Confronting social and health inequalities in the access to Unified Health System

Enfrentando desigualdades sociais e de saúde no acesso ao Sistema Único de Saúde

Afrontar las desigualdades sociales y sanitarias en el acceso al Sistema Único de Salud

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RESUMO
Objetivo: Discutir a relação entre a estrutura social, econômica e de identidade do Brasil e a necessidade de manter o Sistema Único de Saúde como uma política pública mais equitativa.
Métodos: Foi realizada uma pesquisa bibliográfica nas bases de dados MEDLINE, via Pubmed, SciELO e BVS, com os descritores: fatores socioeconômicos, Sistema Único de Saúde e financiamento da saúde, de publicações em inglês e português, sem limitação de período.
Resultados: As consequências das desigualdades sociais se apresentam nos diversos aspectos da vida em sociedade. A falta de acesso a serviços básicos é capaz de agravar situações sociais como a diferença entre a expectativa de vida da população pobre em relação à população rica. Nesse sentido, considerando os impactos negativos na vida humana, a reafirmação de políticas públicas, como o SUS, com seu financiamento adequado, é necessária para minimizar tais desigualdades. Conclusão: Concluiu-se que as desigualdades sociais e suas consequentes iniquidades presentes no Brasil são resultado de processos históricos e sociais que impedem e limitam o acesso a bens e serviços básicos, como a saúde. Assim, políticas de acesso equitativo podem melhorar a qualidade de vida da população e reduzir as iniquidades, de modo que a consolidação do SUS possa ser alcançada.

Palavras-chave: fatores socioeconômicos, Sistema Único de Saúde, financiamento da assistência à saúde.

ABSTRACT
Objective: To discuss the relation between the social, economic and identity structure of Brazil and the need to maintain the Unified Health System as a more equitable public policy.
Methods: A bibliographic search was conducted in MEDLINE databases, via Pubmed, SciELO and BVS, with the descriptors: socioeconomic factors, Unified Health System and health care financing, of publications in English and Portuguese, without limitation of time period.
Results: The Consequences of social inequalities present themselves in the various aspects of life in society. The lack of access to basic services is capable of exacerbating social situations such as the difference between the life expectancy of the poor population when compared to the rich population. In this sense, considering the negative impacts on human life, the reaffirmation of public policies, such as the SUS, with its adequate financing, is necessary to minimize such inequities. Conclusion: It was concluded that social inequalities and their consequent inequities present in Brazil are the result of historical and social processes that impede and limit access to basic goods and services, such as health. Thus, policies of equitable access can improve the quality of life of the population and reduce inequities, so that the consolidation of the SUS can be achieved.
Keywords: socioeconomic factors, Unified Health System, health care financing.

RESUMEN
Objetivo: Discutir la relación entre la estructura social, económica e identitaria de Brasil y la necesidad de mantener el Sistema Único de Salud como política pública más equitativa. Método: Se realizó una búsqueda bibliográfica en las bases de datos MEDLINE, vía Pubmed, SciELO y BVS, con los descriptores: factores socioeconómicos, Sistema Único de Salud y financiación de la atención a la salud, de publicaciones en inglés y portugués, sin limitación de período de tiempo. Resultados: Las consecuencias de las desigualdades sociales se presentan en los diversos aspectos de la vida en sociedad. La falta de acceso a los servicios básicos es capaz de agravar situaciones sociales como la diferencia entre la expectativa de vida de la población pobre en comparación con la población rica. En este sentido, considerando los impactos negativos sobre la vida humana, la reafirmación de políticas públicas, como el SUS, con su adecuada financiación, es necesaria para minimizar tales inequidades. Conclusiones: Se concluyó que las desigualdades sociales y sus consecuentes inequidades presentes en Brasil son el resultado de procesos históricos y sociales que impiden y limitan el acceso a bienes y servicios básicos, como la salud. Así, las políticas de acceso equitativo pueden mejorar la calidad de vida de la población y reducir las inequidades, de modo que se logre la consolidación del SUS.

Palabras clave: factores socioeconómicos, Sistema Único de Salud, financiación de la asistencia sanitaria.

1 INTRODUCTION

Brazil is considered the country with the ninth highest rate of social inequality in the world, according to the Gini Index, which assesses the concentration of income of the population (World Bank, 2020). The country retains social inequalities that are responsible for suppressing access to the basic services and requirements necessary for a decent quality of life, especially the right to health, especially for the indigenous, black, poor and peripheral population.

In order for public policies to guarantee social rights in a universal way, they must be guided by the needs of the population based on equity, making them indispensable and reaffirming the need to maintain and consolidate the Unified Health System (SUS) (Venkatachalam et al., 2020), whether due to funding, constitutional reforms and the neocapitalist vision of laissez faire, laissez passer ("let it be, let it be"), as well as austerity policies and the economic crisis (Campo et al., 2015), or the maintenance of the Organic Health Laws (LOSs), reiterating the equitable role of assistance to the vulnerable population (Guimarães et al., 2021).

The antithesis generated by neo-capitalism, through privatizations and proposals such
as Constitutional Amendment 95 (EC 95) to cap federal public spending, and also considering the demographic and epidemiological transition scenario, which will require the allocation of a greater volume of resources in the future, could reduce SUS funding (Menezes et al., 2019). This system mitigates inequalities and provides for the entry of the low-income population, directly impacting on the Social Determinants of Health (SDH) (Souza et al., 2013), as well as on the equity and universality of health, which is now guaranteed as a social right and recognized as a state responsibility (CF/1988) (Barata, 2006; Pitombeira and Oliveira, 2020).

Therefore, this study aims to discuss the dependency relationship between Brazil's social, economic and identity structure and the need to maintain the SUS as a more equitable public policy, since the Brazilian population has historically been marked by a lack of access to services considered primary and basic, indispensable for a better quality of life.

2 MATERIAL AND METHODS

This study is a narrative review. A bibliographic search was carried out in the Medical Literature Analysis and Retrieval System Online (MEDLINE) databases via Pubmed, Scientific Electronic Library Online (SciELO) and Virtual Health Library (BVS), and analyzed works in the public domain, with no pre-established date.

The descriptors used were socioeconomic factors, the Unified Health System and health care financing. The inclusion criteria for the articles were publications that had one of the descriptors, articles in English and Portuguese. Exclusion criteria were congress or conference proceedings, technical and scientific reports and ministerial documents. The ethical precepts determined by Resolution 510/2016, regulated by the National Health Council, were respected.

3 RESULTS AND DISCUSSION

Since the colonization of Brazil by the Portuguese in the 15th century, the foundations of social inequalities in Brazil have their origins in moments of little social progress when compared to developed or developing countries. This notion of development is based, above all, on societal characteristics according to criteria based on the Western and Eurocentric notion of full citizenship and access to services considered essential for complete well-being in the various aspects of life, a path that Brazil still needs to follow (Carvalho, 2021) in order to achieve equity between the different social strata.
The burden during all periods, since the so-called "discovery of Brazil" in the New World, has made its population a characteristically poor and primitive country in the most diverse aspects, whether related to social organization, culture, education or even health. Despite discreet historical developments, such as the abolition of slavery in 1888 and the promulgation of the Federal Constitution (CF/19889), known worldwide as the "Citizen's Constitution", since it presupposes various social benefits for the citizens or residents of Brazil, the country still resides in the midst of negatively conquered social problems (Carvalho, 2021).

The arrival of the Portuguese and their insurrection against the Indians, then inhabitants, and the blacks brought from Africa as slaves, as a form of enterprise by the colonial government for the profitable purpose of sugar production, generated a population with results that are still observed today, of illiterate people, with slave-like characteristics, misogynistic and prejudiced, and an economy especially based on monoculture and latifundia, since, characteristically, such production required large amounts of capital from the plantation owners and the labor of the other inhabitants, generating the socio-economic-cultural inequality that perpetuates to this day (Carvalho, 2021).

Throughout both republics and the military dictatorship, the country was faced with seven constitutions resulting from moments of institutional rupture in which, only in its last moment, in 1988, did citizens, supported by the precepts of the need for support from the government structure, given its high levels of inequality and social inequities, economic and cultural inequalities, demanded fundamental rights based on the United Nations Charter and, specifically in the area of health, on the 8th National Health Conference (1986), based on the notion that the changes needed to improve the Brazilian health system would not be achieved through administrative and financial reform alone (Pereira et al., 2017).

The process of urbanization, as well as the rural exodus between the 1960s and 1980s, supported, in addition to the complex history of slavery, the current situation of inequality among the Brazilian population. In them, peripheral inequality, as it is called, was established as a way of benefiting only the part of the population that lived in large centers and especially in the central regions of the city (Carvalho, 2021). Although fragile, the existing health system was contracted and benefited, above all, those who paid into the social security system, with medical-centered, hospital-centered and treatment-focused points of care, particularly in places close to the wealthiest. It is noteworthy that, although this may seem like a distant scenario, even today there are still inequities related to the most vulnerable populations (Carvalho, 2021; Vilda et al., 2021).
The term "social inequality" tends to suggest only the concentration of income and capital for a small portion of the population when compared to the more vulnerable and quantitatively dominant portion. However, in addition to said concentration of income, other inequities must be observed, such as the lack of access to quality education, health for the promotion and prevention of diseases, basic sanitation, culture for the establishment of equal ethical and moral norms, and adequate housing for the full development of human life, in addition to the ethnographically abstract condition of the state of citizenship with civil rights and political awareness, necessary for changing the status quo of the punished reality of the less favored (Vilda et al., 2021).

Access to basic services is capable of exacerbating social issues such as the difference in life expectancy between the poorest and most vulnerable populations when compared to the richest, as well as demonstrating the greater risk of violence and marginalization. In addition, there are negative repercussions on the level of education, when people with purchasing power are more likely to have a higher level of education than those with lower purchasing power (Balaj et al., 2021).

Among the unequal issues, it can be inferred that people with greater vulnerability in relation to housing live in extreme situations of access to treated water and sewage, since most of them live in peripheral areas that don't even have public services such as garbage collection or even sewage treatment. Added to this are the diligent privatizations that worsen the state's obligations and provide mechanisms for private companies to select for whom they offer policies that should be public (Balaj et al., 2021). As an influence and complication of the lack of these services, the presence of diseases becomes a constant. Infections and negative repercussions on quality of life and high mortality rates are evident, as in maternal and infant mortality rates, which are higher in poor populations when compared to the same rates in rich populations (Balaj et al., 2021).

In terms of security, the immoral cycle of illiteracy and the constant search for illegal capital, such as drug trafficking in the communities, generate an incessant family progression of people living in these extreme situations. They perpetuate in their generations the lack of opportunity to access the quality education needed to diminish and even annul these negative interests (Balaj et al., 2021). What's more, the risk of a child following their parents into drug trafficking is greater than that of following the social and school standards agreed upon for a dignified life. It is necessary to add to this concept that, despite individual responsibility, the state is the main holder of inequitable origins, making socio-economic and cultural progress
difficult and even impossible, which in itself makes the concept of meritocracy empty (Balaj et al., 2021).

As far as culture is concerned, the concentration of consumption of this singularity is higher in wealthier social groups, since, in most cases, private basic education itself introduces the child or young person to it. On the other hand, young people who are highly vulnerable tend to read less and therefore have less knowledge to prevent health problems from occurring. Culture, as a socializing medium, gives young people a sense of citizenship as a civic weapon and the necessary knowledge of their rights, capable of supporting them in their quest for equality, social justice and reducing the inequities that affect their lives (Even-Zohar et al., 2021).

It is clear, therefore, that when viewing the epidemiological profile, historical and social context of Brazil, with consequent depreciations resulting from social inequalities and inequities, there is a large portion of the poor population that does not carry fullness in itself, since its citizenship has been taken away in the process of collective construction, despite the guarantees of CF/1988. It should be noted that the state’s guiding role has become derisory, because the neo-capitalist, reactionary, conservative, privatizing agenda and its meritocratic concepts disregard its responsibility for inequalities and even see their presence as inevitable or natural.

As we have seen, the colonizing culture and situations associated with slavery are the basis for inequalities, where exclusive social groups are more affected by them. Different social indicators have shown that the highest levels of vulnerability are directly associated with the black, brown and indigenous population (IBGE, 2018; Simões, Athias and Botelho, 2018). It is also important to point out that the conditions in which they occur become predictive factors of given negative conditions, and these are established as SDH, which can appear at an individual or collective, local or social, specific or broad level.

According to data obtained by the Brazilian Institute of Geography and Statistics (IBGE), the illiteracy rate is around 9.1% in the black or brown population compared to 3.9% in the white population. The black rural population has rates close to 20.7% when compared to 3.1% of the white population living in urban centers (IBGE, 2018; Simões, Athias and Botelho, 2018). For higher education, the school attendance rate is 18.3% for blacks or browns compared to 36.1% for whites. There is also an unequal ratio in the attendance rate of these same groups for people aged between 15 and 17, with 64.8% of blacks compared to 76.4% of whites (IBGE, 2018; Simões, Athias and Botelho, 2018).
When it comes to social issues of violence, it can be said that this is mostly associated with the black or brown population, with a homicide rate of 98.5 deaths per 100,000 young people aged between 15 and 29, compared to 34.0 deaths in the white population of the same age (IBGE, 2018). It should also be noted that when the data on information on the situation of violence was evaluated, 15.1% of black or brown people reported being beaten by an adult in the family, which contrasts with the 4.9% of whites who were involved in fights using firearms (Simões, Athias and Botelho, 2018).

As far as health is concerned, research shows that hypertension mostly affects black people. According to data provided by the Institute for Applied Economic Research (IPEA), 28.8% of the white population aged between 45 and 59 have hypertension, compared to 32.3% of the black population. Of particular note is the greater attention and care to be given to black women over 60, who have higher rates of hypertension, accounting for around 57.5% of all individuals analyzed. Health data also indicates that the proportion of women aged 40 and over who have never had a clinical breast exam is higher in the black population, especially in the states of the North and Northeast regions of Brazil (IPEA, 2011).

In terms of the inequalities associated with health, Brazil, which is equivalent to a continent in terms of area and population size, has great potential to drastically reduce poverty through public policies such as the SUS, which, by offering health promotion and disease prevention benefits, directly affects productivity, income and an increase in the Gross Domestic Product (GDP) per capita, generating a cycle of increased income and useful time at work and, consequently, capital for investment in goods and other services (Neri and Soares, 2002). It is worth noting that this is a productivist/quantitativist logic of society, and although imperfect, it is what prevails.

To this end, it should be clarified that health can be affected by socio-economic factors, including the presence of employment, education and ethnicity, as well as other subjective philosophical factors such as class consciousness, which in themselves are capable of generating understanding to change their state of vulnerability (Lima, Kruger and Tennant, 2022). Inequalities, by influencing this aspect of life, can generate differences in access to resources and factors that can influence them, becoming an opportunity for various players in the community to build more assertive public policies that aim for equity as social justice and that mitigate the negative effects on the lives of the population (Lima, Kruger and Tennant, 2022), just like the SUS.

In the case of a system where the pillars are based on equity of care, in which the most needy are prioritized over the most favored, it can be seen, in a conjectural dystopia, that users
with higher incomes and living in the Southeast region use public health services more, when compared to users with lower incomes and living in the Northeast (Travassos et al., 2000), contrary to the notion of social justice. Other incipient conditions, such as color and gender, are characteristics that increase the likelihood of seeking health services, demonstrating the inequity in health care (Travassos et al., 2000). Thus, the political austerity of directing points of care to privileged locations, and consequently urbanized by whites, contrasts with the real role of the SUS in mitigating the various social dysfunctions.

To corroborate the need for the SUS to pay special attention to the black and poor population, epidemiological evaluations provide information that, specifically in terms of the care offered by the SUS, the black population represents 67% and the white population 47.2% of the total public served. Most of the care is concentrated among users with incomes between a quarter and half the minimum wage, distributions that show that the lower-income population and the black population are, in fact, SUS-dependent (IPEA, 2011). However, this information does not take into account the fact that, proportionally, whites receive substantially higher salaries than blacks, which shows that they are able to access supplementary healthcare.

In addition to the favoritism understood by the greater proportional access to health of the more economically, socially and white privileged population, it should be noted that several authors corroborate that poor citizens tend to get sick earlier. Based on variance proportions, studies show that chronic-degenerative diseases, for example, develop approximately 30 years earlier in the poorest people when compared to those at the top of the economic pyramid. In addition, conditions related to schooling are also an important factor associated with early illness (Neri and Soares, 2002; House, Kessler and Herzog, 1990).

When it comes to early illness and its relationship with the economically underprivileged, several authors (Pereira, 2009; Noronha and Andrade, 2002; van Doorslaer et al., 2997) have presented a health concentration index based on the needs of the population. These indices tend to be lower in developed countries, and positive indices closer to 1 reflect greater inequality in health in favor of the wealthier groups. To understand this, the estimated indices for Switzerland are 0.0323, while for Brazil they are 0.0822, suggesting a great disparity in health in favor of the socially less privileged.

A study carried out by Lima and colaborators (2022), when calculating the health inequality map in the city of São Paulo using the Urban Health Index (UHI) methodology, showed that all the indicators studied, such as the proportion of households with access to sewage, the proportion of households with regular waste collection, the proportion of households receiving piped water, average income per household, the percentage of white
people and the literacy rate of people, showed a significant correlation with inequalities. In addition, the place of residence (center or periphery) increases the risk of health inequalities (Lima, Kruger and Tennant, 2022).

In addition to social and economic status and health inequality, the various regions of Brazil are unequal when it comes to concentration indices. Noronha and Andrade (2002) showed that the states of Acre, Minas Gerais, Rio Grande do Sul and the Federal District had the greatest social inequalities in health in their respective regions in favor of the wealthiest, while Rondônia, Amapá and Rio de Janeiro had the lowest concentration indices. Thus, in addition to the economic issue, regions that are more disadvantaged in terms of development have greater inequalities in health (Noronha and Andrade, 2002).

When oral health is deficient, in addition to causing pain, it generates a loss of productivity for the country, since local treatment with a dental surgeon is necessary. Even so, several studies have correlated the socioeconomic position of the population with caries rates. Schwendicke et al. (2015) showed a statistically positive association between socioeconomic inequality, when related to the low level of parental education, low income and not working, and the presence of caries lesions. It should be clarified, however, that the understanding of this situation is centered on the biomedical model of pathological conditions and developmental capitalist production (Schwendicke et al., 2015).

However, beyond the biomedical model, other studies have compared the socioeconomic status and family characteristics of children with the need for curative dental treatment, and have shown that families earning more than one minimum wage, with fewer than four residents in the house, living in their own home and children living with both biological parents have protective factors for the presence of caries (Lisboa et al., 2013).

In relation to illnesses resulting from health inequalities, mortality is an issue to be considered, since in addition to being the result of a process suggestive of lack of access and social inequality, it also legitimizes the state’s responsibility for the need to reaffirm democratic, social and necessary health policies. In light of the above, Chiavegatto Filho et al. (2012) tested the propensity for mortality and income inequality in 96 districts, and observed a statistically significant association between high mortality risk and social inequality based on the Gini parameter (Chiavegatto Filho et al., 2012).Repeatedly, the republican commitment to its people must be a sine qua non condition for establishing protective precepts for social health.

Corroborating the research cited above, Carvalho et al. (2015) studied the relationship between health inequities and housing conditions and infant mortality in the Brazilian Northeast. The study found a decrease in the infant mortality rate over the period studied.
Despite the decrease in rates in all strata, the inequality of mortality risks increased in neighborhoods with worse living conditions compared to areas with better living conditions, demonstrating the relationship between social status and the risk of falling ill from causes resulting from, exempli gratia, parasitic infections due to inadequate basic sanitation (Carvalho et al., 2015).

The SUS, as the universal health policy instituted in Brazil is called, began thanks to the feeling of citizenship and awareness of the various social classes of the Brazilian population, who sought, through comprehensive health care (Araújo et al., 2018), a system with health promotion, prevention and recovery actions accessible to all citizens living in the country, regardless of their contribution to the social security system (Viegas et al., 2021), based, above all, on the broad possibility of health care for any and all Brazilians. It stands out for its democratic, universal, egalitarian and comprehensive care for Brazilian citizens and other people living in the country (Lavras, 2011).

In 1978, the health care system was linked to the National Institute of Medical Assistance for Social Security (INAMPS), and this continued until the creation of the SUS. At the beginning of the 1980s, in order to provide health care to those then unassisted by such a fragmented system, the Health Reform Movement gained strength with the participation of various social subjects, such as the population, teachers and public health scholars (Pereira et al., 2017).

The VIII National Health Conference, marked by a broad process of social mobilization, focused on health as a right, the reformulation of the national health system and the financing of the sector, which, anchored in CF/1988, established the SUS with the doctrinal principles of equity, universality and integrality, guaranteeing health, in the most diverse instances, for the entire Brazilian population (Bispo and Moraes, 2020; Onocko-Campos and Tanaka, 2021).

It is worth noting that the fight for a socialist ideal of health, reducing the historical inequities of care for the poorest population in a country as unequal as Brazil, took place on the margins of an identity construction recognizing the need for a universal health policy that includes care for all people, independent of any situation that defines it (Araújo et al., 2018). Thus, the struggle originated from the population demanding access to health for all, regardless of political actors or specific groups (Onocko-Campos and Tanaka, 2021).

Thus, the CF/1988, through its fundamental principles, proposes to eradicate poverty and marginalization, reduce social and regional inequalities, establish health as a right of all and a duty of the state, guaranteed by social and economic policies that seek to minimize the risk of disease and other illnesses and universal and equal access to actions and services for its
promotion, protection and recovery. Thus, based on the Organic Health Laws (LOS) 8.080/90 and 8.142/90, the SUS is legally and judicially implemented (Menicucci, 2014).

With the intention of resolving the deep social deficit accumulated over decades, especially the social inequality associated with the most vulnerable groups, the text of the Constitution established social security and showed how the development of the health sector depends intrinsically on social and economic policies that must take place in a tripartite manner in order to implement universal and free public policy (Soares, 2019).

The specific definitions on financing the health sector, which are not included in the Constitution and the LOSs, were postponed until later discussions, which took place later and materialized mainly in Constitutional Amendment 29/2000 (EC 29), Complementary Law 141/2012, Constitutional Amendment 86/2015 and EC 95/2016 (Emenda constitucional nº 29, 2000; Lei nº 141, 2012; Emenda constitucional nº 86; Emenda constitucional nº 95). In this way, and as stated in the respective provisions, health policy must be integrally associated with the financing policy of this sector, since in the absence of the former, there is no development of the latter (Soares, 2019). In order to finance the national health policy in Brazil, it was defined that the SUS would be financed through resources from the social security budgets and the federal, state and municipal governments, on a tripartite basis (Oliveira et al., 2022).

Despite the negative projection, EC 29/2000 defined minimum amounts to be invested by the Union, states and municipalities in Public Health Actions and Services (ASPS). In force since the 2000s, the federal government’s investments fell from 60% to 44% in 2011, but despite decreasing, there were real increases in the amount allocated to health. The states' share went from 18.5% to 25.7%, while the municipalities' share went from 21.7% to 29.6% for the same period, mainly in line with the principle of decentralization (Piola et al., 2013).

Recent constitutional provisions have worsened the situation of the SUS, such as EC 87/2015, related to the untying of Union revenues increased to up to 30%, and EC 95/2016 limiting public spending for a period of twenty years, without taking into account, therefore, the characteristics of vulnerability of the Brazilian population and, above all, the growing social inequality with lack of employment and inflation accumulated every year (Tesser et al., 2021).

According to Soares (2014), spending by the federal public sector between 1995 and 2012 remained practically constant, at around 1.7% of the Gross Domestic Product (GDP) and decreasing its percentage of participation in relation to the Union's General Budget (OGU), gross current revenue (RCB) and net current revenue (RCL). This policy of containing public spending on health contributed to the federal government increasing its surplus, which grew by 659% in the period, in order to guarantee interest payments on the internal debt, which grew by
264% in the period. It can be seen that the health budget was and continues to be carried out in deficit, with the real intention of paying off the debt (Faleiros and Pereira, 2021).

This policy, despite the constitutionalization of the right to health, maintained the underfunding of the health sector and deepened the financing crisis by allowing the inflection of government participation levels in sector spending at the expense of states and municipalities, which have higher rates. reductions in collection capacity. The transition of public health financing in Brazil, which became clearer in the 1990s, with a greater relative participation of States and, significantly, of municipalities in total expenses. Federal government spending on health, which represented 74.4% of total spending in Brazil in 1990, now represents just 45.5% in 2012, while state spending goes from 13.5% in 1990 to 26.8% in 2012, and municipal spending increased from 12.1% to 28.2% in the same period (Soares, 2019; Faleiros and Pereira, 2021).

A study carried out by Oliveira et al. (2022) aimed to analyze part of the financial resources used to finance public health actions in the 26 Brazilian capitals in the period between 2008 and 2018. An increase in transfers of municipal resources was observed in almost all capitals, but inequalities are still present in the distribution of financial resources between Brazilian capitals in different regions (Oliveira et al., 2022).

Despite a certain stability in financing the health sector through federal, state and municipal financing, in 2019, due to the COVID-19 pandemic, the transfer increased the financial contribution, resulting in a significant increase. Faleiros and Pereira (2021) analyzed that in a period of twelve months, from January 2019 to January 2021, there was an increase of R$1.51 billion, and from January 2021 to March 2021 an increase of R$6.69 billion, registering a growth trend of 73.3%. Therefore, it is clarified that this increase in transfers was defined by specific laws and ordinances to combat the pandemic in Brazil (Simões et al., 2024; Cedro et al., 2023).

Considering the entire historical context and current condition of the legislation on the financing of ministries and their respective programs, specifically when related to the Ministry of Health, through the SUS, it is clear, clearly, that there is systematic and continuous disruption by the insufficient transfer of funds at federal and state level (Gonçalves et al., 2021; de Oliveira et al., 2022), which ends up overburdening municipalities, which invest well beyond the minimum of their own resources required for health policy to develop in a minimally coherent manner.

Even so, the current legislation regarding EC 95/2016 on the spending ceiling does not consider the epidemiological and demographic transition that Brazil is going through: a moment
in which the demand for health tends to increase due to the greater care that the older population needs, especially when they have chronic non-communicable diseases and become ill due to external factors. Furthermore, the inflationary process, the loss of capital and the high unemployment faced by Brazil further highlight the inequities between people. Therefore, the existence of an equitable and adequately financed public health policy is expressed in order to mitigate disparities and promote physical and social well-being, as required by the Citizen Constitution of Brazil.

4 CONCLUSION

Based on our findings, the social inequalities are present in Brazil and are the result of historical processes that have marked society and continue to this day, preventing and limiting access to basic goods and services, such as health, education and housing, essential for a dignified life. Such inequalities are present in the most diverse aspects of human life and are sine qua non conditions for the development of inequities and disparities capable of directly interfering in the population's quality of life. When related to health, they are capable of reducing life expectancy or advancing diseases, especially among the indigenous, black, poor and peripheral population. In this way, equitable access policies can improve the population's quality of life and reduce inequities, reaffirming the need to implement and consolidate the SUS.
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