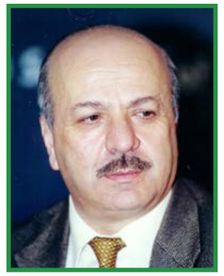
Brazilian Health System



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The Unified Health System (Sistema Único de Saúde (SUS)) has enabled substantial progress towards Universal Health Coverage (UHC) in Brazil. However, structural weakness, economic and political crises and austerity policies that have capped public expenditure growth are threatening its sustainability and outcomes. How does it compare to Lebanon's present situation?

Conceived in the late 1980s by the civil society as part of the 'Sanitary Reform Movement' (Movimento da ReformaSanitária) against the military dictatorship, SUS has been widely acknowledged as an example of successful health system reform in Latin America, and has played a major role in the democratization of Brazil and in the re-establishment of citizens' rights. Reforms in health system governance and major expansion of primary healthcare (PHC) have contributed to major improvements in health service coverage and access, and health outcomes.

Between 2002 and 2013, with expansion of SUS, there was near universal access to essential health services, such as immunizations and antenatal care, with improved population health outcomes, and declines in regional health inequalities. However, despite progress, health inequalities remained a feature of Brazil, mirroring the wealth and income inequalities in the country.

Changes in health system financing

In 2000–2014, total health expenditure rose from 7.0% to 8.3% of GDP, and per-capita health expenditure increased from US$263 in 2000 to US$947 in 2014. Although the level of total health expenditure is comparable to other countries in Latin America, public expenditure is low for a universal healthcare system and burdens individuals with large out-of-pocket costs. Brazil has one of the lowest proportions of public spending on health (46.0%) in Latin America and the Caribbean (average 51.28%), in upper middle-income countries (55.2%) and in Organization for Economic Cooperation and Development countries (62.2%). In addition, although Brazil has reduced out-of-pocket expenditures (as a proportion of private expenditures, part of which is accounted by contributions to private insurance), they still represent a considerable financial burden for households (representing nearly 50% of private expenditures on health).

Resource allocation

Persistent regional and social inequalities in resource allocation left the poor, those with lower education and the populations living in northern regions with greater unmet healthcare needs. Shortages of doctors persist in rural areas and at PHC level, with specialists concentrated in the private sector and unequally distributed around the country, leading to large disparities.

National polices have increased the number of drugs available on the essential medicines list from 327 in 2002 to 869 in 2017, improved access to medicines and encouraged the use of generics. The Popular Pharmacy Program (Farmacia Popular), initiated in 2004, expanded access to medicines with subsidized prices and low level of copayments.

In 2011, a National Commission (ComissãoNacional de Incorporação de Tecnologias) was established to support evidence-based decision-making for adoption of new medicines and technologies in the SUS. The sizeable demand for medicines in the SUS has encouraged industrial domestic production of medicines through public–private partnerships.

Although catastrophic health expenditures have declined since 2004, medicines remain an important component of household budget for the poorest families.

The sustainability of health technology provision in SUS is increasingly challenged by new high-cost medicines and new procedures, which are introduced into SUS as a consequence of 'judicialization' (legal cases brought by individuals claiming their constitutional rights using the judicial system), and ineffective regulation of the medical devices market.

Healthcare coverage

Expansion of SUS has enabled increased provision of public health programmes (e.g., immunization, tuberculosis and HIV) and complex services (e.g., organ transplants, cancer care and kidney dialysis). FHS enabled expansion of PHC as a cost-effective way of covering underserved populations. In 2000–2016, FHS coverage increased from 13.2 to 120.2 million people (from 7.8% to 58.5% of population). However, large variability in the quality and productivity of FHS across the country has contributed to disparities in access to PHC.

Since 2004, access to healthcare was further expanded with investment in emergency services (Serviço de AtendimentoMóvel de Urgência), emergency clinics (Unidade de Pronto Atendimento) and mental health centres (Centros de ApoioPsicossocial), aimed at shifting care away from hospitals that are burdened by high demand.

The interaction among the FHS, hospital system and new emergency services is weak, with duplication and lack of coordination hampering improvements in providing effective and efficient care.

Parallel to expanded coverage by the publicly financed SUS, medical private insurance coverage has increased since 2000 from 30.5 million in 2000 to 50.3 million in 2014 (17.6%–24.8% of population respectively). In 2017, private insurance coverage declined to 47.3 million (22.8% of population), as income and employment levels fell.

The growth of the FHS and private plans has increased coverage of health services, but large disparities remain among regions, and many disadvantaged populations still lack access to high-quality care.

Looking ahead

The political and economic crises have shaken SUS, and constitutional rights to health have been undermined through austerity policies of the current government. The prospect of long-term freeze on public expenditures creates a situation which makes it increasingly impossible for the universality and comprehensiveness principles of the SUS to be pursued and sustained.

As Brazil struggles to preserve its achievements during the political and economic turbulence, the unfolding folly in its health system provides important lessons for other countries, which, we hope, should be wise enough to not replicate the mistakes currently made in Brazil.

In Summary

- Brazil has made good progress towards achieving Universal Health Coverage (UHC) with improvements in population health, but shortages in public funding, suboptimal resource allocation and weaknesses in healthcare delivery persist.
- From 2000 to 2014, total health expenditure rose from 7.0% to 8.3% of gross domestic product and population coverage with the Family Health Strategy rose from 7.6% to 58.2%.
- Since 2015, public health expenditure per capita has declined in real terms, while 2.9 million people lost private health plan coverage, violent deaths have increased and there have been outbreaks of infectious diseases.
- Economic and political crises, combined with austerity policies, pose a major risk to UHC and health gains achieved Brazil, and elsewhere, with detrimental impact on the poorest and the most vulnerable populations, and require development of resilient health systems.