

## **B4 | BRAZIL: THE ROCKY ROAD TO A UNIVERSAL HEALTHCARE SYSTEM**

Brazil's unified national health system, known as the *Sistema Único de Saúde* (SUS), was created by Article 198 of the Federal Constitution adopted in 1988 (Senado Federal 1988). It was the result of pressures generated by popular mobilizations against the dictatorship (1964–85) and as part of the broad struggles for democracy in the country. It represented a commitment to the universal right to social security and health, including a critical approach to the social determinants of health. It was deeply influenced by the Italian health reform of 1978, Catholic ecclesiastical community movements that inspired a popular movement for health, and many groups of university students, labour union activists and other political leaders (Paim et al. 2011).

Brazil's infant mortality rate (IMR) dropped from 58 per 1,000 births in 1990 to 36 in 2000 and 16 in 2011 (UNICEF 2011). As with many industrialized nations, cardiovascular diseases are the leading causes of death in Brazil, followed by cancer, as well as external causes such as homicides and traffic accidents (WHO 2008). As chronic diseases are increasingly contributing to the burden of disease (Schmidt et al. 2011), communicable diseases are decreasing, but they still affect a sizeable portion of the population (Barreto et al. 2011). Injuries are the third general cause of mortality and are increasing owing to homicides and traffic injuries, a direct reflection of urbanization, inequalities and drug trafficking (Reichenheim et al. 2011).

### **The health system in Brazil**

Although Brazil has the largest economy in South America, its government spends less on health (per capita) than those of Argentina, Chile and Uruguay (WHO 2008).

SUS includes more than 73,000 outpatient services, including 32,000 family health teams with a medical doctor, a nurse, one or two nurse technicians and four to six community health agents (Ministério da Saúde 2012). These teams are the basic module of a national strategy of primary healthcare, and each covers around 3,500 people, reaching more than 106 million people throughout the country. The impact of better primary care is evident in a 24 per cent decrease in hospitalization rates from 1999 to 2007 (NESCON 2012). SUS also provides a range of tertiary care services (nearly 24,000 transplantations, over 84,000 cardiac surgeries, 62,000 cancer surgeries, and

care to over eleven million inpatients). However, there is a persistent unmet demand for such care (Ministério da Saúde 2008).

Approximately 144 million people depend exclusively on SUS, while the remaining 46 million are covered by private insurance (CFM/CREMESP 2011). Approximately 94 per cent of the privately insured (including a large proportion of civil servants) have insurance protection provided through agreements with employers. A majority of these insurance plans do not cover a number of services, such as transplantations, dialysis, expensive drugs, intensive care, etc.

*Human rights and accountability* Article 196 of the Brazilian Constitution of 1988 denotes health as a human right and its provision as a duty of the state. It faced strong resistance from politically conservative sections, who favoured the privatization of the healthcare system. Immediately following the adoption of the new Constitution, a neoliberal government was elected in 1989, which presented significant barriers for the implementation of the legislation and regulations necessary for the financing of the new universal health system. The implementation of SUS was therefore very slow until the end of 1992 (until the impeachment of President Collor de Mello).

*Decentralized financing of health services* Fiscal decentralization was implemented in 1993, facilitating the transfer of federal funds to municipal health funds. This provided the opportunity to local governments to fulfil their responsibilities regarding primary healthcare and health surveillance. This has led to the adoption of the ‘family health’ strategy as a cornerstone of primary healthcare since 1994 (Ministério da Saúde 1993, 1994).

A constitutional amendment permitted the restoration of a constitutional rule that had been eliminated by the Collor government, which guarantees a minimum amount of funds to finance public health services. Federal, state and municipal revenues were earmarked to jointly finance basic health services. It is mandated that, each year, federal government expenditures must increase by an amount equal to the nominal GDP growth rate. Municipal governments are required to spend 15 per cent and states and federal districts 12 per cent of their own net revenues on health services (Governo Federal 2000a). A long-standing demand of Brazilian civil society has been that the federal government should spend 10 per cent of the federal budget on health. In the face of reluctance by the government to guarantee this level of expenditure, a broad movement, initiated in September 2013, collected 2.2 million signatures demanding immediate compliance by the government.

In two decades, major progress has been made in Brazil as regards universal access to comprehensive healthcare services, but significant challenges remain. These relate to the continued presence of a strong private sector, the need to promote a more progressive taxation system to finance social security, and the need for a solidarity-based social protection system.



**Image B4.1** Rio de Janeiro, Brazil: inequity in society impacts on the health system (Janie Ewen)

*Social control* Federal Law No. 8.142/1990 mandates that the health system must be under social control. Health councils at different levels – national, state and municipality – have decision-making powers over health plans and budgets. Citizens’ representatives compose half of the membership on these councils, and the other half is divided among representatives from government, health workers and health providers. In addition, a National Health Conference organized every four years and attended by representatives of the health council at all levels determines the strategic pathway of the system (Governo Federal 1990b).

The extensive system of social control has promoted consciousness regarding citizens’ right to health. This has led to an increasing incidence of litigation claiming health rights, and courts are beginning to liberally interpret the constitutional guarantee on right to health (Cubillos et al. 2012).

*Accessibility* SUS is a single-payer system financed through general taxation. According to Federal Law No. 8.080/1990, healthcare must be: provided in all parts of the country, with the same universal coverage and quality, with no restrictions except on purely cosmetic procedures; provided free at the point of service; and egalitarian, with no restrictions to any person as regards access or kinds of treatment (Governo Federal 1990a). SUS integrates all government facilities as part of the universal system. In addition, many

private service providers (mostly non-profit institutions) remain a substantial complementary part of the public system. Private providers account for 60 per cent of hospital beds under SUS.

Despite improved access to tertiary care through SUS, significant gaps remain. For instance, while there are 356,000 hospital beds (1.85 beds per 1,000 people) in the public system. In order to achieve a minimum of four beds per 1,000 inhabitants (the rate in Spain), Brazil would need 335,000 new hospital beds. Lack of sufficient tertiary-care services pushes people to the private sector, thus continuing to perpetuate a private market for healthcare. Improved and more equitable funding is necessary to break this dynamic, which continues to block the full development of SUS (DATASUS 2012).

*Acceptability and quality* When the 1988 Constitution was drafted, lobbyists successfully pushed for the exclusion from SUS of health services for the military, civil servants and employees of state-owned enterprises. Unfortunately, legislators and government employees who seldom use SUS continue to promote a widespread notion that high-quality care is available only in the private sector, while the public system is simply a solution for the more 'vulnerable'. Nevertheless, the government of Brazil has taken continuous steps to improve the quality of public services, including in traditionally deficient areas, such as for emergency services (Machado et al. 2011; Ministério da Saúde 2002, 2003a, 2003b, 2011).

### **Challenges and limitations of SUS**

Until 1988, only formal workers and their families were covered by social insurance, while 85 per cent of the population received care at charitable institutions and through inadequate public facilities in some cities and states. The main accomplishment of SUS has been to make health a right for all. However, public expenditure represents only 45 per cent of total health expenditure in Brazil, which accounts for 8.8 per cent of GDP. Private expenditure on health is still very high, at US\$44,300 per capita per year (IBGE 2010). As health costs rise while public expenditures remain relatively constant, out-of-pocket payments are higher at present than in the late 1990s, though catastrophic impoverishment because of such payments remains relatively low, affecting 2 per cent of the population (Gragnotati et al. 2013).

About 46 million people are primarily serviced by the private sector, which operates in tandem with private insurance companies, including those that manage the funds of social security systems of large public sector enterprises. The private sector is regulated by the National Agency of Supplementary Health, under the aegis of the minister of health. Despite some advances in regulations to protect patients' rights, there are major gaps in effective regulation of the private system (CFM/CREMESP 2011).

The SUS, despite its accomplishments, remains in permanent conflict

with unfavourable power structures embedded in the political and economic system in Brazil. It has been systemically underfinanced, posing a major barrier to the building of a truly universal system which is entirely public and provides comprehensive healthcare services to all citizens. Powerful politically conservative sections continue to obstruct the allocation of increased finances for SUS.

The SUS is also hamstrung in its ability to deploy adequate human resources for health, by a law on ‘fiscal responsibility’ approved in the 1990s. The law decrees that the total cost on personnel (wages, etc.) cannot exceed 53 per cent of the total budgets for public administration (Governo Federal 2000b). The law forces public authorities to contract personnel through intermediaries such as cooperatives or enterprises. This practice promotes discontinuity in the provision of public services and exacerbates corrupt practices.

The fact that a large section of the middle class and high-income employees remain outside SUS also acts as a barrier for SUS itself. Under Brazilian law, personal expenditures on private health and education are deductible from personal income tax (Nyman and Barleen 2005). In effect, this means that those who rely on public systems ultimately subsidize the rich, who save taxes while accessing private healthcare and education.

### Looking ahead

After twenty-five years of social participation through the health councils, it is time to reflect about the need to overcome the structural barriers that prevent the full implementation of SUS. In order for SUS to be truly universal and in a position to provide comprehensive services to all, government expenditure on health should increase from US\$367 per capita/year to US\$1,000, reaching around 10 per cent of GDP. Also needed are enhanced public management standards to eliminate gaps in access and quality. This will require the promotion of progressive tax reforms, political reforms that ensure participatory democracy, and a rights-based approach to state reform.

A clear plan and process are needed to ensure that public services provided by the state are progressively expanded so that they become the dominant form of healthcare provision in the Brazilian health system. Moreover, it is necessary to establish public regulation of private–public provider contracts that complement state-owned services, and contracted private providers need to be regulated to ensure that they promote public health goals.

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