%	1.73%
2021		52.77%	34.21%	1.57%	2.45%
2022		51.79%	31.21%	1.56%	3.44%
2018	Health Surveillance	52.81%	39.51%	1.39%	6.29%
2019		54.76%	37.36%	1.08%	6.80%
2020		49.09%	41.69%	1.81%	7.42%
2021		55.42%	37.54%	2.13%	4.91%
2022		55.79%	36.30%	4.86%	3.05%

Table 4.5. Distribution of spending by subfunction by source in % 2018 to 2022

Year	Subfunction	Own resources	Transfers from the federal government	Transfers from the state government	Others
2018	Epidemiological Surveillance	43.69%	53.15%	1.86%	1.30%
2019		48.34%	48.91%	1.45%	1.30%
2020		39.05%	55.86%	1.43%	3.67%
2021		47.83%	45.17%	3.29%	3.71%
2022		50.28%	42.22%	4.86%	2.64%
2018	Food and Nutrition	77.89%	20.68%	0.76%	0.68%
2019		65.56%	26.80%	1.41%	6.23%
2020		73.46%	19.17%	3.69%	3.68%
2021		76.82%	12.67%	3.45%	7.06%
2022		65.75%	25.69%	4.86%	3.71%

Source: own elaboration based on Siops.

Note: for the distribution of spending in the subfunction in total, see table 04.

In table 4.5, the analysis of the distribution of municipal spending by subfunction and source of funds between 2018 and 2022 confirms the central role of municipalities in financing public health, despite the fact that their revenue base is significantly smaller and more volatile than that of the state and federal levels. Even with fluctuations in transfers, own resources continued to support most of the expenditure in several essential areas.

In PC, municipalities have historically been the main funders, covering 59.67% of expenditure in 2018. This percentage fell slightly until 2021, when it reached its lowest level (49.16%), but rose again in 2022, reaching 57.82%. Over this period, the share of federal transfers increased until 2021, reaching 47.32%, but fell to 34.37% in 2022. The states' share, although small, grew from 1.70% to 4.86% between 2021 and 2022. This dynamic shows that, even in the face of changes in the composition of intergovernmental transfers, the municipalities continue to be primarily responsible for financing PC, guaranteeing the continuity of the service even in scenarios of fiscal instability.

In the HOC, the municipal share also fluctuated, falling from 46.57% in 2018 to 42.96% in 2020, but recovering to 48.95% in 2022. In contrast, federal transfers, which reached 48.52% in 2020, progressively decreased to 37.23% in 2022. There was some growth in state transfers, which went from 3.76% in 2018 to 8.72% in 2022, although

they remained at very low levels. However, most of the expenses still fall on the municipalities, which, despite having less revenue capacity, need to allocate their resources to guarantee the continuity of hospital and outpatient care.

In the PTS, municipalities increased their share from 47.74% in 2018 to 52.77% in 2021, but recorded a slight drop to 51.79% in 2022. At the same time, federal transfers followed a downward trajectory, falling from 44.11% in 2018 to 31.21% in 2022. The state's share, on the other hand, grew slightly to 13.56% in 2022, the highest percentage in the period analyzed. Even so, the figures show that municipalities continue to be the main source of funding in this area, despite the instability of transfers.

Health Surveillance also remained largely supported by the municipalities, whose share ranged from 49.09% to 55.79% over the period. Federal transfers, which accounted for 41.69% in 2020, fell to 36.30% in 2022, while state transfers, although still modest, more than tripled between 2018 and 2022, reaching 4.86%. This pattern reinforces that, despite fluctuations in external transfers, fiscal and administrative responsibility for Health Surveillance remains with the municipalities.

In Epidemiological Surveillance, the participation of municipalities varied from 39.05% in 2020 to 50.28% in 2022, while federal transfers, which reached 55.86% in 2020, fell to 42.22% in 2022. This drop in federal funding was partially offset by an increase in state participation, which rose from 1.86% in 2018 to 4.86% in 2022. Despite this growth, municipalities continue to play a central role in financing this subfunction, being responsible for absorbing most of the variations in transfers.

With regard to F&N financing , municipalities have also taken on the greatest burden, although their share has decreased from 77.89% in 2018 to 65.75% in 2022. Federal transfers, which had reached their lowest level in 2021 (12.67%), grew again to 25.69% in 2022. The states, on the other hand, increased their participation to 4.86% in the same period, which may indicate a regional effort to complement municipal actions. Even with this reinforcement, most of the funding still depends directly on municipal revenue.

Table 4.6. Distribution of spending by subfunction by source per capita in R$ - 2018 to 2022

Year	Subfunction	Own Resources	Transf. Government federal	Government transfers state	Others
2018	Primary Care	201.78	124.18	7.15	5.08
2019		204.43	126.77	6.71	5.23
2020		201.65	147.62	9.21	9.40
2021		176.54	169.93	6.09	6.56
2022		253.71	150.79	21.32	13.00
2018	Hospital Outpatient Care	173.53	177.32	14.01	7.77
2019		186.77	186.54	17.37	7.66
2020		194.14	219.26	23.05	15.44
2021		218.97	191.40	27.85	16.03
2022		251.20	191.02	44.76	26.15
2018	Prophylactic and Therapeutic Support	8.01	7.39	1.10	0.29
2019		9.23	7.47	1.19	0.19
2020		9.96	7.51	1.56	0.33
2021		10.88	7.08	2.20	0.52
2022		13.00	7.83	3.40	0.89
2018	Health Surveillance	4.32	3.21	0.10	0.53
2019		4.71	3.19	0.10	0.57
2020		4.63	3.92	0.19	0.71
2021		5.44	3.70	0.19	0.47
2022		6.60	4.28	0.59	0.34
2018	Epidemiological Surveillance	6.47	7.91	0.29	0.19
2019		8.04	8.14	0.24	0.24
2020		9.21	13.18	0.33	0.85
2021		10.97	10.36	0.75	0.84
2022		12.85	10.83	1.23	0.69
2018	Food and Nutrition	0.29	0.10	0.00	0.00
2019		0.24	0.10	0.00	0.00
2020		0.33	0.09	0.00	0.00
2021		0.23	0.05	0.00	0.00
2022		0.44	0.15	0.05	0.00

Source: own elaboration based on Siops.

Table 4.6 shows the same distribution by subfunction and source of funding as Table 4.5, but now expressed in per capita terms (R$ per inhabitant), which allows the fiscal effort of the different levels of government to be measured more precisely over

time. The data confirms the predominance of municipalities in primary care, whose own investment fluctuated, but reached R$ 253.71 per capita in 2022 - the highest figure for the period. Despite the drop in federal transfers (from R$169.93 in 2021 to R$150.79 in 2022), municipalities managed to substantially increase their allocation. Also noteworthy is the significant increase in the state's share that same year, from R$6.09 to R$21.32 per inhabitant.

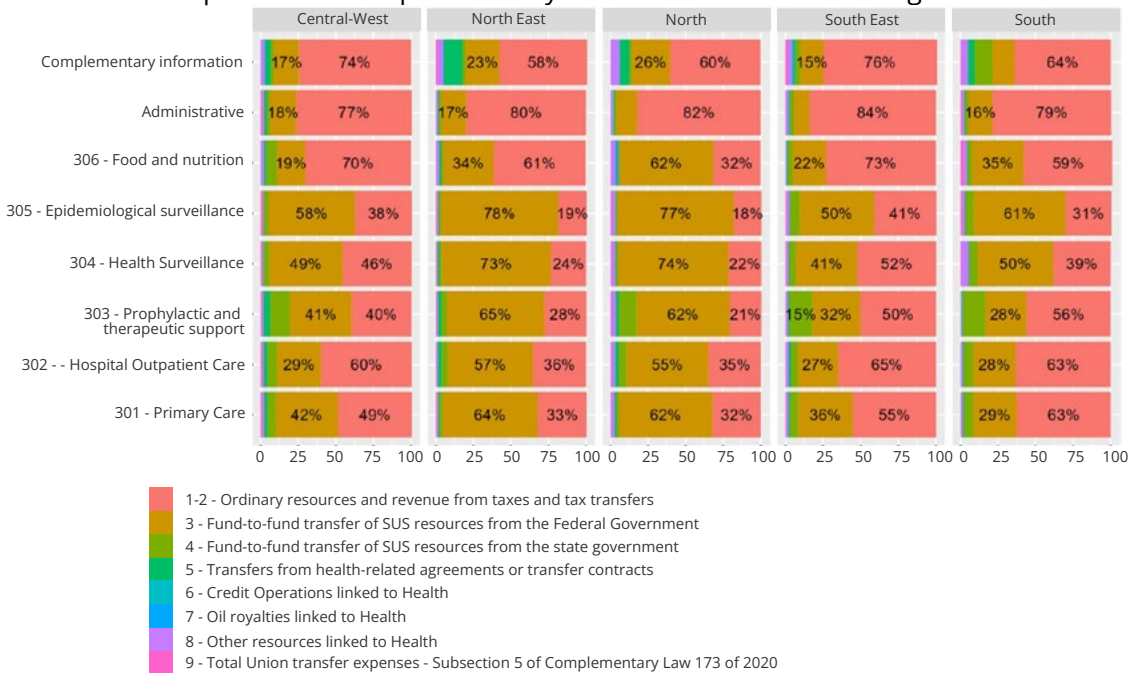
In the other subfunctions, the pattern repeats itself: municipal spending not only remains high, but also grows in absolute terms, even when other sources fluctuate. In the HOC, for example, own investments rose from R$173.53 in 2018 to R$251.20 in 2022, partially offsetting the reduction in federal transfers observed from 2020 onwards. Even subfunctions with lower values, such as Health Surveillance or F&N, show this municipal resilience, with per capita increases even in the face of low state or federal collaboration. The per capita reading, therefore, illustrates even more clearly the local redistributive effort and the budgetary pressure borne by municipal administrations in guaranteeing access to health.

In summary, the analysis of the historical series shows that, although state and federal transfers have varied over the period, the financial responsibility of municipalities has remained high, growing again in 2022 after occasional reductions in previous years. The municipal revenue base, in addition to being smaller than that of the state and federal levels, is more volatile and depends on external factors, such as economic cycles and tax policies. However, municipalities, faced with the challenge of responding to the population's health demands, began to sustain much of the expenditure, adjusting their allocation of resources even in the face of uncertainties regarding intergovernmental transfers. This scenario reinforces the need for mechanisms that ensure greater budget predictability for municipalities, allowing them to maintain the provision of essential services without suffering the deleterious consequences of transfer instability.

The following graphs analyze the distribution of spending by different categories. Graph 4.14, for example, shows the distribution of sources of revenue for health spending by subfunction, broken down by region of Brazil (Central-West, Northeast, North, Southeast and South), based on the average of municipalities for the period from 2018 to 2022. The analysis reveals significant differences in funding sources between regions and subfunctions.

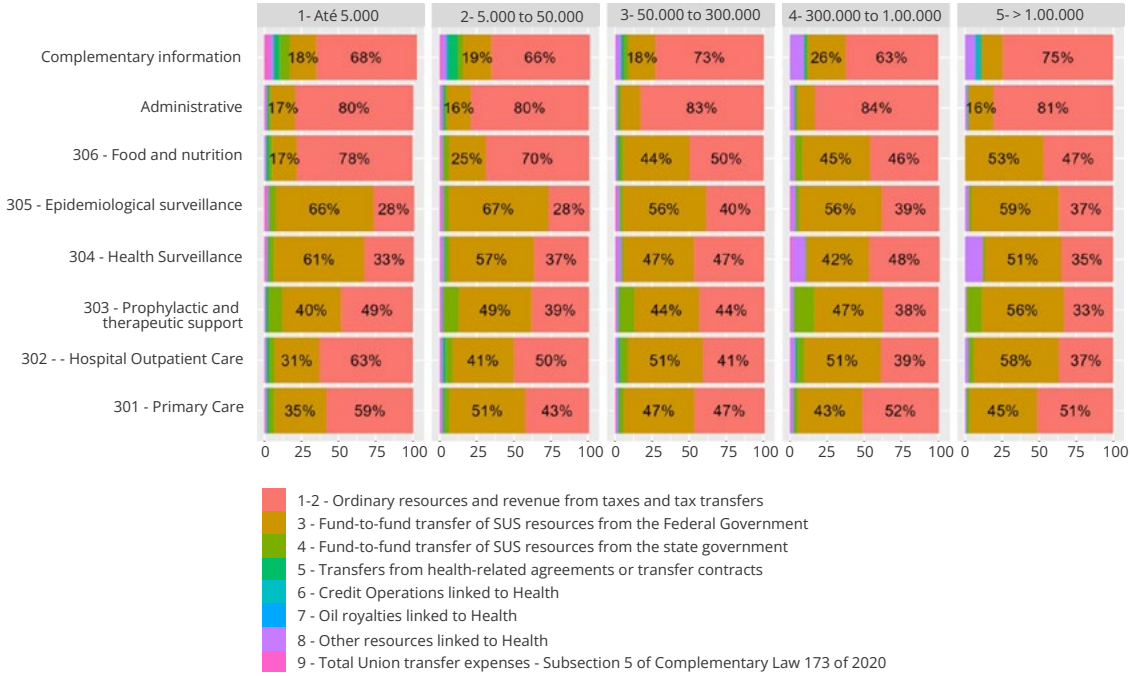
These regional differences in revenue sources by spending subfunction reflect variations in the economic capacities and public health policy priorities of each region. Regions with less capacity to mobilize their own resources, such as the North and Northeast, contrast with the Southeast and South, which have a greater share of ordinary income in health spending.

Graph 4.14. % of expenditure by subfunctio nand source - regions



Source: own elaboration based on Siops.

Graph 4.15. % of expenditure by subfunction and source - municipality size



Source: own elaboration based on Siops.

Graph 4.15 shows the distribution of health expenditure revenue sources by subfunction, broken down by population size of Brazilian municipalities, based on the average of municipalities for the period from 2018 to 2022. The data shows that smaller municipalities are more dependent on federal transfers to finance their health spending, especially in the F&N, Epidemiological Surveillance and Health Surveillance subfunctions. As the population size of municipalities increases, the share of ordinary revenue tends to grow, reflecting a greater capacity to raise its own revenue. Larger municipalities, especially those with more than 1 million inhabitants, show a greater diversification of revenue sources, although federal transfers and own spending still account for a significant part of funding.

Graph 4.16. % of expenditure by subfunction and source - by type of municipality

Source: own elaboration based on Siops.

Graph 4.16 shows the distribution of sources of revenue for health expenditure by subfunction, broken down by type of city (capitals, metropolitan regions without capitals and other municipalities), based on the average of the municipalities for the period from 2018 to 2022. An analysis of the distribution of health spending between capitals, municipalities in metropolitan regions (not including capitals) and other municipalities

reveals significant differences in the capacity of each group to articulate its own resources to compensate for its dependence on federal transfers.

The capital cities have a greater capacity to collect and diversify their sources of revenue, which allows them to reduce their dependence on federal transfers and maintain greater financial autonomy in the allocation of resources. This pattern is reflected, for example, in Administrative expenses, where 81% of expenses are covered by own revenues, and in Complementary Information, where own resources account for 29%. In the case of PC and HOC (302), own revenues represent 47% and 50% respectively, which shows that even in subfunctions traditionally financed by transfers, the capitals manage to mobilize their own resources to balance financing.

In the municipalities of the metropolitan regions without the capitals, there is an intermediate profile, in which there is a combination of own resources and federal transfers, but with less capacity to compensate for the reduction in transfers. These municipalities still have some structure for raising their own funds, but their financial articulation is less robust than that of the capitals. This is reflected in PC and HOC, where own resources cover 47% and 45% of spending, while federal transfers account for 44% and 48% respectively. However, in areas such as F&N (306) and Epidemiological Surveillance, the dependence on federal transfers is evident, reaching 63% and 62% of spending. This lower capacity to compensate with their own resources makes these municipalities more vulnerable to fluctuations in federal funding, affecting their financial stability in the provision of health services.

In the other municipalities, which include smaller towns and cities further away from large urban centers, the fragility imposed by federal transfers is even more accentuated due to their lower capacity to mobilize their own resources to make up for possible gaps in federal funding. These municipalities, unlike the capitals and metropolitan regions, have fewer instruments to compensate for any reductions in the volume of federal transfers, making them more financially vulnerable and susceptible to budget cuts in the health sector.

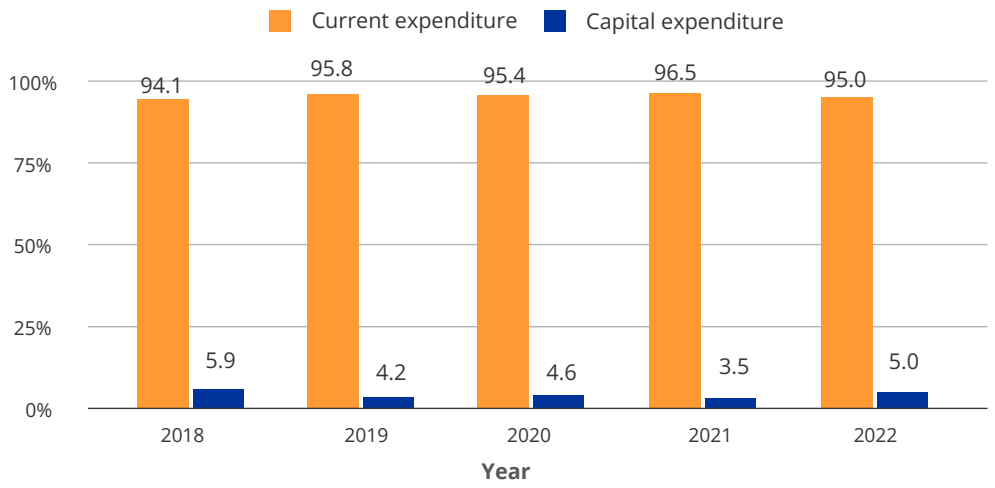
The relationship between dependence on federal transfers and the ability to mobilize own resources highlights the importance of a health financing model that takes these structural differences into account. While the capitals manage to generate their own revenue to reduce their dependence on federal transfers, the municipalities in the metropolitan regions without the capitals have limited spending capacity, and the other municipalities face greater difficulties in balancing their financing. This scenario reinforces the need for public policies that guarantee greater predictability in federal

transfers and encourage the strengthening of municipal revenue, in order to reduce inequalities in access to and quality of health services between different types of cities.

4.3 EXPENSES BY ECONOMIC CATEGORY

In this subchapter, we analyze the composition of expenditure by economic category. Capital expenditure is fundamental, as it indicates the system's capacity for expansion, while current expenditure indicates the cost of running the current structure. We used the values reported by economic classification as contained in Siops. In short, out of every R$100, almost 95% is spent on current expenses, in line with the average for the whole period.

Graph 4.17. Municipalities' current and capital expenditure - distribution in %



Source: own elaboration based on Siops.

Graph 4.17 shows the distribution of current and capital expenditure on health, based on the average of the municipalities between 2018 and 2022, in percentages. Current expenditure, shown in blue, indicates the cost of running the current health structure, while capital expenditure, in red, indicates the system's capacity for expansion.

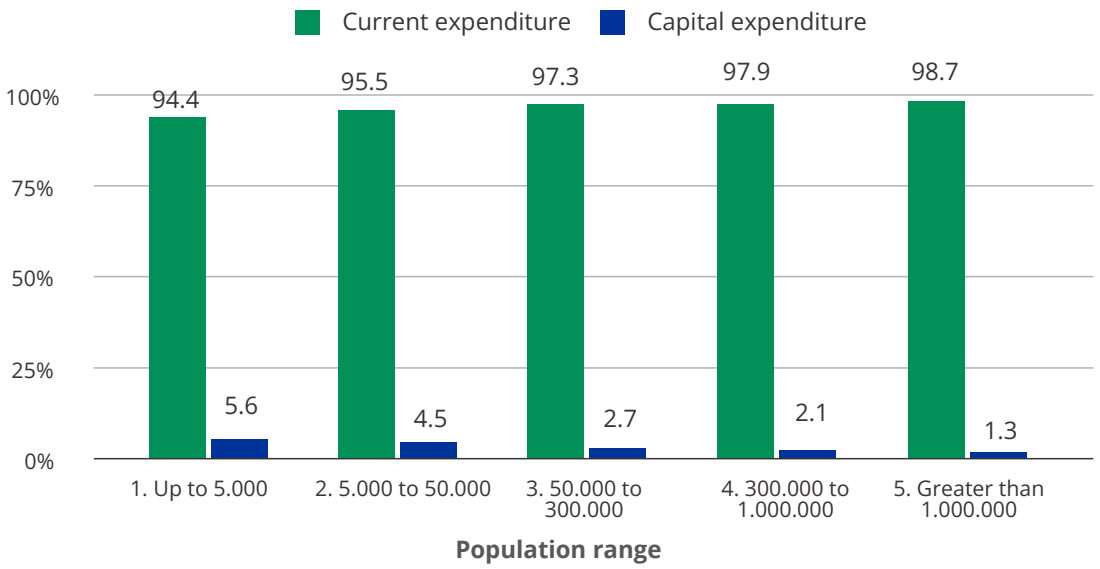
In 2018, current expenditure accounted for 94.1% of the total, while capital expenditure was 5.9%. In 2019, current expenditure increased to 95.8%, with capital expenditure falling to 4.2%. In 2020, current expenditure continued rising to 95.4%, while capital expenditure fell to 4.6%. In 2021, the upward trend in current expenditure con-

tinued, reaching 96.5%, with a reduction in capital expenditure to 3.5%. In 2022, current expenditure was 95%, and capital expenditure rose slightly to 5%.

This pattern indicates that while current expenditure is growing, capital expenditure is losing ground. This may suggest a higher priority given to the day-to-day running of health services to the detriment of expanding and improving health infrastructures. The average ratio of current expenditure to capital expenditure in the OECD is 6.82, highlighting a significant difference between the average of Brazilian municipalities and international standards.

The analysis highlights the need to better balance current and capital expenditure in order to guarantee not only the maintenance of health services, but also the expansion and modernization of infrastructure, with a view to continuous improvement in the health system.

Graph 4.18. Current and capital expenditure by population group



Source: own elaboration based on Siops.

Graph 4.18 shows the distribution of current and capital expenditure on health, broken down by population group of municipalities, based on average spending from 2018 to 2021. Current expenses, shown in blue, reflect operating costs of the existing health structure while capital expenditure, in red, represents investments to expand and improve the system.

These figures indicate that capital expenditure is higher in the smaller municipalities, suggesting that they are still in the process of developing and expanding their health infrastructures. In contrast, larger municipalities have a significantly higher proportion of current expenditure, indicating a greater focus on maintaining and operating the existing health infrastructure.

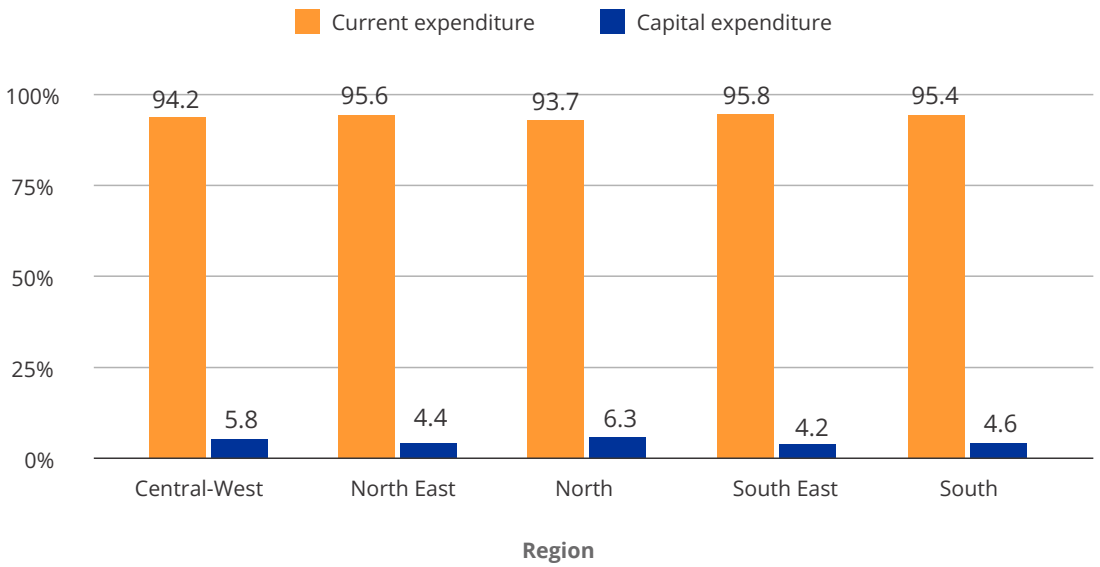
The analysis reveals the importance of resuming continuous investment in health infrastructure, especially in the smaller municipalities, in order to guarantee the capacity to expand and improve health services. For larger municipalities, there is a need to better balance current expenditure with capital investments to ensure continuous modernization and adaptation to the growing demands of the population.

Graph 4.19 shows the distribution of current and capital expenditure on health in the municipalities, by region, based on the average for the years 2018 to 2021. Current expenditure, represented in blue, shows the cost of running the existing health structure while capital expenditure, in red, represents investments to expand and improve the system.

These figures indicate that capital expenditure is higher in the North, suggesting that this region is investing proportionally more in expanding and improving its health infrastructure. In contrast, the Southeast region has the lowest proportion of capital expenditure, reflecting greater pressure on the maintenance and operation of existing health infrastructure.

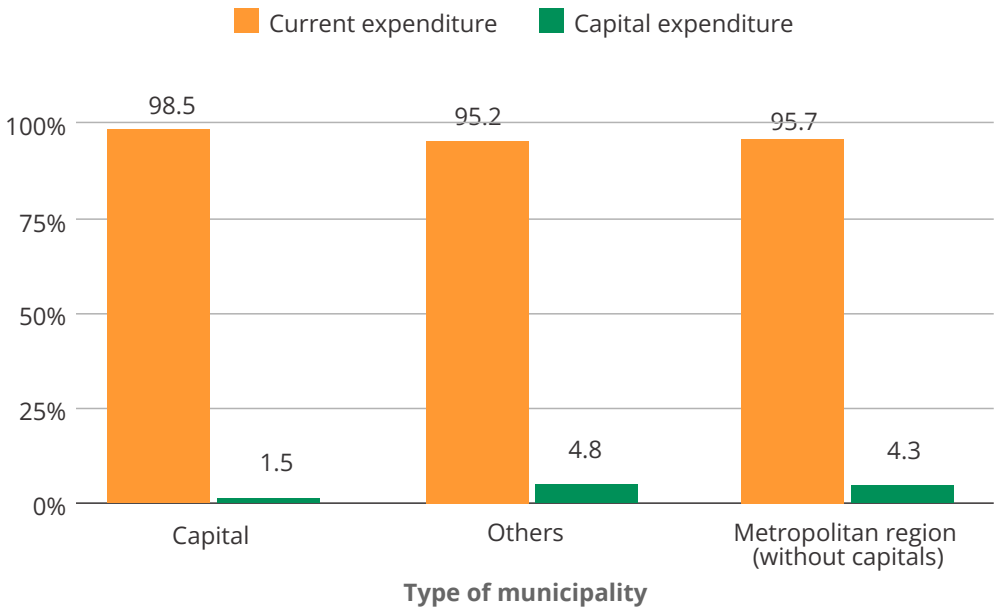
The analysis reveals that the different regions of Brazil have a varied composition in terms of health expenditure per capital. This highlights the importance of specific regional strategies to meet the needs and challenges of each area, ensuring a balanced and sustainable development of the health system throughout the country.

Graph 4.19. Current and capital expenditure by region



Source: own elaboration based on Siops.

Graph 4.20. Current and capital expenditure by region type of municipality



Source: own elaboration based on Siops.

Graph 4.20 shows the distribution of current and capital expenditure on health, by type of municipality (capitals, others and metropolitan regions without capitals), based on the average for the years 2018 to 2021. Current expenditure, shown in blue, reflects the cost of running the existing health structure while capital expenditure, in red, represents investments to expand and improve the system.

In the capitals, 98.5% of expenditure is current and 1.5% is capital. In other municipalities, 95.2% of expenditure is current and 4.8% is capital. In the metropolitan regions without the capitals, 95.7% of expenditure is current and 4.3% is capital.

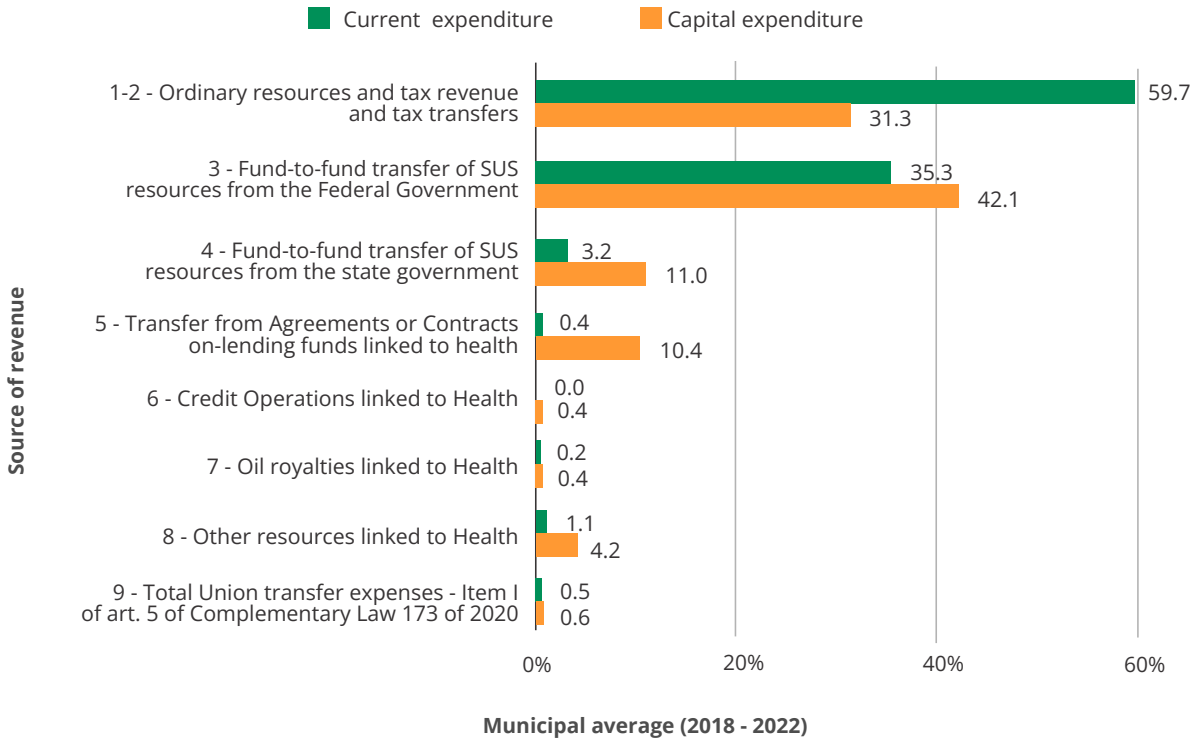
The data shows that the capitals allocate a smaller share of their health budgets to capital expenditure than municipalities that are not capitals. This may be related to the strong pressure exerted by current spending to maintain existing infrastructure and services, reducing the scope for new investment. In contrast, other municipalities and metropolitan regions without capitals devote a greater proportion of their budgets to capital expenditure because they are relatively less susceptible to such pressures.

The analysis reveals that the different health infrastructure needs vary according to the type of municipality. The capitals, with more consolidated structures, prioritize maintenance and operation, while the other municipalities and metropolitan regions without the capitals are more focused on expanding and modernizing their health services to meet growing demands.

Graph 4.21 shows the distribution of current and capital expenditure on health by source of revenue based on the average of the municipalities for the period from 2018 to 2021. Current expenditure, shown in blue, is mainly financed by own revenues, while capital expenditure, in red, depends mostly on transfers.

For current expenditure, 59.7% is financed by ordinary resources and tax revenues, including tax transfers. Other sources include FAF transfers of SUS resources from the federal (35.3%) and state (3.2%) governments, transfers from agreements or on-lending contracts linked to health (0.4%), credit operations linked to health (0.1%), oil *royalties* linked to health (0.4%) other resources linked to health (1.2%) and total expenditure on transfers from the Union (0.4%).

Graph 4.21. Current and capital expenditure by source of revenue



Source: own elaboration based on Siops.

For capital expenditure, the main source of funding is FAF transfers of SUS resources from the federal government (42.1%). This was followed by ordinary resources and tax revenues (31.3%), transfers from agreements or on-lending contracts linked to health (11%), FAF transfers of SUS resources from the state government (3.2%), other resources linked to health (1%), credit operations linked to health (0.4%), oil royalties linked to health (0.1%) and total expenses from Union transfers (0.1%).

These figures indicate that the main source of current expenditure is own revenues, reflecting local tax collection and transfers. In contrast, the main source of capital expenditure is transfers, especially from the federal government. This shows that while the day-to-day running of health services depends heavily on local revenue, investments in infrastructure and expansion of the health system are more dependent on funds transferred by the federal and state governments, especially parliamentary amendments.

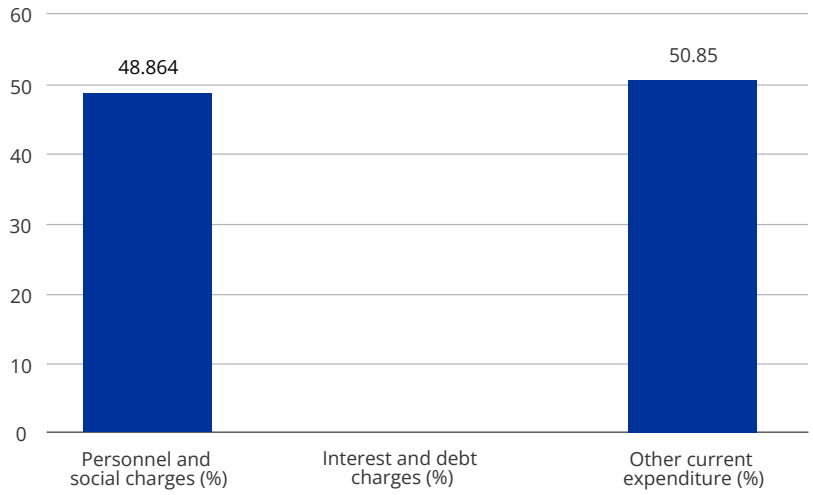
This analysis highlights the importance of a balanced funding structure that allows for both the maintenance and expansion of health services. Municipalities that man-

age to balance the shortfalls in transfers with their own revenues are better placed to guarantee the sustainability and continuous improvement of their health systems, even though this ends up compromising spending in other sectors and constitutes a breach of the SUS responsibility pact.

4.3.1 CURRENT EXPENDITURE

Let's take a closer look at current expenditure

Graph 4.22. Distribution of current expenditure

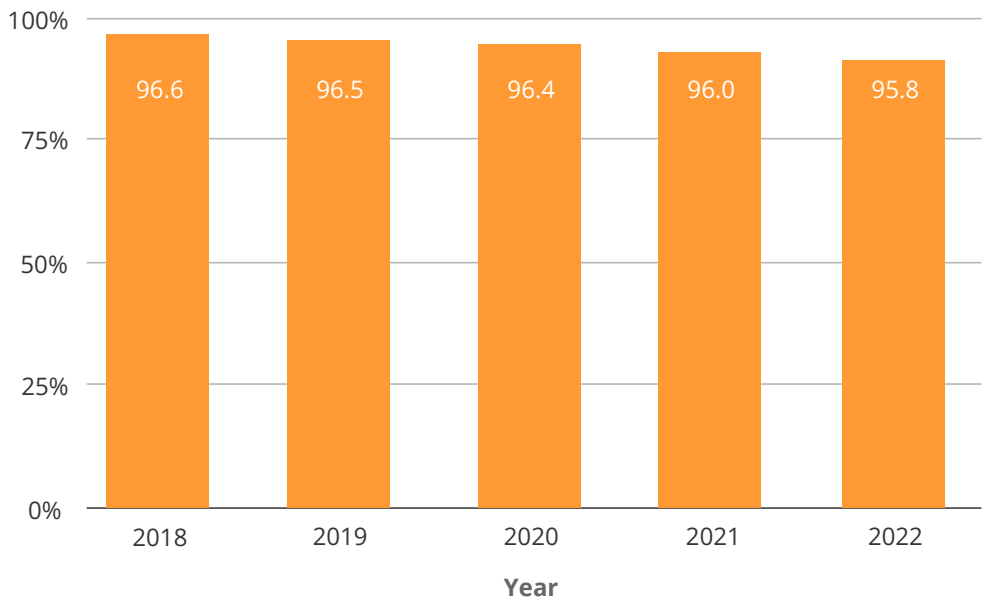


Source: own elaboration based on Siops.

Graph 4.22 shows the distribution of current health expenditure on average over the period from 2018 to 2022, divided into three categories: personnel and social charges, interest and debt charges, and other current expenditure. The overall picture shows a downward trend in the share of the personnel and social charges category over the years, falling from 52.15% in 2018 to 47.43% in 2022. On the other hand, other current expenditure gradually increased, from 47.94% in 2018 to 52.55% in 2022, indicating a redistribution of spending within current health expenditure. This change may reflect a greater allocation of resources to the costing of expenses, outsourced services and infrastructure maintenance, to the detriment of payroll. In addition, interest and debt charges were not significant during most of the period analyzed, remaining at 0% between 2018 and 2021, but with a slight increase in 2022 (0.02%), possibly reflecting some fiscal adjustment or re-financing of liabilities in the health sector.

These data suggest a reorientation of current expenditure, with less emphasis on personnel and social charges and a greater focus on other current expenditure, possibly reflecting changes in funding priorities within the health system. This redistribution may indicate an adaptation to the growing demands for health services and the need to allocate resources to various operational areas in addition to paying staff. The group of other current expenses includes transfers to Private Non-Profit Institutions and Public Consortia. This group of expenses will be explored in more detail later.

Graph 4.23. Direct applications

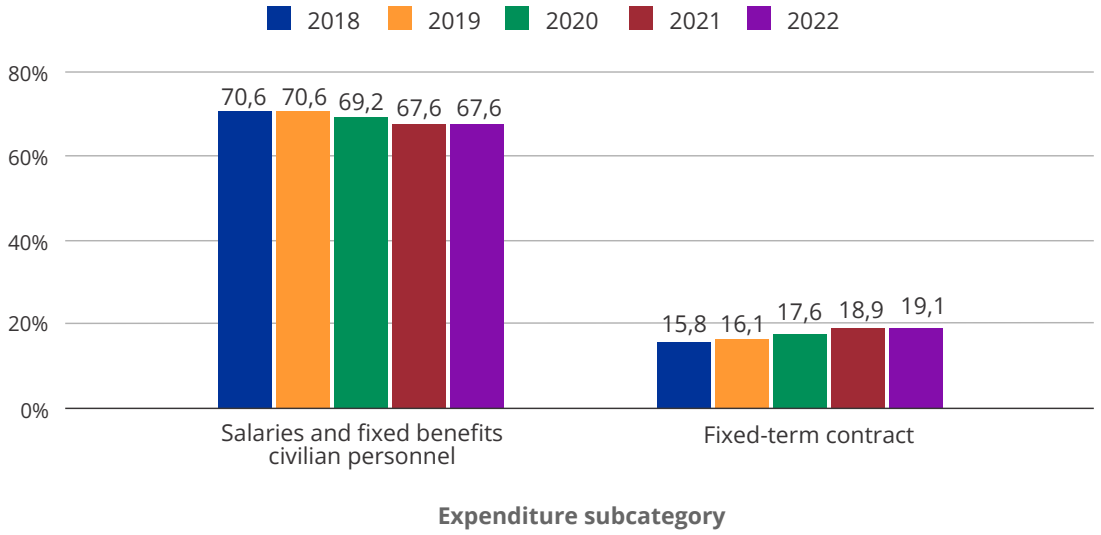


Source: own elaboration based on Siops.

Graph 4.23 shows the evolution of the percentage of direct applications in total expenditure on personnel and social charges between 2018 and 2022. The data shows that more than 90% of these expenses were made through direct investments, which shows a consolidated pattern in the management of these resources. In 2018, 96.6% of personnel costs and social charges were applied directly, remaining practically stable in the following years: 96.5% in 2019, 96.4% in 2020, 96% in 2021 and 95.8% in 2022. This slight reduction over the period indicates a slight flexibilization in the execution model, but without significant changes in the predominance of direct applications. Direct applications refer to the execution of budget credits carried out directly by the unit

responsible for the budget or through the decentralization of resources to other entities within the same levelof government, covering the Fiscal and Social Security Budgets.

Graph 4.24. Direct applications in detail



Source: own elaboration based on Siops.

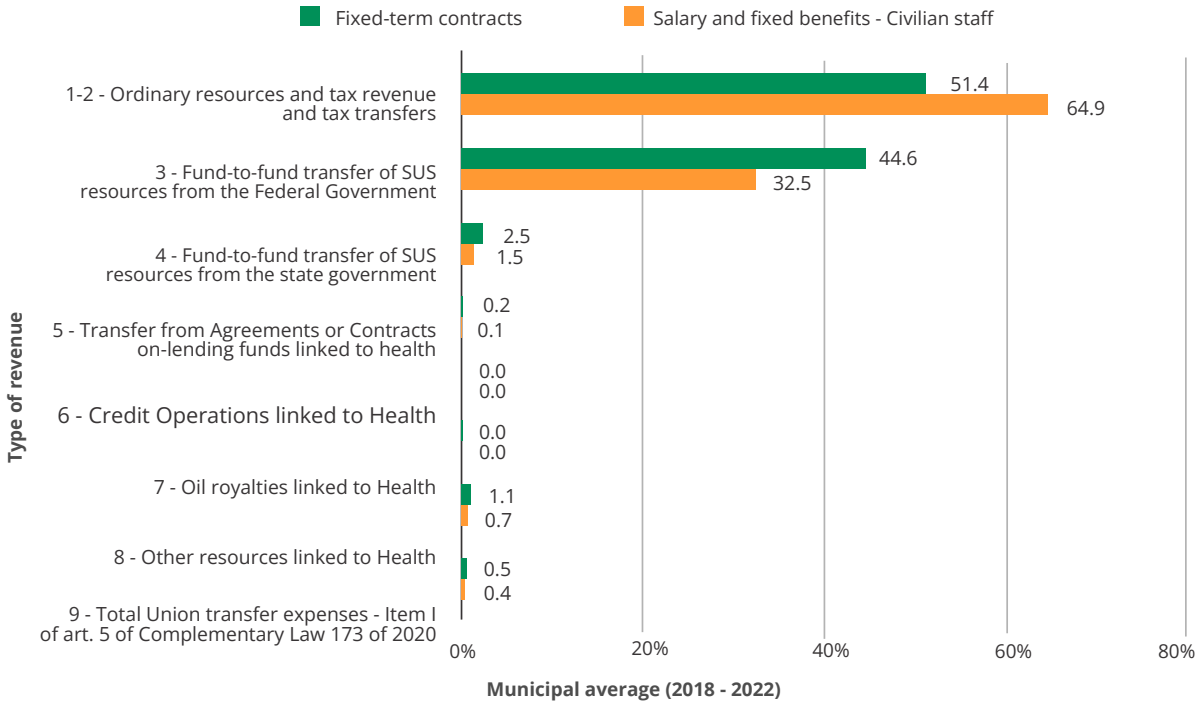
Graph 4.24 shows the breakdown of direct spending on personnel costs and social contributions, divided into two subcategories: salaries and fixed advantages for civilian staff and fixed-term contract, from 2018 to 2022.

In 2018, 70.6% of direct investments were earmarked for salaries and fixed benefits for civilian staff. In 2019, this percentage remained stable at 70.6%. In 2020, there was a slight reduction to 69.2%. In 2021, the share fell to 67.6% and in 2022 it remained stable at 67.6%. As for the subcategory of fixed-term contracts, in 2018, 15.8% of direct applications were earmarked for this purpose. In 2019, this percentage increased to 16.1%. In 2020, the share rose to 17.6%. In 2021, there was a significant increase to 18.9% and, in 2022, the share continued to grow, reaching 19.1%.

These figures indicate that, within the direct application of personnel costs and social contributions, salaries and fixed advantages for civilian staff have been losing ground to fixed-term contracts over the years. This trend may reflect greater flexibility in personnel management, with an increase in the use of temporary contracts to the detriment of fixed expenditure on civilian staff.

The analysis reveals a change in the priorities for allocating resources within personnel expenses, indicating a possible adaptation to the changing needs and growing demands in the health sector. This can also point to short-term strategies to meet emerging or specific needs, without compromising long-term resources.

Graph 4.25. Direct applications in detail by source



Source: own elaboration based on Siops.

Graph 4.25 shows the selected accounts for direct applications of personnel costs and social charges, broken down by source of revenue into two categories: fixed-term contracts and salaries and fixed advantages for civilian staff.

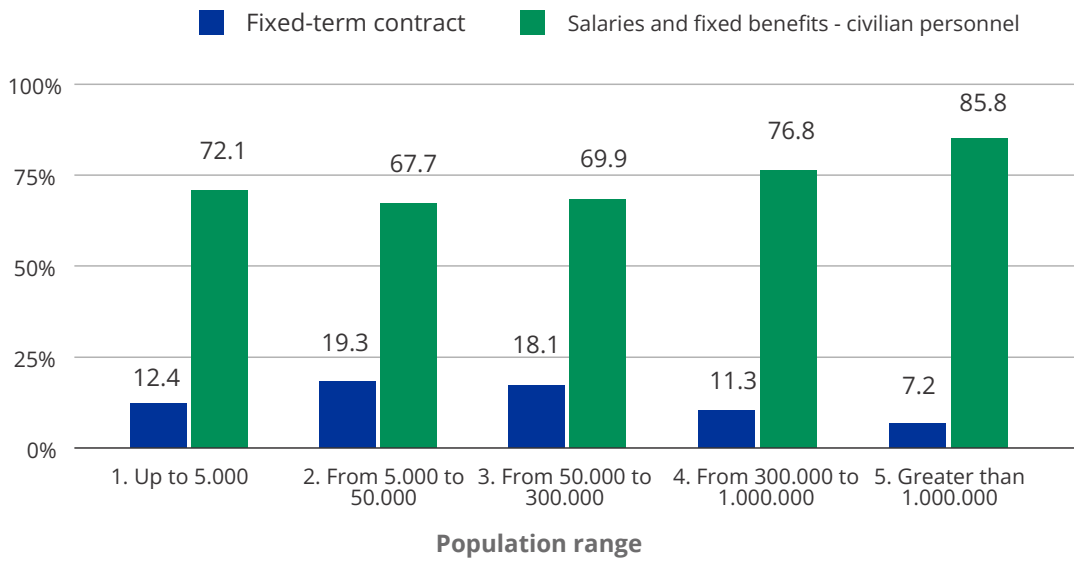
For civilian staff salaries and benefits, 64.9% of revenue comes from ordinary resources and tax revenue, including tax transfers. FAF transfers of SUS funds from the federal government contribute 32.5%, while 1.5% of revenue comes from FAF transfers of SUS funds from the state government. Other sources, such as transfers from agreements, credit operations, oil *royalties* , other resources linked to health and total federal transfer expenses, have smaller shares, ranging from 0% to 0.4%.

For fixed-term contracts, 51.4% of revenue comes from ordinary resources and tax revenue, including tax transfers. FAF transfers of SUS funds from the federal government account for 44.6%, and 2.5% of revenues come from FAF transfers of SUS funds from the state government. Other sources, such as transfers from agreements, credit operations, oil *royalties* , other resources linked to health and total federal transfer expenses, have smaller shares, ranging from 0% to 1.7%.

These figures indicate that most of the expenditure on civilian staff salaries and fixed benefits is financed by ordinary resources and tax revenue, while FAF transfers of SUS resources from the federal government also play a significant role, especially in fixed-term contracts, where they account for almost half of the revenue.

The analysis shows that although both categories of expenditure are heavily dependent on ordinary resources and tax transfers, fixed-term contracts are more dependent on FAF transfers of SUS resources from the federal government than salaries and fixed advantages for civilian staff. This suggests a diversified funding approach for different types of personnel expenses, reflecting the complexity and varied sources of funding needed to maintain and expand the workforce in the health sector.

Graph 4.26. Direct applications in detail by population group

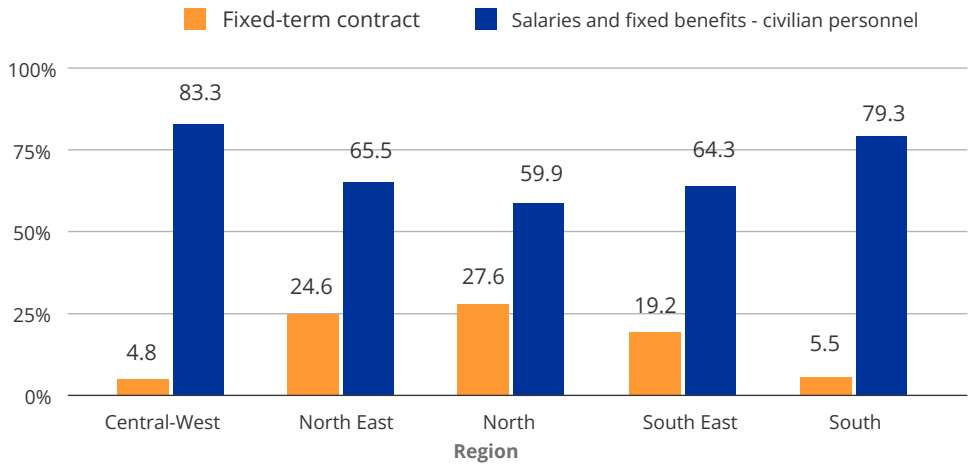


Source: own elaboration based on Siops.

Graph 4.26 shows the breakdown of direct spending on personnel costs and social contributions by population group. The data shows that the proportion of expenditure on civilian staff salaries and benefits increases with the size of the municipality's population. On the other hand, the proportion of expenditure on fixed-term contracts decreases as the population increases. This suggests that smaller municipalities rely more on temporary hires to meet their staffing needs, while larger municipalities have a more stable and fixed staffing structure, reflected in higher expenditure on fixed salaries and benefits.

This analysis reveals the variation in the management of personnel costs according to the population size of the municipalities, highlighting the different strategies adopted to deal with health demands in each context. Smaller municipalities tend to use more temporary contracts, possibly to maintain flexibility and control costs, while larger municipalities invest more in permanent staff, indicating a greater ability to maintain a permanent workforce.

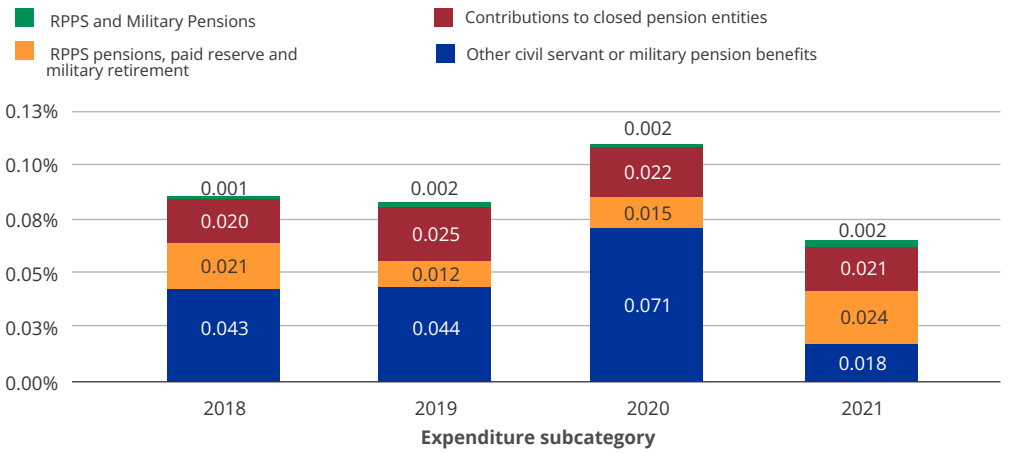
Graph 4.27. Direct applications in detail by region



Source: own elaboration based on Siops.

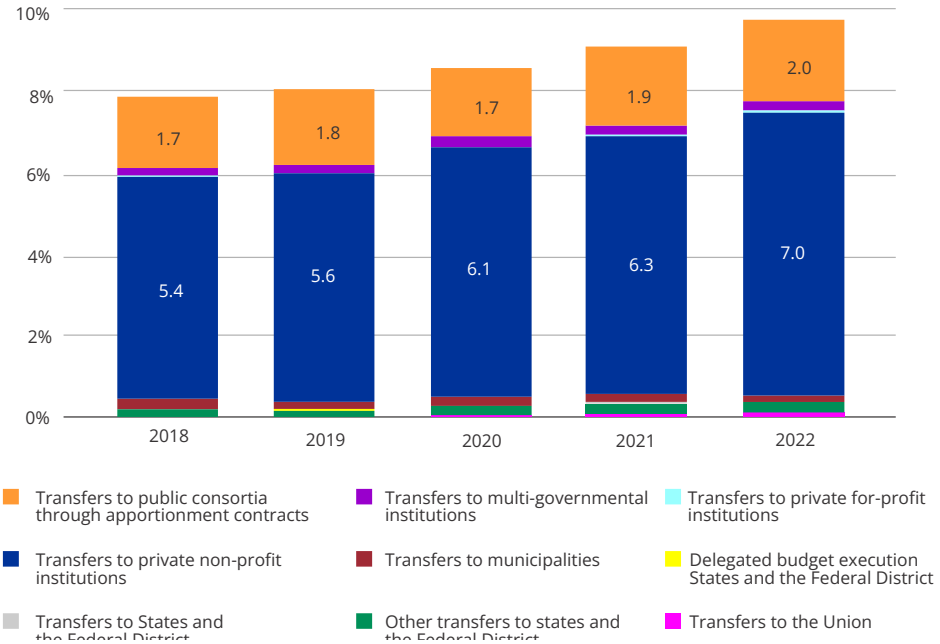
Graph 4.27 shows the breakdown of direct spending on personnel costs and social contributions by region. As expected, in all regions, most of the expenditure goes on salaries and fixed benefits for civilian staff. However, the proportion of this expenditure varies between regions. The Central-West region has the highest proportion of expenditure on salaries and fixed benefits (83.3%), followed by the South (79.3%). The North region has the lowest proportion of expenditure on salaries and fixed benefits (59.9%), indicating a greater dependence on fixed-term contracts (27.6%).

Graph 4.28. Direct investment in expenses - other expenses



Source: own elaboration based on Siops.

Graph 4.29. Other current expenditure - transfers



Source: own elaboration based on Siops.

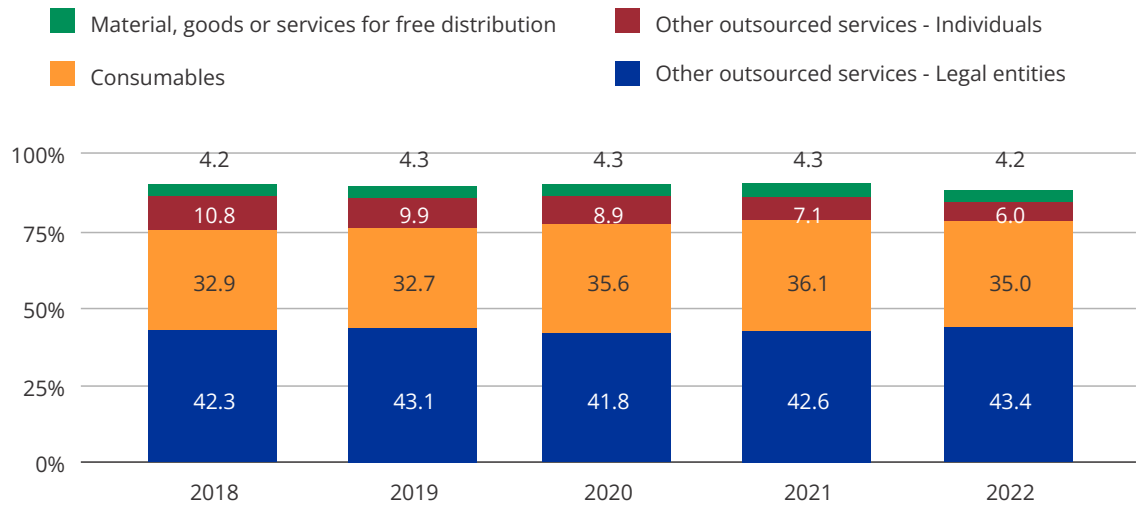
Graph 4.29 shows the percentage of transfers in relation to total other current expenditure from 2018 to 2022. The data shows that transfers to private non-profit institutions (philanthropic) and transfers to Public Consortia represent a significant fraction of this expenditure, amounting to around 10% of the total.

Over the years, there has been an upward trend in these transfers, with an increase in the participation of philanthropic institutions, from 5.4% in 2018 to 7% in 2022. This growth indicates an increase in the role of these entities in health spending, especially in the provision of hospital and specialized services.

Transfers to Public Consortia, on the other hand, also grew, from 1.7% in 2018 to 2% in 2022. This increase suggests a wider use of inter-municipal consortia as a strategy for shared management of health services.

The continuous increase in these transfers over the years reflects a growing dependence on these institutional arrangements in the execution of health services. This dynamic reinforces the need to monitor and evaluate the sustainability of these partnerships, ensuring that the resource transfer model continues to meet the demands of the municipalities and the population in an efficient and equitable manner.

Graph 4.30. Other current expenditure - composition



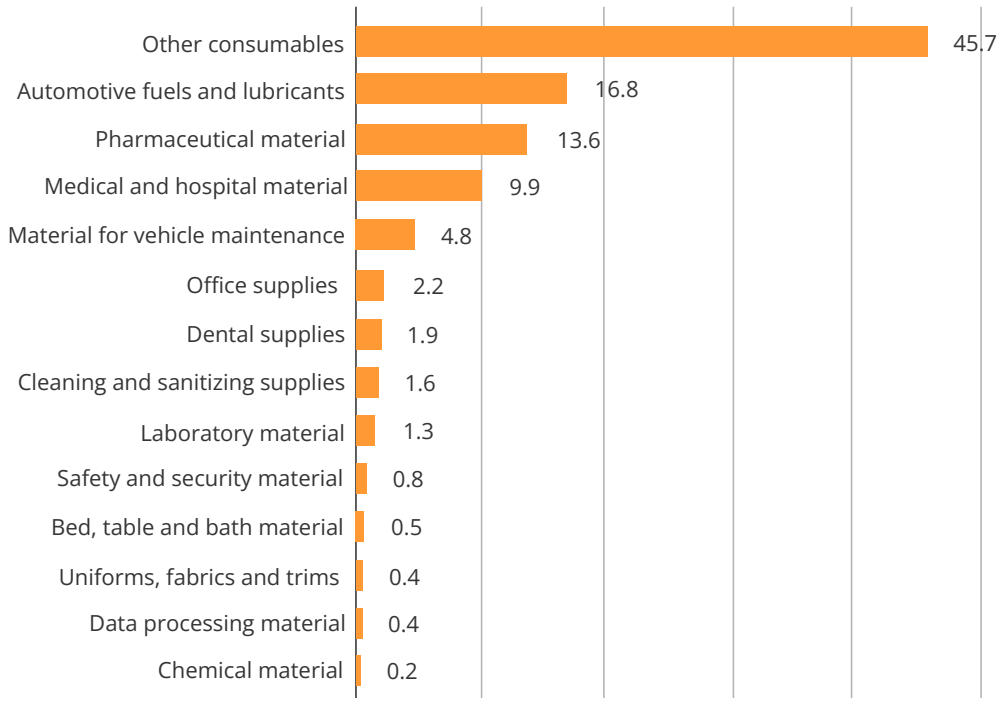
Source: own elaboration based on Siops.

Graph 4.30 shows the composition of direct applications of other current expenses, by year, from 2018 to 2022, divided into five categories: material, goods or services for free distribution; other outsourced services - individual entity; consumables; and other outsourced services - legal entity.

The data show that outsourced services and the purchase of consumables account for the largest share of direct investments over the years analyzed. In particular, outsourced services (PJ) have the largest share, ranging from 41.8% to 43.4%, while the purchase of consumables ranges from 32.7% to 36.1%. Material, goods or services for free distribution and other outsourced services (individual entity) have a smaller but constant share over the years.

This composition of expenses reflects a strong dependence on outsourced services, especially those provided by legal entities, as well as the ongoing need for consumables to maintain health care operations. The allocation strategy prioritizes contracts and outsourced services, along with the purchase of essential materials, guaranteeing the efficient operation of health services.

Graph 4.31. Other current expenditure - composition



Source: own elaboration based on Siops.

Graph 4.31 presents the composition of consumables, showing the different categories of materials and their respective percentage shares. Most of the products bought as consumables are not classified, accounting for 45.7% of the total.

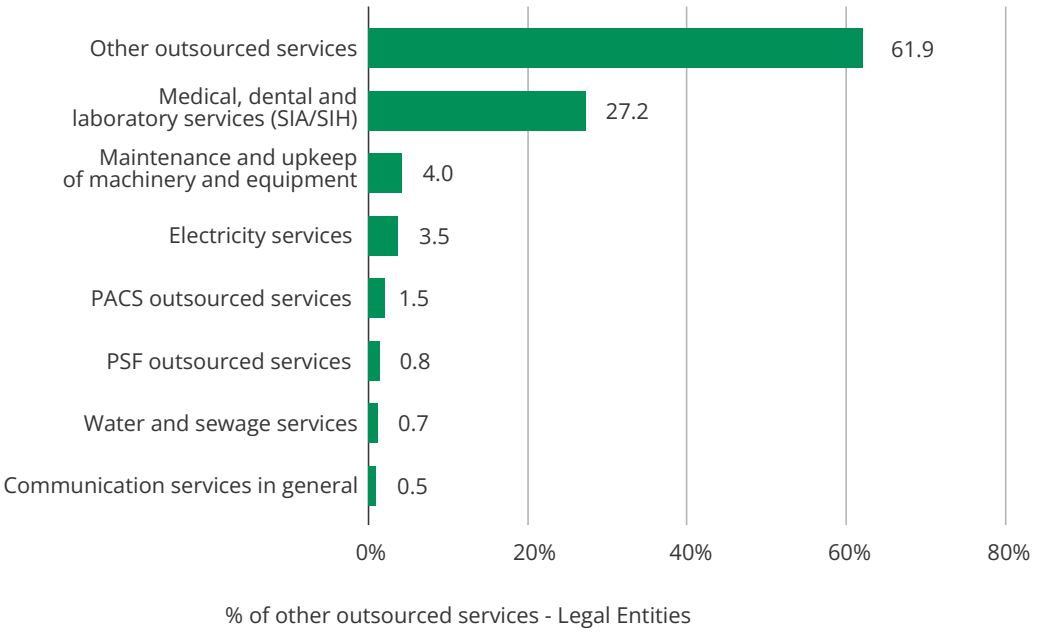
Among classified consumables, automotive fuels and lubricants occupy a significant share, accounting for 16.8% of the total. Pharmaceutical supplies account for 13.6% of the total, and medical and hospital supplies, which include orthoses and prostheses, account for 9.9% of the total.

Other important categories include vehicle maintenance equipment (4.8%), office equipment (2.2%), dental equipment (1.9%), cleaning and sanitizing equipment (1.6%) and laboratory equipment (1.3%).

Other categories with a smaller share include safety and security equipment (0.8%), bed, table and bath equipment (0.5%), uniforms, fabrics and trims (0.4%), data processing equipment (0.4%) and chemical equipment (0.2%).

This data indicates that a substantial part of spending on consumables goes to unclassified items, which suggests an opportunity to improve the categorization and transparency of spending. Expenditure on cars represents an important fraction of the total, reflecting the continuing need for maintenance and operation of vehicles in the health sector. In addition, spending on pharmaceutical supplies and medical and hospital supplies also account for significant portions, underlining the importance of these items for the functioning of health services.

Graph 4.32. Other current expenditure - composition



Source: own elaboration based on Siops.

Graph 4.32 shows the breakdown of other outsourced services - PJ, highlighting the various categories of services and their respective percentage shares. Most of the other outsourced services are unclassified, accounting for 61.9% of the total.

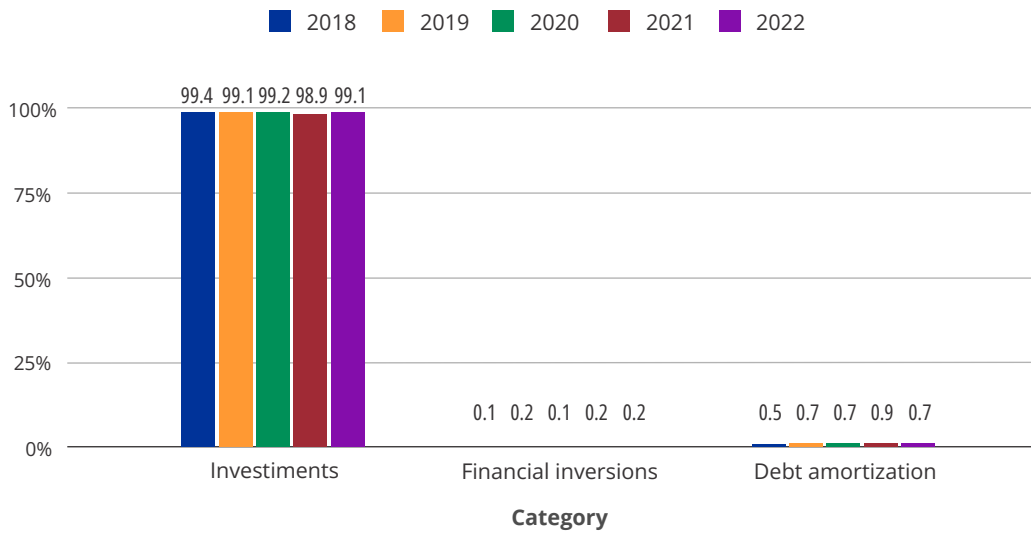
Among classified services, medical-hospital, dental and laboratory services (SIA/SIH) occupy a significant share, accounting for 27.2% of the total. Maintenance and upkeep of machinery and equipment accounted for 4%, and electricity services for 3.5%. Other important categories include PACS outsourced services (1.5%), PSF outsourced services (0.8%), water and sewage services (0.7%) and communication services in general (0.5%).

This data indicates that a substantial part of spending on other outsourced services is on unclassified items, which suggests an opportunity to improve the categorization and transparency of spending. Medical, hospital, dental and laboratory services represent an important fraction of outsourced services provided by private companies, underlining the importance of these services for the functioning of health systems. The maintenance and upkeep of machinery and equipment, as well as electricity services, are also significant components, reflecting the continuing need for efficient infrastructure and operations in the health sector.

4.3.2 CAPITAL EXPENDITURE

Now let's take a look at capital expenditure. Graph 4.33 shows the distribution of health capital expenditure by year, from 2018 to 2022, divided into three main categories: investments, financial investments and debt amortization.

Graph 4.33. Capital expenditure

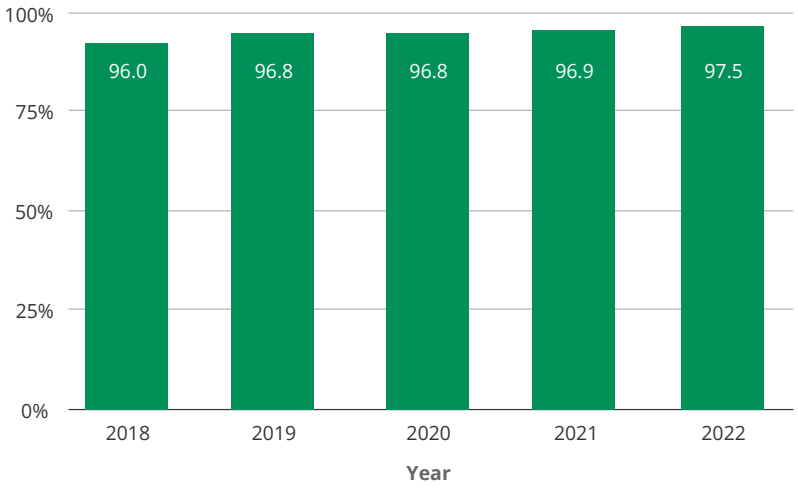


Source: own elaboration based on Siops.

The distribution indicates that most of the resources earmarked for capital expenditure in health are directed towards investments, reflecting the eventual expansion and improvement of health infrastructures and services. The categories of financial investments and debt amortization have very limited participation, suggesting that spending on these areas is minimized in favor of direct investments in health assets and capacities - generally through parliamentary amendments, although this issue is beyond the scope of this work.

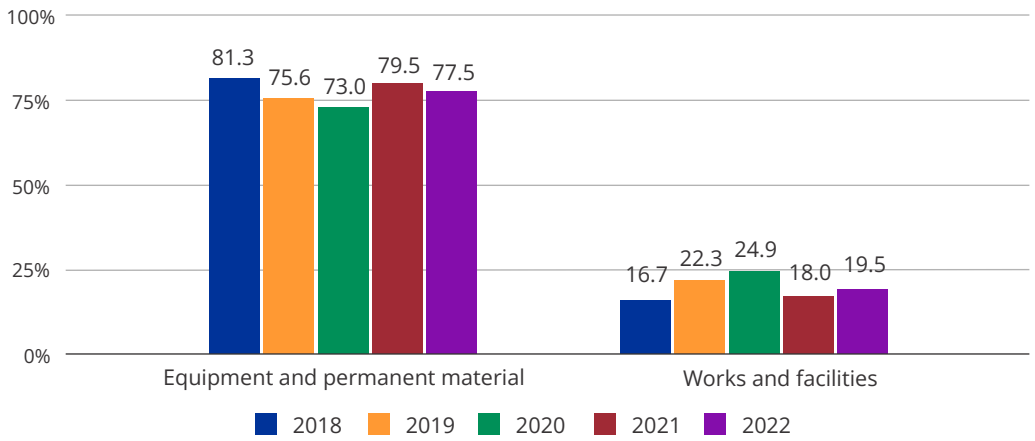
Graph 4.34 shows the percentage of direct investments in relation to total investments in health, from 2018 to 2022. These figures indicate that more than 90% of health investments are made through direct investments over the years analyzed. It is important to remember that budget credits are used directly by the budget unit holding the budget credit, or through decentralization to other budget entities within the same levelof government. In other words, they are investments made directly by the government.

Graph 4.34. Capital expenditure - direct application



Source: own elaboration based on Siops.

Graph 4.35 - Capital expenditure - direct application - breakdown



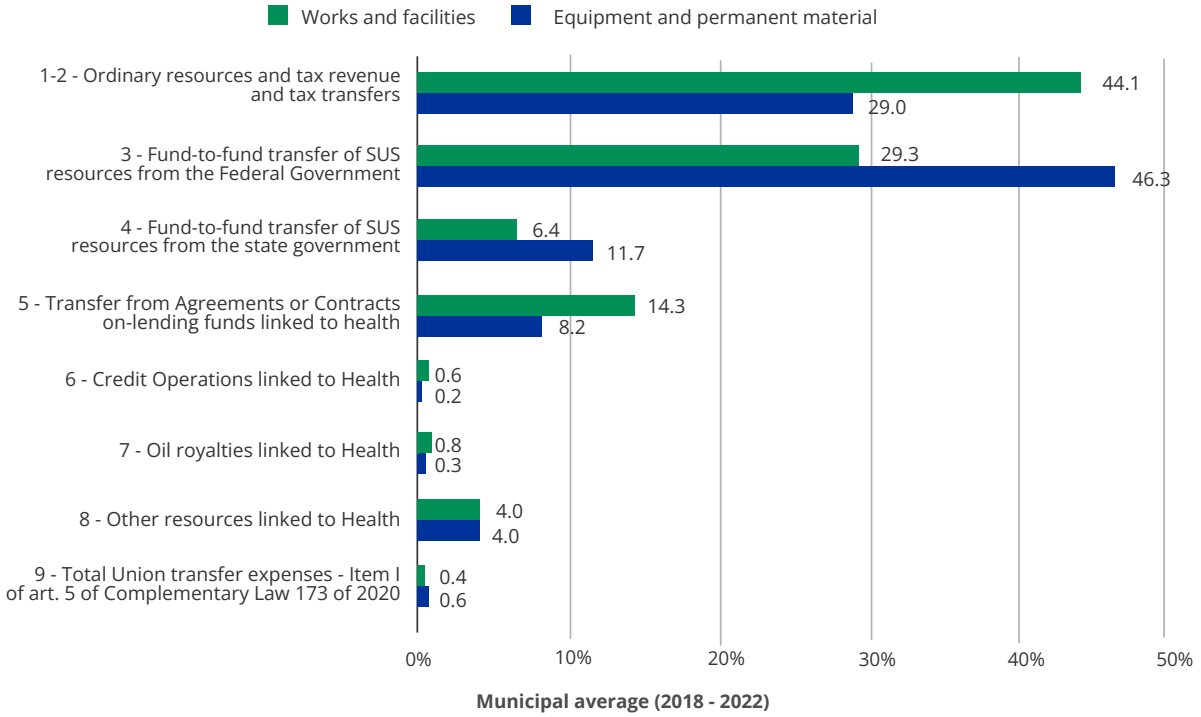
Source: own elaboration based on Siops

Graph 4.35 shows the breakdown of direct investments in health spending, divided between equipment and permanent material, and works and facilities, from 2018 to 2022. The data shows that almost three quarters of investment spending is directed towards equipment and permanent material over the years analyzed. This pattern reflects the

importance given to the acquisition and maintenance of equipment necessary for the functioning of health services.

Compared to the OECD, where 40% of investments are in works and facilities, 46% are in equipment and permanent material and 14% are in intellectual property, it can be seen that in Brazil there is a greater emphasis on equipment and permanent material, with fewer resources allocated to works and facilities. This difference may indicate different priorities in terms of infrastructure and the acquisition of permanent assets in the Brazilian health sector compared to OECD countries.

Graph 4.36. Capital expenditure - direct application - by source



Source: own elaboration based on Siops.

Graph 4.36 shows the selected accounts of direct investments in health, divided by source of revenue between works and facilities and equipment and permanent material, based on the average of the municipalities between 2018 and 2021.

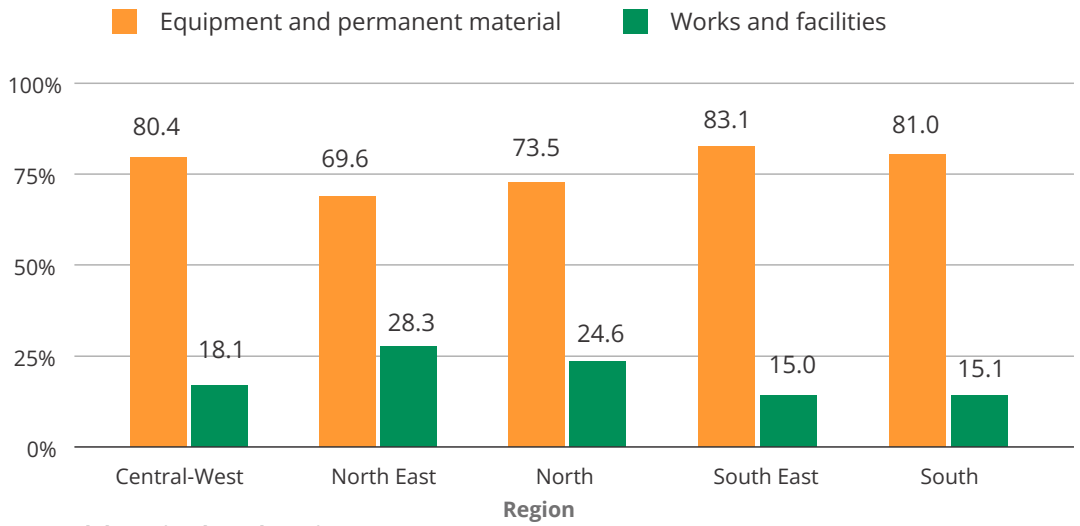
Works and facilities are mainly funded from own resources, re-presented by ordinary resources and income from taxes and tax transfers, which account for 44.1% of

the total. For equipment and permanent material, the most relevant source of income is the FAF from SUS resources from the federal government, which contributes 46.3%.

This data shows that works and facilities are predominantly supported by own resources, while the financing of equipment and permanent material depends more on federal support. The FAF of SUS resources from the state government is less relevant in general terms, but still concentrates a greater proportion of resources on equipment and permanent material (11.7%) than on works and facilities (6.7%).

In short, the financing of works and facilities is mainly supported by own resources, while the financing of equipment and permanent material depends more on federal support. This highlights the difference in resource allocation strategies between these two categories of investments in the health sector.

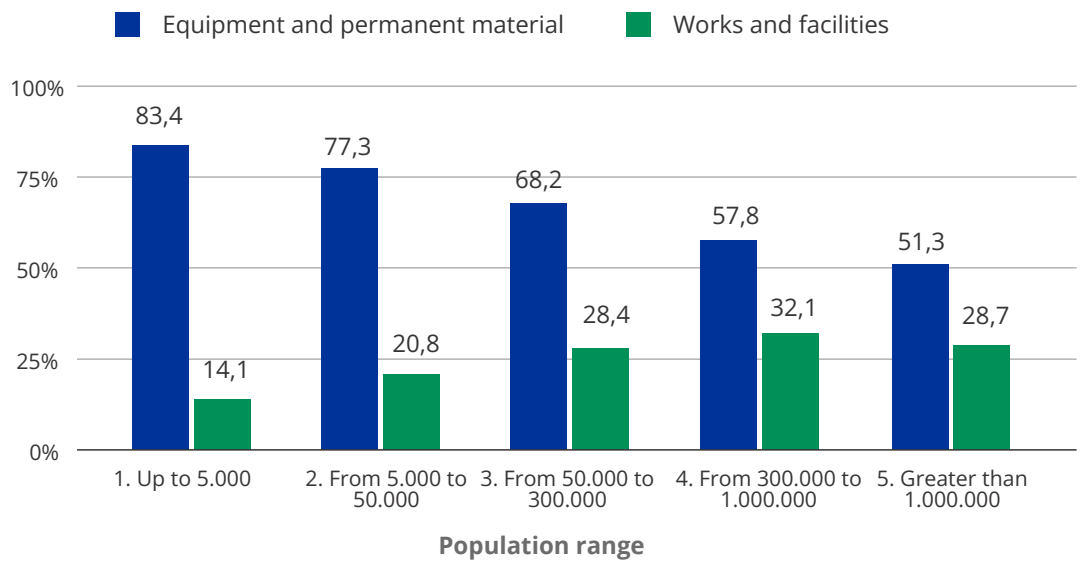
Graph 4.37. Capital expenditure - direct application - by region



Source: own elaboration based on Siops.

Graph 4.37 shows the breakdown of direct investments in health spending, divided between equipment and permanent material, and works and facilities, by region. The data shows that there are significant differences in the profile of capital expenditure between regions. While the Southeast and South concentrate most of their investments on equipment and permanent material, the Northeast has a higher proportion of spending on works and facilities. This regional variation may reflect differences in priorities and specific infrastructure and equipment needs in different areas of the country.

Graph 4.38. Capital expenditure - direct application - by population group



Source: own elaboration based on Siops.

Graph 4.38 shows the breakdown of direct applications of investment spending on health, divided between equipment and permanent material, and works and facilities, by city population group.

This data reveals significant differences in the profile of capital expenditure by city population profile. Smaller cities tend to concentrate a greater part of their investments in equipment and permanent material, while larger cities have an increasing proportion of spending on works and facilities. This may reflect the different infrastructure and equipment needs according to the size of the population and the complexity of the health services offered in each type of municipality.

4.4 CONCLUSIONS

The detailed analysis presented in this study highlights the complexity of the financial management of Brazilian municipalities in the area of health, which is marked by a significant fiscal effort on the part of the local authorities in the face of limited collaboration from the state and federal levels. The sustainability of public health services has increasingly fallen on the coffers of municipalities, requiring them not only to manage their day-to-day affairs, but also to make up for the gaps left by intergovernmental transfers.

A structural weakness was found in the way health financing is organized in Brazil: municipalities, especially smaller ones located in regions with less economic dynamism, face severe difficulties in making up for insufficient state and federal transfers. Although constitutional and legal transfers - such as the FPM - continue to be fundamental, in many subfunctions, municipalities' own resources exceed the amounts transferred, confirming the central role of local entities in sustaining the SUS. Capitals and municipalities in metropolitan regions have managed, to some extent, to compensate for these shortcomings with their own revenue; however, the majority of subnational entities remain highly vulnerable to the instability of transfers.

Low fiscal autonomy remains one of the main obstacles to strengthening local response capacity. Despite a slight increase in autonomy indicators over the last few years, this improvement has been insufficient to reduce structural dependence on intergovernmental transfers. The scarce capacity to generate their own revenues imposes additional restrictions on the management of health and other public policies, aggravating the exposure of municipalities to the volatility of federal revenues.

Regional inequalities intensify this scenario: while municipalities in the South and Southeast manage to mobilize more of their own resources and thus reduce their vulnerability, those in the North and Northeast remain heavily dependent on transfers that are often unstable, insufficient or delayed. The disparity highlights the need to review funding mechanisms in order to ensure greater predictability, equity and redistributive capacity.

From the point of view of the spending profile, there is a prevalence of PC and HOC as priority areas for investment. However, strategic subfunctions for disease surveillance and prevention - such as Health and Epidemiological Surveillance - continue to receive a modest share of resources, which compromises the resilience of the system in the face of health crises. Furthermore, the rigidity of budget allocation is reflected in the predominance of current expenditure, with capital investments representing only a fraction of spending, which limits the ability to modernize and expand the health system.

The heterogeneity between municipalities also manifests itself in the composition of revenues: larger municipalities tend to have more diversified sources of income, while smaller ones continue to depend almost exclusively on transfers. This context reinforces the urgency of differentiated public policies, capable of recognizing and responding to local specificities in terms of tax collection capacity, institutional structure and population profile.

Given this context, it is recommended that municipal fiscal autonomy be strengthened through measures that increase local tax collection, such as modernizing local tax

administration, reviewing tax bases and promoting local economic development. At the same time, it is essential to rebalance the composition of expenditure, with greater emphasis on investments in infrastructure, which will make it possible to expand and qualify the supply of health services.

It is also essential to adopt financing policies that take into account regional asymmetries and the fiscal capacity of the entities through more effective redistributive criteria, greater predictability in transfers and the strengthening of inter-federative cooperation. Strengthening the subfunctions linked to surveillance, prevention and response to health emergencies must be a priority in a global scenario where pandemics and health crises have a lasting impact on health systems.

In short, the data gathered in this study shows that, even in the face of structural limitations and funding uncertainties, Brazilian municipalities have played a central role in financing public health. Thus, strengthening fiscal autonomy, correcting regional inequalities and restructuring financing mechanisms are fundamental measures to consolidate a more robust, equitable and sustainable health system.

FINANCING THE SUS: BETWEEN CONSTITUTIONAL EFFECTIVENESS AND POLITICAL CHALLENGES OF SUSTAINABILITY

5

The construction of the SUS in Brazil is one of the most significant achievements of the social pact signed in the 1988 Federal Constitution Letter. Built on the principles of universality, integrality and equity, the SUS not only incorporated new rights into the Brazilian legal system, but also reaffirmed the role of the state as a guarantor of social citizenship. However, the realization of this constitutional project has been systematically strained by shortcomings in public funding, the maintenance of deep regional inequalities and successive political clashes over the prioritization of social rights in the public budget.

The analysis developed here revealed that, despite the institutional advances achieved - such as the regulation of constitutional floors and the consolidation of FAF transfers - health financing in Brazil remains marked by instability and subordination to economic, fiscal and political cycles that do not interact with the expansive and permanent nature of the right to health. The underfunding of the SUS, more than a technical failure, is an expression of political choices that repeatedly weaken public health policy to the detriment of other economic agendas.

In the federative context, the decentralization of SUS management, which is fundamental for bringing public policies closer to the health needs of the territory, has also implied the transfer of responsibilities without the corresponding distribution of fiscal capacity. The Federal Government, which has the largest share of tax revenues, has been reducing its proportional participation in health financing, imposing on states and municipalities the difficult task of increasing the cost of services without the necessary fiscal instruments to support this responsibility. This imbalance deepens regional inequalities and compromises equity, one of the foundations of the SUS itself.

The study showed that formal compliance with the constitutional floors by states and municipalities, although significant, does not in itself guarantee sufficient resources

to meet the population's health demands. Compliance with the minimum percentages established by law has not been able to compensate for the mismatch between growing needs - driven by the demographic, epidemiological and technological transition - and the volume of resources actually available. This finding reinforces that the problem of health financing goes beyond the normative dimension and requires structuring solutions of a political and economic nature.

The adoption of fiscal austerity policies, especially after the enactment of EC No. 95/2016, imposed severe restrictions on the growth of public spending, subjecting social rights to a compression regime incompatible with the expansion of health needs. Although the new fiscal regime, established by LC 200/2023, has repealed some of the stricter provisions of the spending ceiling, the dispute over health financing remains alive. Public demonstrations defending the flexibilization of the constitutional health and education floors reveal that social rights remain vulnerable to the dominant fiscal logics, which often subordinate public policies to short-term macroeconomic stabilization interests.

It is in this scenario that we need to reaffirm the SUS not only as a public policy, but also as a civilizational choice and as an ethical commitment of the Brazilian state to its citizens. The financial sustainability of the SUS will not be solved just by making technical adjustments to budget management or improving planning instruments. This is a political dispute over the meaning of the public budget: whether it should be an instrument for realizing rights or just a mechanism for containing social spending.

Strengthening state and municipal funding for the SUS therefore requires a political agenda capable of reconnecting the public budget to social needs. This implies redefining the federal pact, increasing the Union's participation in health financing and adopting apportionment criteria that are more sensitive to regional inequalities. It also requires the expansion and diversification of funding sources, through an effective Tax Reform, with mechanisms that burden privileged sectors of society and exempt the vulnerable population.

Alongside these structural measures, it is imperative to qualify the management of resources, strengthen health funds as financial execution instruments and integrate planning and budgeting instruments more effectively at each level of government. Efficiency in the allocation and execution of resources is essential, but does not replace the need to increase the overall volume of resources available for public health.

Likewise, the defense of public health requires the strengthening of transparency and social control, so that Brazilian society can monitor, evaluate and intervene in the

management of public resources. Realizing the right to health, in this sense, is not just a technical challenge, but also a political and civic task.

In short, the results presented here indicate that the future of the SUS will depend on Brazilian society's ability to reaffirm the right to health as a right of all and a duty of the state, rejecting the logic that subordinates rights to circumstantial fiscal restrictions. Defending the adequate funding of public health is therefore defending democracy, inclusion and social justice.

The SUS is not just a government policy, it is a country project. A project that requires a renewed commitment from managers, legislators, academics, health workers and organized civil society if it is to be fully realized. By organizing analyses and critical reflections, may this book strengthen the commitment to consolidating the SUS as an instrument for the realization of social rights, reaffirming the democratic and solidarity principles enshrined in the 1988 Constitution Letter.

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