2.3.4. Brazil

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"Strengthen democratic and participative management in the Sistema Único di Saúde by broadening the level of health awareness, as Giovanni Berlinguer taught us".

(Extract from the inaugural speech by Brazilian Minister of Health, Dr. José Gomes Temporão, on 19/3/2007)

Brazil's socio-economic and health profile

Brazil has a population of about 184 million people with a Gross Domestic Product (GDP) per capita of about 5,000 dollars. The real problem, however, is the enormous inequity in the distribution of national wealth; and the most recent census[1] illustrates that the situation is getting worse. Traditional regional inequalities are also still evident: the number of people receiving a minimum wage (about 180 dollars a month by the current exchange rate) has risen considerably in the North and North-East states, but has fallen in the South and South-East states. Figures in the most recent census show improvements in education, although 23.5% of people over fifteen (36% in North-East states) have fewer than four years of schooling. The growth rate of the population, 84% of which live in urban areas, has dropped over the last 30 years on account of lower fertility rates; it went from 6.3 children per women in 1960 to 2.04 in 2004[2]. The mortality rate has also dropped, thus increasing life expectancy at birth to 68 years for men and to 75 years for women. The constant fall in infant mortality is also noteworthy, as it has gone from 82.90 in 1980 to 22.58 in 2002[2]. This fall has been felt throughout the country, although there are still major regional inequalities.

Brazil's national health system, the *Sistema Único de Saúde* (SUS), was founded in 1988. It comprises more than 56,000 health units supplying a wide range of services, from primary health care to highly complex treatment. The hospital network comprises more than 6,000 units and about 500,000 bed places[4].

Since 1994, the SUS has undergone a process of decentralization, one that launched the *Saúde da Família* programme, a health care strategy that would transform the dominant health care model and strengthen the activities of health prevention and promotion. This model, which is still being consolidated, has significantly improved the population's access to primary care, especially among the most disadvantaged social groups[3].

The huge challenges facing Brazilian health: inequalities and segmentation of the health care system

Despite its progress, the Brazilian health system has still not made any real effort to address the country's social and regional inequalities, which include resource distribution and service access, as well as the differences in health between social groups. There is widespread agreement among sector experts[5,6,7,8,9,10] that equity is an enormous challenge for a national health system that aims to improve the health of all its citizens, especially in a society as markedly unequal as Brazil's.

According to some estimates, about 25% of the population is covered by voluntary health insurance and accounts for 71% of diagnosis and treatment, spending about 819 reais per capita (409 dollars). About 75% of the population is covered by the SUS and accounts for 29% of diagnosis and treatment, spending about 264 reais per capita (132 dollars). The difference between offer and demand is clearly reflected in the extent of service utilization. In Brazil, 71.9% of those with private insurance visited a doctor at least once a year against 41% of those covered by the SUS. As stated by Maria Alicia Ugá and Rosa Maria Marques[11], two well-known Brazilian health economists, the organization of national health expenditure is still feeling the effects of the health care model in force before the 1988 reform. Their article[11] goes on to state that the Brazilian health care system, which is based on the principles of equal, universal and integral care, employs an expenditure framework that has little in common with national health systems in countries such as the United Kingdom, Denmark and Sweden, and much more in common with the US's market-dominated system. According to 2003 figures, Brazilian public health expenditure accounted for 42% of its total health expenditure, just below the US, which spent 44%. This means that the private sector contributes 58% to total health expenditure, 37.65% of which is family spending, especially on medicine, and 20.34% the costs of stipulating voluntary insurance policies[11]. This is why some experts prefer to define the Brazilian health model as a "segmented system" that encompasses three distinct sub-systems:

i) the SUS, i.e. the national health system;
ii) supplementary health care, financed through private insurance contracts;
iii) fees for services paid directly by families, which are also private but financed by patients when they pay for health services[7,12].

Eugênio Vilaça Mendes[12], expert on Brazil's health system reform, states that under the aforementioned system, private services encroach upon the public sphere and the SUS risks being a service for the poor. This trend towards a segmented health system is further strengthened by Brazil's federal state waiving taxes, especially since the 1990s. What is more, government policy supports private health systems both by granting tax subsidies to private health services and by stipulating private health insurance policies for public administration employees[8]. Furthermore, limitless tax allowances for private health spending is another major sacrifice for the State, one that ran into more than one billion dollars in 2004, over 2% of GDP[11].

Health under the first Lula government (2003-2006)

On the eve of the Presidential elections in November 2002, the social and health situation was characterized by a series of structural problems that required far-reaching reform and interventions to reduce inequity. The country expected significant changes that were coherent with the Constitutional Charter and the legislation governing the *Sistema Único de Saúde*. In other words, it was believed that the economic situation was favourable enough to implement health policies that would provide integral and equal care. The government's first steps seemed to be heading in the right direction. Indeed, after the country's socio-economic and health situation had been thoroughly examined, the National Health Plan 2004–2007 (*Um Pacto pela Saúde no Brasil*) identified five areas where priority intervention was needed[3]:

1) Reduce health inequity, which was considered "the main challenge for the Brazilian health system";
2) Increase access to qualified health services that ensure humanization;
3) Reduce health risks and avoidable diseases;
4) Reform a health care model still heavily unbalanced towards treatment;
5) Improve management, financial and social participation mechanisms.

Among the wide range of action taken to achieve these goals, the following deserve special mention as they were geared towards broadening access to care for public health care users[3,13]:

a) Primary health care was to be strengthened nationwide by increasing the number of *Equipe Saúde da Família* [Family Health Teams] from about 20,000 to more than 27,000 units, covering 46% of the population (about 85 million people);
b) The *Programa Brasil Sorridente* was strengthened, which increased the number of specialist orthodontist centres to 584, thus guaranteeing this service to about 28 million Brazilians; the number of Dental Care and Prevention teams was also extended to more than 15,000 units, thus covering 70 million people;
c) An Emergency Service was set up in order to guarantee treatment for patients of the public health network;
d) High-complexity health services were reorganized;
e) Community pharmacies were opened where SUS users could purchase medication at subsidized prices;
f) 218 new Mental Health Centres and 160 Treatment and Residential Care Homes were opened, broadening previous cover by more than 50%;
g) The national family planning policy was consolidated with the objective of meeting 100% of demand for contraception.

The implementation of these programmes unquestionably contributed to improving the health system's ability to meet a range of the population's health needs. However, it failed to redress the traditional imbalance between the public and private health sectors, a situation that is the root cause of the health system's inequalities. Indeed, public health expenditure did not increase significantly under this government, remaining under 3.5% of GDP. As reported by the health-profession-

als movement[14], public expenditure still hovered around 150 dollars per capita, about half the expenditure of other countries in the region (e.g. Argentina 360 dollars and Uruguay 300 dollars). The government's economic team continued with a policy of austerity in order to contain the budget for social interventions. Furthermore, the government was still unable to implement the full extent of a constitutional amendment introduced in 2000, which established the amount of health funding provided by national, regional and municipal authorities[11]. As regards granting exemption and allowances to private enterprises and services, it should be noted that the Lula government did not differ substantially from the governments that had preceded it. In 2004, it exempted hospitals and other private health facilities from paying a share towards the Contribution for the Financing of Social Security (COFINS). In 2003 Brazil's Supreme Court of Justice (STJ) exempted UNIMED organizations from taxes and social contributions, a move that dented State revenue. UNIMED is a national private network that organizes and provides medical services; it was founded as a cooperative but is now more akin to the US's Health Maintenance Organization. All of these difficulties and obstacles have actually helped to strengthen private health insurance rather than resize it.

The new health plan for the second Lula government (2007-2010)

The second national health plan (*Mais Saúde, Direito de Todos*), which was drawn up in the first year of the second Lula government in 2007, mentioned the most important targets that had been achieved by the public health system. However, as we can see from the extract below, it also acknowledged the incoherencies and limits of the government's work:

"It is not enough to have a dynamic economy with a high growth rate and rising participation in international trade if the development model does not encompass social inclusion, overturning social and geographical inequalities, the fight against poverty and the involvement of society in setting objectives"[15].

"There is a contradiction," continues the plan[15] "between the efforts and orientations geared towards achieving a system that provides universal access to care and the actual process of consolidating the *Sistema Único de Saúde*". The health plan 2008-2011 highlights the following structural limitations among its "major shortcomings":

a) Poor alignment of health with other public policies;
b) Major inequality in health access;
c) Major disparity in territorial distribution of goods and services, leading to the social and regional inequalities that characterize Brazilian development;
d) Health system decentralization is still fragmented and insufficiently integrated at regional level, thus making it impossible to overcome service inequalities;
e) Predominance of a bureaucratic management model that is insufficiently geared towards results-based, quality-care logic;
f) Under-financing of SUS as highlighted by expenditure per capita;
g) Lack of job stability and poor investment in training human resources.

As we can see, the issue of health inequality is omnipresent and has been analyzed carefully and thoroughly. In order to deal with the aforementioned situation, the plan outlines the following areas of intervention:

1) Develop and strengthen promotion of health and cross-sector interventions by aligning economic and social policy at municipal, state and federal levels;
2) Broaden the health care system by promoting both preventive and primary medicine, as well as highly and medium-complex services;
3) Develop industry and health innovation by equipping the country with a production and knowledge base that can meet the population's health needs;
4) Invest in the health workforce in order to improve its training and to introduce contracts that increase job stability;
5) Innovate management processes in order to guarantee effective, efficient and optimum use of resources;
6) Strengthen the participation of citizens and their spokespeople;
7) Give Brazil's health system an international outlook so that Brazil can play a major role in health cooperation.

International cooperation

For the first time, the national health plan has branched into international cooperation as a strategy geared towards strengthening its solidarity with other parts of the world and consequently raising Brazil's international visibility. After its first timid steps into health cooperation in Latin America and Africa, Brazil launched its cooperation programme by providing partners with the technical and scientific progress it has made in some sectors of medicine (mainly the fight against AIDS) and in the field of collective health (Family health, Community health agents, etc.). According to the 2008–2011 plan, health is one of the areas with "the greatest potential for contributing to international cooperation strategies" so that regional integration can be strengthened and, at the same time, "relations of solidarity with less developed nations" enhanced[15]. Working closely with the Ministry of Foreign Affairs, the government intends to strengthen Brazil's presence on the international health scene by increasing its participation both in UN organizations and programmes and in cooperation with Latin America, in particular with Southern Common Market countries (MERCOSUR) (Member States are Argentina, Brazil, Paraguay, Uruguay and Venezuela), with the Community of Portuguese Language Countries (CPLP), and with Africa. In order to achieve these aims, the plan includes a series of interventions, actions and investments, which are summarized below:

1) Contribute to developing health systems in the countries of South America, Central America, CPLP and Africa. To achieve this, the plan envisages the following activities: i) support for the creation of 20 National Health Institutes, 25 Public Health Schools and 50 Technical Schools; ii) production of anti-retroviral drugs in Mozambique; iii) technical cooperation for the treatment and rehabilitation of landmine victims, in particular with Angola; iv) cooperation with the Cuban government for the production of Interferon.

2) Support the training of health workers in CPLP countries by using Brazil's experience in nursing. Cooperation intervention has been envisaged with Angola, São Tomé, Guinea Bissau, Mozambique and Cape Verde in order to train teachers and to promote courses for auxiliary nurses and community health workers.

3) Promote agreements with seven South American countries in order to strengthen the integration process and to improve health services in 121 border municipalities.

4) Support the creation of the Pan Amazonian of Science, Technology and Innovation network.

The budget envisaged for the international health organization is 15 million reais (about 8.5 million dollars) with further investment forecast in subsequent plans for another 43 million reais (about 21.5 millions dollars).

Conclusions

Despite the limited results achieved by the Lula government in reducing health inequalities, at least up to the end of its first term, we need to recognize the efforts that the Ministry of Health, the academic world and the health-professionals movement have made in bringing equity and access to health services to the centre of political debate. This development should not be underestimated in a country that has one of the worst national wealth distribution indices. The awareness-raising and social-mobilization initiatives introduced during this period of left-wing government led to the establishment of the National Commission on Social Health Determinants (CNDSS), which was launched in March 2006. By following the recommendations of the eponymous World Health Organization Commission, which was set up in 2005, the CNDSS plans to fight the major health inequalities that affect the population of Brazil. The analysis behind the commission's work produced the results of recent international research into inequity and identifies the following problems, which reflect Brazil's social and economic situation: a) above a certain level of income per-capita, the most important factor for explaining the health situation in a country is not total wealth, but the way in which wealth is distributed among the population; b) the deterioration of solidarity and trust between people and social groups is one of the main paths that lead income inequalities to affect health negatively. The spotlight has been shone upon the negative impact that social disparity has on health and upon the role that social cohesion and solidarity networks have in addressing critical events and mobilizing available resources. Thus a first step has been taken towards devising and implementing health policies that will be able to improve access to services and health equity.

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