Photo: Claudio Araújo



Is Brazil's health care model misguided?

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THE PUBLIC HEALTH CRISIS IN RIO DE JANEIRO has set off alarms across the country about how one of the most important public services for Brazilians has deteriorated. Eugenio Vilaça Mendes, public health consultant and former professor in the Dentistry and Medicine Schools of the Federal University of Minas Gerais, points out that the health sector's problems go far beyond the financial. "The 1988 Constitution established that health care is a right for all and a responsibility of the government, but it did not provide the resources to support universal health care," he says. Mendes highlights the need to ease the predatory competition between public and private health systems and redefine the health model that the country wants and can afford. He also advocates enhancing health management to make the health system sustainable and prepare it for the technological, demographic, and disease profile changes in store for the country. "What produces the most diseconomies in the health system is a misguided health care model," he says.

One item of bad news as 2016 began was the public health crisis in Rio de Janeiro that was attributed to the fiscal crisis of the states. How do you see this situation?

The health crisis in Brazil has two perspectives: structural and cyclical. The cyclical that we see today is an intensification of the structural problems that arose when the Unified Health System (SUS) was established. It was conceived as a universal public health system like those in Western Europe, characterized by funding through general taxes, universal access, public

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management, and delivery of health care services by public and private providers.

In practice in Brazil this aspiration has devolved into a health system consisting of three subsystems—SUS and two private options, health insurance and direct payment—which do not communicate and which compete with each other. When the 1988 Constitution established the SUS, Brazil already had private health insurance. Shortly after the Constitution was adopted, the Itamar Franco government ended public health insurance for workers and transferred its large revenues, estimated at today's prices at more than R$100 billion, to the Social Security program, and what was left for SUS was not enough to fund a universal public health care system.

SUS has good points. It delivers significant services every year: more than two billion outpatient procedures, 11 million hospital admissions, health programs that are internationally respected, such as the program to control HIV-AIDS and the National System of Organ and Tissue Transplantation. The Family Health program, which covers 120 million Brazilians, is the most comprehensive primary health care program in the world. … Moreover, according to the 2015 World Health Organization report, total Brazilian spending on health was 9.5% of GDP, similar to several developed countries. But public health spending is only 4.5% of GDP, compared to 7.8% in the UK, 7.6% in Canada, 5.5% in Uruguay, and 4.8% in Argentina. These numbers say, eloquently, that SUS is underfinanced. At the current level of public spending, we cannot have a quality universal health care system.

Was the creation of the SUS too ambitious?

I don't know. The 1988 Constitution had a very strong social democratic approach, not just in health care. The constitutional assembly conceived of health care as a right for all and a responsibility of government, but it did not provide the resources to support universal health care. As a result, those who can pay have moved to private health insurance. In countries that have truly universal public health care, private health insurance is effectively just a supplement. In Canada, for example, private health insurance covers services not provided by the public health care such as some types of eye, dental, and home care. In theory, Brazil has a universal health care system, but in practice we have a dilemma about whether the health system is universal or segmented.

Given Brazil's fiscal constraints, to what extent do you think the earmarking revenues for specific uses may have contributed to the health care crisis?

In theory we can agree with most economists that earmarking revenues to specific uses is a problem in the long run because it makes it harder to create a more efficient economy.

Other economists, however, argue that in countries where the Congress is unlikely to respond to the interests of the majority of the population, revenue earmarking is necessary; they argue that had we not earmarked revenues to health and education, today we would have a lot less money directed to these two sectors. There is a certain rationality to that argument, and to this day any survey shows the population's main concern is health care.

But, compared to the current need for fiscal adjustment, there are proposals for at least reducing earmarking revenues. Do you think that could be possible?

To have a health care system that works, the discussion at the macroeconomic level is not, in my opinion, about economic technicalities but about the system the population wants, and is willing to pay for. When you segment the health care system so that public health care goes mainly to the poorest, it will always be underfinanced.

What do you think would be a possible health care system in the Brazilian case?

I am in favor of a universal public health care system. The evidence is abundant that such a system is more efficient, more effective, offers better services, and is more equitable. We could conceive of gradually building a strong universal public health care system over the long term. Alternatively, we could consolidate the current system: the SUS would continue to serve the low-income population and keep private health care. … Building a universal public health care system is possible, but not likely today; the second alternative is more likely. It would be kicking the can down the road, leaving the health crisis deepening

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in both the SUS and the private sector. A segmented health care system is inherently expensive, ineffective, and poor quality. The best example is American health care: Today the United States spends almost 18% of GDP on health. Per capita spending in 2012 was US$8,845—more than double the UK, which has better health outcomes and higher-quality services. But we do not have as much money as they have, which makes this choice unsustainable in the long run.

A third alternative is Obamacare: It provides access for all to both public and private health care systems. It is based on a reformulation by the World Health Organization (WHO) of the concept of universal health care that emphasizes universal coverage: Instead of the government doing everything, it seeks to overcome the public/private segmentation by enabling access for all to both systems, with the public and private sectors organizing to ensure health coverage for all the people.

What would be the main challenge to building a similar system in Brazil?

Although in the short term it is impossible, we could invest in building a universal health care system based on a long-term plan with assurances that funding for public health care

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in Brazil would be gradually increased along with an efficiency and quality agenda. This is important. So far we have been discussing macro-level health care organization, but the essence of the system is closer to its micro-level performance. At the microeconomic level we have the issue of how health care is delivered —the difference between fragmentation and integration that influences the efficiency of a health care system. Why is health care so expensive in the US? The American system is totally fragmented at the micro level. There is no coordination, no primary care that integrates the system and communicates with specialty medical centers, hospitals, clinical analysis laboratories, and imaging centers, among others.

In Brazil it is necessary to have an efficiency agenda because the system is also very fragmented. In recent years, the Ministry of Health has been spending much less on primary health than on medium and high-complexity medical procedures. In Brazil, I estimate that systemic health care inefficiencies—technical, scale, or allocative—consume 30% of the already limited resources, and that is not even mentioning private health insurance. You do not have scale, and in health care scale is important for both economic efficiency and quality. Think about hospital care: Most hospitals (58%) have fewer than 50 beds and about 45% of hospitalizations are unnecessary. The average Brazilian hospital produces a third of what it could produce with the same resources. Brazilian hospitals have on average 50% more employees per bed than hospitals of member countries of the Organisation for Economic Co-operation and Development. Low scale is associated with a lower quality of care.

There are other important micro factors. Payment for health care is based on fee-for-service, which encourages the use of technology-intensive services, rather than services patients need. The fee-for-service system increases the number of services provided and encourages provision of unjustified services. In contrast, the value-based payment system aligns the incentives of health organizations and health care providers, improves clinical outcomes and the experience of patients, reduces costs, and raises efficiency.

How are changing demographic and epidemiological profiles affecting the financial sustainability of the Brazilian health system?

Health systems undergo transitions. Brazil is experiencing a fast and profound demographic transition: the population is aging and that means more old people with chronic diseases. A second deep and fast transition is nutritional: half of adults and a third of Brazilian children are overweight or obese, which means more people with

chronic diseases like diabetes. A third transition is that health technologies are emerging tremendously; the number of medical papers published doubles every 10 years. But several authors have pointed out a paradox: there is an avalanche of new technologies but we are unable to use the technologies rationally. The United States is a model of excessive use of medical technology in tests and treatment, but health care outcomes are no better and there is unnecessary expense.

The fourth speeding transition is epidemiological. In the middle of the last century, half of the deaths registered in Brazil were due to infectious diseases and maternal and perinatal causes. Today, they represent less than 4% of total deaths. Instead, since the 1970s, we now have what some authors call an epidemic of chronic diseases. Cancer mortality has risen and cardiovascular diseases now constitute 66% of the disease burden (which encompasses both illness and mortality). We have also begun to see increased illness and mortality from external causes, such as traffic accidents and homicides. Brazil today has a triple burden of disease: 14.8% infectious diseases and malnutrition, 10.2% externally-related diseases, and 66.2% chronic diseases. Rich countries have got rid of infectious diseases; some, like Sweden, are already moving to do away with externally-related diseases; but for a long time Brazil will continue living with its triple disease burden.

We still have outbreaks of dengue and other diseases like cholera that should have been eradicated long ago....

Obviously, we must be alert to emerging situations like the zika virus, or reemerging infectious diseases like cholera. But this is not our biggest problem. While in Brazil dengue, unfortunately, kills 600 people a year, together heart attack and stroke kill 500 a day.

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Today we have the situation of a 21st century triple disease burden being addressed by a mid-20th century health care system that focuses on acute, infectious conditions, while today chronic diseases like diabetes, hypertension, and mental diseases predominate.

To generate efficiency in a health care system we need good interdisciplinary primary care, using new technologies and networking. For example, a doctor without the support of a nutritionist does not cure diabetes.... People diagnosed with hypertension at 40 who do not control their blood glucose will be diabetic at 45, and after that risk having a heart attack, going blind, or suffering amputation. That's where the money goes. Health care is unique in this: What produces the most diseconomies is a misguided health care model.