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Forum: Practical Perspectives

Spending constraint and unpaid commitments on the federal budget for the Brazilian public health system

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This article explores the execution of the Brazilian federal budget for public health programs and services (ASPS), from 2002 to 2015, analyzing the impact of the spending constraint and unpaid commitments on the public healthcare system (SUS) financing. It was found that in this period the authorized payment limit for the Ministry of Health was insufficient to pay yearly expenses, engendering significant amounts of unpaid commitments. In addition, the cancellation of part of the unpaid commitments impacts the allocation of resources in ASPS, further aggravating SUS financing difficulties.

Keywords: healthcare financing; unified health system; financing government; budgets; Brazil.

Contingenciamento do pagamento de despesas e restos a pagar no orçamento federal do SUS

Discute-se a execução orçamentária e financeira das despesas com ações e serviços públicos de saúde (ASPS) do governo federal, no período de 2002 a 2015, especialmente quanto às implicações do contingenciamento do pagamento de despesas e de sua inscrição como restos a pagar para o financiamento do Sistema Único de Saúde (SUS). Observou-se que o limite de pagamento autorizado para o Ministério da Saúde nesse período foi insuficiente para pagar as despesas do órgão em cada exercício, provocando elevada inscrição de despesas como restos a pagar. Ademais, que o cancelamento de parte dos restos a pagar impactou a aplicação de recursos em ASPS, contribuindo para agravar o problema de financiamento do SUS.

Palavras-chave: financiamento da assistência à saúde; Sistema Único de Saúde; financiamento público; orçamento fiscal; Brasil.

Restricción de gastos y gastos no pagados en el presupuesto federal del sistema público de salud de Brasil

En este trabajo, se discute la ejecución presupuestaria y financiera con las acciones y servicios de salud pública (ASPS) del gobierno federal, de 2002 a 2015, en cuanto al impacto de la restricción de gastos y de los gastos no pagados para la financiación del sistema público de salud de Brasil (SUS). Se encontró que en este periodo el límite de pago autorizado para el Ministerio de Salud no fue suficiente para pagar los gastos de cada año, causando alto registro de gastos no pagados. Además, que la cancelación de parte de esos gastos impactó la asignación de recursos en ASPS, contribuyendo para el agravamiento del problema de financiamiento del SUS.

Palabras claves: financiación de la atención de la salud; Sistema Único de Salud; financiación gubernamental; presupuestos; Brasil.

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1. INTRODUCTION

Since the inception of the Unified Health System (SUS), financing has been a recurring theme among supporters of universal right to health care in Brazil. Given the scope of constitutionally-enforced entitlements, resources allocated by the three tiered-financing arrangement based on federal and local (states and municipalities) governments tax-based contributions are considered insufficient to ensure access to public health programs and services (ASPS) (Servo et al., 2011; Mendes, 2013). In countries with universal health care systems similar to the SUS, governments commit close to 6% of GDP to healthcare, whereas, for Brazil, government expenditures on health remain below 4% of GDP.

Several authors have also alerted to the gradual reduction in central government´s share in SUS financing — from 59,8% (2000) to 44,7% (2011) of total government expenditures on health (Piola et al., 2013; Soares and Santos, 2014). By force of Constitutional Amendment 95/2016, the recently approved "New Fiscal Regime" establishes a ceiling on federal government´s primary expenditures for the next 20 years (Vieira and Benevides, 2016). This will further aggravate this tendency. In this scenario, discussing aspects of the budgetary execution which may impact the availability of resources for the SUS gains further importance. The description of the budgetary execution from 2002 to 2015 bellow intends to illustrate the most critical issues in this process.

2. FEDERAL FINANCING AND BUDGETARY EXECUTION OF RESOURCES FOR HEALTH CARE

The SUS is financed by the allocation to healthcare of mandatory minimum percentages of net current government income by the three government levels. From 2002 to 2012, minimum allocations to health programs and services (ASPS) were defined by Constitutional Amendment 29/2000 and, from 2013 to 2015, by the Complementary Law 41/2012. Throughout this period, mandatory allocations to healthcare by the federal government were equivalent to committed expenditures in the preceding year plus the nominal variation of the GDP (Brazil, 2000, 2012).

Under the Brazilian public administration budgetary cycle, following budget approval of authorised appropriations by the National Congress, budget and financial programming decrees establish schedules for resource availability and spending constraints with which government agencies must comply. Programming decrees establish ceilings for commitments and payments made by the Executive branch of government on budgetary titles (GND) "other current expenditures" (GND3), "capital expenditure" (GND 4) and "financial investment" (GND5). Expenditure titles (GND) referring to staff payment and charges and interest and amortizations may not, as a rule, suffer any spending constraint.

Spending constraints established in budgetary and financial programming decrees force government agencies to carry forward expenditures exceeding ceilings. Unpaid commitments for which goods and services that were not actually delivered are called unprocessed carry-overs and unpaid commitments for delivered products are called processed carry- overs (Albuquerque, Medeiros and Feijó, 2008).

Decree 93.872/1986, altered by Decree 7.654/201, establishes that federal liabilities in respect to carry-overs are automatically time-barred after five years, with the exception of Ministry of Health's (MoH) unprocessed carry-overs, which may undergo time extensions by force of presidential decrees (Gontijo and Pereira Júnior, 2010). The potential longevity of MoH carry-overs and the

intense budgetary decentralization to states and municipalities are singular features of the MoH budgetary cycle.

Specificities of unpaid commitment (carry-over) regulation help us to understand their role in governmental accounting. Existing processed carry-overs at the end of any fiscal year are not counted as expenses incurred to calculate the government primary surplus (Aquino and Azevedo, 2017), i.e, unpaid commitments are interpreted as a government non-financial savings effort. Thus, it is worthwhile carrying unpaid commitments across fiscal years to boost government primary surplus.

3. DATA SOURCE AND METHODOLOGICAL PROCEDURES

To support the discussion brought up in this article, MoH budget and financial execution data were obtained from SIGA- Federal Senate for the years 2005 to 2015 (Brazil, 2016b).

To determine the constitutional minimum allocation to health care, we adjusted expenditures committed to health care services and programmes (ASPS) in the preceding year by the nominal variation in GDP. The former were obtained in the Summary Budget Implementation Report (RREO), published in the Official Journal of the Union. Expenditures typified as ASPS were defined in ordinance MS/GM 2047/2002 (Brazil, 2002) and in the resolution CNS 322/2003 (Brazil, 2003) for 2003-2012 and by the Complementary Law 141/2012 for years 2013 to 2015 (Brazil, 2012).

The MoH payment limits for expenditures under titles (GND) 3, 4 and 5 were obtained in the Federal Treasury electronic site (www.tesouro.fazenda.gov.br/contabilidade). Processed, unprocessed and cancelled carry-overs for ASPS spending were obtained from Siga Brasil (www12.senado.leg.br/orcamento/sigabrasil) and calculated according to Vieira and Piola (2016).

4. BUDGETARY AND FINANCIAL EXECUTION OF FEDERAL EXPENDITURES ON ASPS

Table 1 shows that, for every year of the series, the National Congress authorized appropriations for health care (column B) which exceeded the constitutionally-defined minimums (column A). Until 2011, differences between authorized appropriations and commitments (column D) averaged 4.4%. From then on, differences between them doubled (8.2%), peaking in 2015. This shows there was an increasing mismatch between resources assigned to health care by the legislature and actual expenditures on health care. Column C shows that for six of the 14 years in the series, committed expenditures — which define constitutional minimum allocations for health care - did not reach the mandatory levels of allocation (column A).

Carry-overs (column E) significantly increased in 2009 and since then have amounted to an annual average of 7.8 billion BR reais. An analysis of the reference fiscal year of 2016 unpaid commitments (column F) shows that part of them can date as far back as 2003. Cancellations occurred along the years (column G) and 2007 and 2009 outstand for amounts cancelled. Actual allocations to health services and programs (column H) correspond to committed payments (column C) minus cancelled unpaid commitments (column G). Upon subtracting actual allocations from mandatory health care allocations (column A) one can calculate allocations surpluses or deficits relative to these mandatory minimum allocations (column I). For nine of the 14 years in the series there were deficits relative to minimum mandatory allocations.

TABLE 1 **FEDERAL GOVERNMENT SPENDING IN PUBLIC SERVICES AND PROGRAMMES (ASPS). BRAZIL, 2002-2016**

Current BR reais

Fiscal year	Minimum mandatory health care (ASPS) allocation (A)	Authorised appropriation (B)	Committed expenditures in ASPS (C)	Differences between authorized appropriations and committed expenditures (D)=(B)-(C)	Confirmed unpaid commitments (E)	Reference fiscal year of 2016 unpaid commitments (F)	Unpaid commitments cancelled up to December 2015 (G)	Actual allocations to health services and programs (H) = (C) - (G)	Allocation deficit or surplus relative to mandatory allocation (I) = (H) - (A)
2002	23,654,072,386	25,863,275,274	24,708,886,048	1,154,389,226	1,775,608,171	–	500,621,283	24,208,264,765	554,192,380
2003	27,775,574,922	27,862,427,795	27,012,053,580	850,374,215	1,988,250,476	15,210,023	191,385,917	26,820,667,663	-954,907,259
2004	31,368,169,963	33,946,102,413	32,505,074,531	1,441,027,882	2,835,359,333	27,742,489	709,684,457	31,795,390,074	427,220,111
2005	37,051,473,809	38,790,692,865	36,291,911,037	2,498,781,828	3,292,101,800	36,723,950	609,518,424	35,682,392,612	-1,369,081,196
2006	40,613,666,045	42,236,890,275	40,520,675,993	1,716,214,282	4,357,106,368	42,008,726	809,448,929	39,711,227,063	-902,438,981
2007	44,275,043,408	47,488,689,966	44,051,896,820	3,436,793,146	5,603,463,981	188,985,510	1,330,410,968	42,721,485,852	-1,553,557,555
2008	48,561,056,485	51,012,550,613	48,428,024,812	2,584,525,801	5,684,995,031	179,790,177	1,062,962,895	47,365,061,917	-1,195,994,568
2009	54,963,098,717	59,425,947,559	58,016,587,301	1,409,360,258	8,562,061,372	512,361,286	1,378,579,078	56,638,008,223	1,674,909,506
2010	61,230,118,407	64,097,993,244	61,655,883,258	2,442,109,986	6,256,801,120	371,551,174	945,703,271	60,710,179,987	-519,938,420
2011	72,128,481,132	74,307,027,814	71,986,348,320	2,320,679,494	8,411,506,344	842,141,407	928,733,013	71,057,615,307	-1,070,865,826
2012	79,512,720,487	88,807,286,534	79,720,365,348	9,086,921,186	8,530,343,582	1,127,156,083	659,200,419	79,061,164,928	-451,555,559
2013	82,911,207,594	90,161,494,440	83,053,255,549	7,108,238,891	7,642,873,364	1,071,932,777	386,814,320	82,666,441,229	-244,766,366
2014	91,616,046,694	97,932,046,073	92,243,191,171	5,688,854,902	7,136,587,185	2,216,549,138	235,994,424	92,007,196,747	391,150,053
2015	98,313,048,464	110,449,163,999	100,460,337,118	9,988,826,881	7,880,465,468	7,880,465,468	–	100,460,337,118	2,147,288,654
2016	–	109,020,795,238	–	–	–	–	–	–	–

Source: Based on yearly Summary Budget Implementation Reports (RREO), published by the National Treasury (data in column A) and Siga Brasil (data in all other columns).

Table 2 summarizes MoH budget and financial execution and associated spending limits. The payment limit (column A) established by the programming decrees was complied with and exceeded expenditures plus carry-overs paid (column E) for the majority of years in the series. This shows that the MoH did not manage to execute its entire payment limits. Obstacles to budget execution may be either linked to National Treasury resource availability schedules or to delays in processing of acquisition of goods and contracting of services by the MoH, states or municipal health secretariats affecting resource transfers.

Differences between payment limits and the sum of all committed expenses plus unpaid commitments may exceed carry-overs between fiscal years. Part of this difference is due to unpaid commitment cancellations. An alternative explanation is MoH payments exceeding payment limits seen for specific years, as was the case from 2010 to 2012 and in 2015 (column H). These correspond to payments made on the last working day of the year, which are in fact due in the subsequent fiscal year, and therefore accounted as such. This accounting manoeuvre is subject to much criticism (Alves, 2012; Pinto, 2014).Differences between annual current expenditures plus unpaid commitments (column D) and spending constraints in budget programming decrees (column A) originates carry-overs to the following fiscal years. These differences, on average, amounted to 5% of the payment limit between 2002 to 2004. From 2009 to 2012, they amounted an average of 22% of the payment limit, returning to levels of 15% from then on.

Seven per cent of all committed expenditures in 2002 were carried over to the following fiscal years, and 28% of those had been cancelled by the end of 2015. On average, 10% of all committed expenditures between 2002 and 2014 (ranging from 7% in 2002 to 15% in 2009) were carried over to the following years. Corrected to 2015 values (IPCA), unpaid commitments from 2002 to 2015 amount to R $13.6 billion. This means that health services and programmes financed by these resources were not actually delivered, even though they were counted as part of mandatory minimum allocations to health care by the federal government.

Budget titles (GND) related to "Investments", which amount to 5% of the MoH budget, and "Other current expenditures" (costing expenses), amounting to approximately 77% of the budget, were respectively responsible for 50.8% and 45.1% of total cancellations. It is clear that investments tend to be preferential targets of cancellations.

Capital spending (investment) is usually deemed less urgent than costing expenses and this may explain their preferential postponement, a pattern shared by all government functions (Santos et al., 2014). In addition, federal government payments are often hindered due to problems in subnational bidding processes or in project schedules. This can eventually lead to cancellation of these carry-overs, after a few years of reassignment to annual MoH budgets.

As for the modality of application, the largest cancellation volume occurred for unpaid commitments related to transfers to municipalities (44.3%), followed by direct applications (26.1%) and transfers to the states (19.9%). Overall, an average of 41% of carry-overs were related to transfers to municipalities, 30%, to direct applications, 18%, to transfers to States, and 7%, to transfers to private institutions. Over the years, cancellations have tended to be proportional to the budget allocated to each of these modalities of application. The exception was transfers to private institutions, which represented 1% of the budget and 7% of these unpaid commitments.

TABLE 2 MINISTRY OF HEALTH'S SPENDING LIMITS AND EFFECTS ON ABILITY TO PAY FOR HEALTH CARE AND PROGRAMMES (ASPS). BRAZIL, 2002-2015

Current BR reais

Fiscal year	Payment limit plus unpaid commitments (A)	Committed expenditures on ASPS under titles GND 3,4,and 5*	Unpaid commitments for ASPS under titles GND 3,4 and 5	Expenditures for fiscal year plus unpaid commitments for ASPS under titles GND 3,4 and 5	Paid commitments plus unpaid commitments for GND 3,4 and 5 (E)	Differences between expenditures for fiscal year plus sum of commitments payed and unpaid commitments (F) = (D) - (E)	Net result considering payment limits and total expenditures G) = (A) - (D)	Net result considering payment limits and commitments paid (H) = (A) - (E)
2002	22,020,079,000	21,734,961,450	2,012,332,130	23,747,293,580	21,641,881,165	2,105,412,414	-1,727,214,580	378,197,835
2003	24,037,787,600	23,676,395,615	1,962,834,126	25,639,229,741	22,998,574,696	2,640,655,045	-1,601,442,141	1,039,212,904
2004	30,266,942,000	28,695,034,233	2,065,031,605	30,760,065,837	27,579,439,253	3,180,626,585	-493,123,837	2,687,502,747
2005	33,267,273,000	33,004,362,446	3,064,373,564	36,068,736,011	31,684,584,920	4,384,151,090	-2,801,463,011	1,582,688,080
2006	35,733,750,406	35,800,293,804	4,028,433,436	39,828,727,239	33,753,470,588	6,075,256,651	-4,094,976,833	1,980,279,818
2007	37,958,009,000	39,275,114,343	5,881,811,106	45,156,925,449	37,219,812,986	7,937,112,463	-7,198,916,449	738,196,014
2008	44,449,736,000	42,756,447,360	7,537,308,863	50,293,756,222	40,327,976,976	9,965,779,246	-5,844,020,222	4,121,759,024
2009	47,876,506,000	51,322,711,566	9,601,734,891	60,924,446,457	46,852,345,487	14,072,100,970	-13,047,940,457	1,024,160,513
2010	52,189,615,000	54,129,788,691	13,177,267,418	67,307,056,109	54,323,458,605	12,983,597,503	-15,117,441,109	-2,133,843,605
2011	57,879,618,000	63,717,161,007	12,517,714,428	76,234,875,435	60,495,685,416	15,739,190,018	-18,355,257,435	-2,616,067,416
2012	68,327,412,000	71,200,300,603	13,970,080,582	85,170,381,186	69,130,382,154	16,039,999,032	-16,842,969,186	-802,970,154
2013	74,445,610,000	74,253,107,705	14,827,018,446	89,080,126,150	73,578,344,389	15,501,781,761	-14,634,516,150	867,265,611
2014	84,643,171,201	82,944,282,440	14,243,901,288	97,188,183,728	83,001,094,821	14,187,088,907	-12,545,012,527	1,642,076,380
2015	86,991,129,000	90,940,466,983	13,339,827,565	104,280,294,548	88,982,681,364	15,297,613,185	-17,289,165,548	-1,991,552,364

Source: Siga Brasil administrative data.

* Spending under budget titles (GND) GND1 — Personnel expenses and charges, GND 2 — Interest and other debt liabilities and 6 — Debt amortization are not eligible for constraints.

A percentage of 58% of cancelled carry-overs refers to commitments settled, i.e. in theory to goods or services that had already been delivered, according to the legal concept of settlement of the expenditure. However, most of these expenditures may not in fact have been settled, as up to at least 2011, an accounting procedure of "virtual settlement", which automatically assigned all government commitments to the settled status was standard (Gobetti, 2006; Vieira and Patil, 2016). In any case, payment of cancelled processed carry-overs may occur subsequently upon creditor complaint (George and Pereira Júnior, 2010). It is not known to which extent creditors are suing the public administration on the grounds of these cancellations in the SUS.

In summary, between 2002 and 2015, financial programming established in the programming decrees to meet primary surplus goals disrupted the implementation of yearly budgets, thus creating a budget scrolling carry-over cycle. Part of these carry-overs were cancelled.

This situation has led to public debt growth and to loss of budgetary cycle credibility and transparency, leading to the creation of "parallel budgets" (Aquino and Azevedo, 2017). In the case of healthcare, even though control bodies recommend payment of the cancelled carry-overs (Pinto, 2014; Brazil, 2015), these may be "forgotten" with the new Fiscal Regime. Paying them would engender a reduction in resources available for federal government primary expenditure, as they would count as additional application to the minimum mandatory allocations to healthcare.

5. FINAL THOUGHTS

It is clear that mismatches between authorized appropriations, committed expenditures and payments may engender significant losses or postponements in the availability of resources for the SUS. Insufficient payment ceilings, mismatching between financial schedules and payment schedules and insufficient execution ability of decentralized and sub-national government agencies can all contribute to this.

Concentration of unpaid commitments on investments limits capacity expansion of the SUS. The attempt to preserve investments has probably motivated the recent decision of the SUS Inter-government Management Commission (Comissão Intergestores Tripartite) to approve use of distinct and specific budgets for investments and costing expenditures in government transfers.

In the case of SUS, the impacts of spending constraints and unpaid commitments not only contribute to the creation of a "parallel budget" (Aquino and Azevedo, 2017), but hold a true potential for engendering "institutional default".

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