Access to and Financing of Health Care in Brazil

SÃO PAULO, AUGUST 2010

EDITIONS SPECIALS HEALTH
VOLUME I
A Interfarma – Associação da Indústria Farmacêutica de Pesquisa – é a entidade que congrega as indústrias farmacêuticas instaladas no Brasil, responsáveis por promover e incentivar a pesquisa e o desenvolvimento de novos medicamentos. Fundada em 1990, a Interfarma reúne 36 laboratórios que representam 57% do mercado brasileiro de medicamentos.
Health is not everything, but without it, the rest is nothing

SCHOPENHAUER
Introduction

The Constitution of 1988 was a milestone in our country’s recent history. The rights of Brazilian citizens were duly guaranteed through the mobilization of society, represented by legislators imbued with civic and democratic spirit. With regard to health, Article 196 stipulates that this is a right for all and an obligation of the government.

In this important year of presidential elections, the issue of public health has become one of the main concerns for the candidates.

Interfarma believes this is a timely moment to strengthen the rational dialogue concerning the health issue in Brazil, looking towards the future, where not only the candidates, but also the authorities, politicians, entrepreneurs, sector leaders, scholars, researchers and service providers can each give their contribution.

By promoting the seminar “Paths for Financing and Accessing Health Care” in June 2010, in São Paulo, in partnership with Valor Econômico, Interfarma understood the initiative as being part of its contribution, further amplified now through this publication. The publication “Access to and Financing of Health in Brazil” will be sent to all of the candidates for President of the Republic, state governors and National Congress.

For Interfarma, construction of an open dialogue with society concerning public health in the country should always be above political and partisan divergences and interests, and it hopes that the big winner of these elections will be the Health Party.

Eloi Bosio Antônio Britto
Chairman of the Board CEO

Creation of the Single Health System (SUS) in 1988 represented one of the most significant advances in the process towards construction of Brazilian citizenship. In a climate of relief after the country’s redemocratization, with the idealism of constructing a new, modern and more just society, legislation, bearing a brand of renewal, received multi-partisan support in the National Constituent Assembly. It was with this renewed spirit that the Federal Constitution of 1988 guaranteed every Brazilian citizen the universal, integral and equal right of access to health care.

However, more than 20 years after enacting the Constitution, the model drawn up by the legislators is still far from attending to all, as determined by law. Making matters worse, during this same period, Brazil’s population grew nearly 40 million, practically an Argentina, increasing to more than 190 million people. “The Constitution was appropriate, but the legislators forgot that all this needs financing and the government needs money for all this,” observes the president of Hospital Israelita Albert Einstein, Claudio Luiz Lottenberg.

“Our system has been suffering from a chronic problem of underfinancing that can compromise what is most precious in it, which is its universal nature,” says the Secretary of Science, Technology and Strategic Inputs of the Ministry of Health, Reinaldo Guimarães. According to the Secretary, in the representatives’ original proposal, the health system should receive one-third of total revenues destined to social security, which in 2010 would be equal to a budget of nearly R$ 130 billion for the Ministry of Health, “more than double the projected budget,” says Guimarães.

Per capita spending

Even with the increase in government investment, especially over recent years, when considering public and private funds, the per capita spending on health care in Brazil is below the global average. The “Analysis of the Medication Sector in Brazil 2004-2007”, published by Interfarma – Brazilian Research-based Pharmaceutical Manufacturers Association and based on World Health Organization (WHO) and Datasus data, shows that health care spending per Brazilian inhabitant was US$ 715, in 2007, whereas the global average was US$ 857. In Argentina, it exceeded US$ 1.2 thousand per capita and in the United States, which leads the ranking, it was almost US$ 7.3 thousand. In countries with a similar health care model to Brazil, health care spending are almost fourfold greater, as in the case of Spain, US$ 2.6 thousand per capita; or almost sevenfold, as in Canada, US$ 4.9 thousand (see figure 1).

Economist Maria Cristina Sanches Amorim, head professor of the Department of Economics and the Graduate Studies Program in Business Administration at Pontifícia Universidade Católica of São Paulo (PUC), one of the authors of the Interfarma Study, says that this scenario does not change much when compared to 2010, since a notable growth in these numbers would depend on an expressive increase in income and greater public investment, which did not occur.

Low government investment resulted in the growth of the private health care market. “The population yearns for a health plan because people know there is a long wait for care at the Single Health System (SUS), even when we are speaking of an emergency,” says José Cechin, executive superintendent of the Institute of Supplementary Health Studies. Thus, the population of private health plan users has grown in the country. Today, there are nearly 42 million people, which represent 21% of the population. In those countries where a universal public health system prevails, this percentage is much lower, around 10%. “This adherence to health plans in Brazil demonstrates that health needs are not being met,” says Cechin.
Smaller slice

The Ministry of Health’s budget for 2009 did not reach 1985’s, says cardiologist and former Minister of Health Adib Jatene. “If we look at the portion of security set aside for the health sector, in 1995, we had 22% of the total budget; in 1998, we had 18%; in 2009, we had 14%. It’s clear the resources are decreasing,” says Jatene, pointing out that over this period the population grew, has been aging more and the incorporation of technology has no precedents. “If we had 35% of the total security budget, like the representatives wanted, we would not be discussing the lack of funds for health today,” ensures the former Minister.

A more current portrait of this scenario, with a specific eye on federal government spending, shows that in 2008 the health budget was R$ 54.1 billion, and in 2009, it was R$ 59.8 billion. For 2010, the bill sent to Congress set the budget at R$ 62.5 billion, an increase of 4.5% over 2009. This sum left the health sector in third in terms of distribution of social security revenues, which includes spending for guaranteeing citizen rights to health, social security and welfare. Social Security got more than half, 55.6%, of the R$ 456.7 billion total, and health only 13.7%.

Management problems

The Interfarma Study points out failures in the system, which needs to be reformed to gain efficiency. According to the survey, the system is inoperant, does not know how to properly invest funds and spends poorly. There are countless examples of waste, for example, paying for services provided, visits and procedures. “It’s like running a campaign to get rid of dengue fever and paying per dead mosquito, for example. There would certainly be many people raising mosquitoes,” says economist Maria Cristina Amorim, observing that data from the National Health Confederation (CNS) indicate the occupancy rate for hospital beds today is 38%, while hundreds of people are waiting in the corridors for...
an opening in hospitals. “That is an example of process failure.”

Federal deputy and former Secretary of Health of Rio Grande do Sul, Osmar Terra, joins the numbers who believe resources must be well invested at every public level. “When I was Secretary of Health in Rio Grande do Sul I could not explain to the population why spending on admissions in the public system were six times higher than in the best private hospital in Porto Alegre. There must be rationalization and that is a great challenge,” he says. According to the Secretary of Science, Technology and Strategic Inputs of the Ministry of Health, Reinaldo Guimarães, management failures are not an exclusive problem of that Ministry and result from the rigid and obsolete rules that govern personnel policy in the Brazilian public sector.

Health never had its own, exclusive and stable funds, adjusted to its needs

In the mid-1970s, more than 68% of available tax revenues belonged to the Union. States and municipalities received 23.3% and 8.6%, respectively. The Constitution of 1988 reversed that centralization, establishing a new tax division that favored the states and municipalities, especially the latter, to the detriment of the Union.

In 1993, at the end of the gradual execution of this decentralization process, the percentages were 57.8% (Union), 26.4% (states) and 15.8% (municipalities). Thus, while relative participation of the Union fell ten percentage points, states and municipalities saw an increase in available funds of around 13.3% and 83.7%, respectively.

However, Union “losses” were limited to the scope of Income Tax and the Tax on Industrialized Products, which comprise the State Participation Fund (FPE) and the Municipality Participation Fund (FPM), with the as or even more substantial revenue from the Social Contributions created by the Constitution of 1988 remaining intact and under full federal control.

The Social Contributions constitute a privileged source of revenue when compared to other taxes. The reasons:

1. They correspond to more than half the federal tax revenue.

2. They are not subject to the principle of annuality (Federal Constitution Art. 150, III b) and can be collected ninety days after their creation or alteration (Federal Constitution Art.195, § 6).

3. Since they are destined for a social cause, they are better accepted by society than tax burden increases without any specific destination.

4. Since they have a more encompassing collection, they tend to grow more than other taxes.

One explanation for the greater relative growth of the gross tax burden compared to Social Welfare and Security Transfers and Subsidies (TAPS) is the increase social contribution revenues (Cofins, CPMF, CSLL, etc.) had compared to spending on welfare and security.

This increase in revenue led to the implementation of a mechanism for unbinding the budget, created in 1994, soon after implementation of the Real, initially by the Social Emergency Fund (FSE) and later the Unbinding of Union Revenue (DRU). The DRU stipulated that 20% of revenues collected with those contributions are free and thus should not be obligatorily allocated to the areas of social security, social welfare and health.

The justification for implementing the DRU was:

a) “Excess” budget rigidity derived from free revenues equivalent to just 15% of the budget which limited the possibility of the government to schedule new public policies;

b) Avoid spending with an excess of funds tied to them while others have shortages of funds;

c) Permit financing of irreducible spending with additional Union indebtedness; and most especially,

d) Make it possible to obtain primary surpluses to meet fiscal goals in the Budget Guidelines Law – LDO.
According to estimates presented by the National Association of Fiscal Auditors of Brazil's Federal Internal Revenue Service (ANFIP, 2009), the DRU diverted more than R$ 145 billion of social security budget revenues to other purposes between 2005 and 2008.

Since the text of the Constitution of 1988 did not ensure a specific binding of resources to Health, destination of finances was left up to the oscillations in the economy. Only in the Transitory Constitutional Dispositions Act – ADCT was it determined in Article 55 that: “Until the Budget Guidelines Law is approved, a minimum of thirty percent of the Social Security budget, excluding unemployment insurance, shall be destined to the Health Sector.”

The Budget Guidelines Laws of 1990 to 1993 reproduced what was stipulated in Article 55 of the ADCT, but the Annual Budget Laws did not comply with what was stipulated in the respective LDO, culminating in Health's financial crisis of 1992, a crisis that was only abated after a loan from the Workers Support Fund - FAT in 1993 and 1994.

The imperative need for complementary funds for health to overcome the crisis led to the creation of the Provisional Contribution on Financial Transactions (CPMF). In the beginning, Article 18 of Law no. 9.311, of October 1996, stipulated that the totality of collections would be exclusively destined to the National Health Fund. But after 1999, with Constitutional Amendment 21, the CPMF began to destine part of its resources to Social Security...
and the eradication of poverty. Thus, the destination of the Provisional Contribution on Financial Transactions (CPMF) was gradually diverted from its original intention.

Removal of the CPMF in 2008 caused an immediate reduction of approximately R$ 16 billion, which had to be covered by Budget free revenues (figure 3). For illustration purposes, in 2008 the Ministry of Health received R$ 54.1 billion, only half of what it would have received if 30% of the Social Security Budget had been applied as stipulated in Article 55 of the Transitory Constitutional Disposition Act (ADCT) and the Budget Guidelines Law of 1990.

Tax burden hampers access, say specialists

According to a survey by the National Health Confederation (CNS), the federal, state and municipal governments collected R$ 30.4 billion in taxes from the health sector in 2009, compared to R$ 27.5 billion in 2008. Compared to 2003, when the sector contributed with R$ 14.3 billion, there was a real increase of 57.19% and a no-
Statistics indicate that the country’s option for the public health model did not correspond to prioritizing Union, state and municipality spending. In 2000, Congress approved Constitutional Amendment (EC) 29 which increased minimum spending on health. For the Union, a 5% increase was defined over the sum spent in 1999, and for 2001 to 2004, a readjustment was stipulated in accordance with the variation in Gross Domestic Product (GDP). In the case of states, the amendment established a minimum percentage of 12% of tax collections, and 15% for municipalities. However, the readjustment defined was not complied with because the amendment has yet to be enacted.

“More than a dozen states infringe the determination and that can all be discussed because EC 29 has yet to be regulated,” says Sérgio Francisco Piola, coordinator of the health area at the directorate of social studies of the Institute of Applied Economic Research IPEA). Piola says if all the states complied with EC 29, the Brazilian health system would have received at least R$ 2 billion per year since 2003. The IPEA coordinator figures that just the regulation of projects that propose more federal resources for health would have increased the Ministry of Health’s budget by R$ 7.5 billion in 2009, to more than R$ 65 billion. “And that doesn’t move the Gross Domestic Product (GDP) one point,” says Piola, affirming that investment in the Brazilian health system is around 3.5% of GDP, whereas others, with similar integral and universal systems, invest closer to an average of 6.5%. “Just a regulation is not going to bring more resources for health. Above all else, it is necessary to increase public spending on health equivalent to the GDP,” he says.

Senator Flavio Arns (PSDB) closely accompanies the allocation of resources and is one of those in government who advocates complying with the Constitution. “Unfortunately, the government does not want to discuss the health budget, which is absolutely insufficient. If the required minimum were applied, there would already be an impact on people’s everyday lives,” says the Senator.

One of the main arguments for not complying with the law is the absence of a “public health actions and services” concept as well as the different criteria for accounting for revenues that should be tied to health. “There are always attempts at inserting spending in the health item that are not directly related, such as sanitation,” explains economist Raul Velloso, specialized in public policies. “There are many states and municipalities entering a series of actions in the health account, from water treatment to food for the prison system, because they allege they are beneficial for health, for example, treated water avoids disease, and the well-nourished prisoner. And all this with the indulgence of many audit courts,” says public health physician Gonzalo Vecina Neto, business superintendent of the Hospital Sírio-Libanés and former president of the National Health Surveillance Agency (Anvisa).

Despite the difficulty in applying the projected minimum, since 2002, there is a proposal in Congress to increase investments in health. The text explains the concepts and revenues that should be considered for investing in health and also stipulates that the Union should invest a minimum of 10% of the sum collected from taxes in the sector. Users of the Single Health System (SUS) are mobilizing to approve the project. “We are fighting for the federal government to invest the 10%, which will mean a R$ 12 billion increase for the area,” says attorney Sérgio Metzger, director of institutional relations for the Juvenile Diabetes Association (ADJ).
minal increase of 112.73%. At the federal level, collections totaled R$ 7.6 billion in 2003, doubling to R$ 15.7 billion in 2008, and reaching R$ 17.4 billion in 2009.

The CEO of Interfarma, Antônio Britto, observes that in the case of medications, the tax burden in Brazil is higher than for taxes on diamonds or veterinary products, for example. "This is curious because it makes the government’s purchases of these medications more expensive," he says. Britto adds the most perverse data is that the government collects practically the same sum from taxes on medications as it spends on purchasing them. "It is a reasonably simple sum to make. The Brazilian market is around R$ 35 billion, and when the tax load is applied to this sum, which is always difficult because the country’s tax system is very complex, we find a sum of at least R$ 5 billion in taxes imbedded, almost the same amount as is destined for purchasing medications by the Ministry of Health." On average, the tax load on medications in the country reaches nearly 34%, whereas in most of the world it is under a single digit. However, former Minister of Health Adib Jatene points out that if the tax load were reduced, there would be even less for investing in health, since only 10% of the federal government’s total budget is destined to the area, plus education, infrastructure programs and funding.

Inequity, poor distribution of income and the tax system hamper access to health care for the most needy

Brazil has made some progress, but it still maintains a high concentration of income when compared to other economies, especially the most developed ones.

In the United Nations Human Development Report of 2009, out of a list of 182 countries, Brazil presented an income concentration index better than only nine countries, four from the Americas (Haiti, Bolivia, Honduras and Colombia) and five from Africa (Botswana, Namibia, Comorros, Angola and South Africa). Although, there has been a recent reduction in inequity, this improvement in unequal distribution of income in Brazil mainly results from social income transfer policies. Without questioning the undeniable merit of these transfers to mitigate the immediate impact of poverty, this perpetuates the "fiscal illusion" of the least favored classes who believe they pay few if any taxes. This illusion results from the high and complex indirect tax load that makes the true onus of taxes little transparent in the products consumed by the population. Marcelo Liebhardt, director of Economics at Interfarma, says: "Because of the indirect tax load, the group of families earning up to two minimum wages is burdened with almost twice the gross tax load if compared to families earning more than 30 minimum wages" (see figure 4). The Social Welfare and Security Transfers and Subsidies (TAPS) reached 15.4% for a Gross Tax Load (CTB) of 34.7% of GDP in 2007. According to figure 5, Brazil has a Gross Tax Load and TAPS very similar to those in Portugal and Poland. The surprising difference is due to the very high net interest bill paid by Brazil. The interest payment corresponds to more than 30% of the Net Tax Load. For a net public sector debt of almost 43% the Gross Domestic Product, Brazil paid 6.2% of the GDP in interest. This percentage represents 138% more than the average net interest paid in the Euro zone and 229% more than the average paid by Organization for Economic Cooperation and Development (OECD) countries for an equal net debt level.

If on one hand, the economic areas of governments tend to argue that a Net Tax Load - Interest of 13.1% does not leave much room to maneuver for allocating supplementary resources for health, due to the range of other public policies, in one other hand, there is a growing view opposing this argument. The redistributive role of social taxes and welfare programs in anchoring tax systems and thus reducing the current level of income inequality is an important factor. The successful experience of countries like Sweden, the Netherlands and others in providing universal high-quality health care access and reducing poverty has shown that both poverty and inequality can be reduced through social and fiscal policies. The political and economic context in Brazil is quite different from these countries, but the principles remain relevant. The challenge is to design and implement policies that effectively reduce poverty and inequality, while also promoting economic growth and social inclusion. This requires a comprehensive approach that addresses both the immediate needs of the poorest and the long-term goals of social and economic development. 

1. In England, as in other developed countries, the net effect of taxation is neutral, as pointed out by Glommster (2006, p. 25): (...) "indirect taxes have had a growing part to play in countering the equalizing effect of direct taxation since they fall most heavily on the poor". The redistribution role is up to social policies - the welfare state. In Brazil's case, as will be seen, besides the distribution gains from social policies – or better, from government monetary transfers – being much more modest, they are neutralized by the regressive taxation result. As mentioned, this result is mainly due to the composition of the taxation in terms of direct and indirect taxes, and not because they are progressive or regressive. Silveira, Fernando Gaiger. "Distribuição previdência e assistência social: impactos distributivos". PhD Thesis, Unicamp, Campinas, SP: [s.n.], 2008, p. 125.

2. According to Silveira, "it is worth underscoring that public debt and its financing are the main causes for increasing the tax load, where it can be affirmed it is a regressive income transfer mechanism, and thus reinforces our standards of inequity." Silveira, Fernando Gaiger. "Distribuição previdência e assistência social: impactos distributivos". PhD Thesis, Unicamp, Campinas, SP: [s.n.], 2008, p. 125.
policies that need to be implemented, the potential of additional resources that can be released is also clear, improving, for example, the administration and cost of public debt.

**International Comparison:**

Brazil falls short of expectations in health care for its population

An analysis of the Global Health Statistics published in 2009 by the World Health Organization (WHO) with data from 2006, involving 193 countries, permits some

---

**Figure 4.** Brazil – Distribution of the Gross Tax Load as per minimum wage bracket.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 2 MW</td>
<td>48.8</td>
<td>53.9</td>
<td>197</td>
</tr>
<tr>
<td>2 to 3</td>
<td>38.0</td>
<td>41.9</td>
<td>153</td>
</tr>
<tr>
<td>3 to 5</td>
<td>33.9</td>
<td>37.4</td>
<td>137</td>
</tr>
<tr>
<td>5 to 6</td>
<td>32.0</td>
<td>35.3</td>
<td>129</td>
</tr>
<tr>
<td>6 to 8</td>
<td>31.7</td>
<td>35.0</td>
<td>128</td>
</tr>
<tr>
<td>8 to 10</td>
<td>31.7</td>
<td>35.0</td>
<td>128</td>
</tr>
<tr>
<td>10 to 15</td>
<td>30.5</td>
<td>33.7</td>
<td>123</td>
</tr>
<tr>
<td>15 to 20</td>
<td>28.4</td>
<td>31.3</td>
<td>115</td>
</tr>
<tr>
<td>20 to 30</td>
<td>28.7</td>
<td>31.7</td>
<td>116</td>
</tr>
<tr>
<td>More than 20 MW</td>
<td>26.3</td>
<td>29.0</td>
<td>106</td>
</tr>
<tr>
<td>CTB as per CFP/DIMAC</td>
<td>32.8</td>
<td>36.2</td>
<td>132</td>
</tr>
</tbody>
</table>


**Figure 5.** Gross (CTB) and Net (CLT) Tax Load, Social Welfare and Security Transfers and Subsidies (TAPS) and Net Interest Payment in Brazil and selected countries in 2007.

<table>
<thead>
<tr>
<th>Pays</th>
<th>CTB</th>
<th>TAPS</th>
<th>CTL = CTB-TAPS</th>
<th>Juros Liquidos</th>
<th>CTL - juros</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>39.2%</td>
<td>18.1%</td>
<td>21.1%</td>
<td>2.4%</td>
<td>18.7%</td>
</tr>
<tr>
<td>Brazil</td>
<td>34.7%</td>
<td>15.4%</td>
<td>19.3%</td>
<td>6.2%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Canada</td>
<td>33.1%</td>
<td>10.9%</td>
<td>23.2%</td>
<td>0.7%</td>
<td>22.5%</td>
</tr>
<tr>
<td>South Korea</td>
<td>26.8%</td>
<td>3.6%</td>
<td>23.2%</td>
<td>-1.5%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Spain</td>
<td>32.7%</td>
<td>13.4%</td>
<td>19.3%</td>
<td>1.2%</td>
<td>18.1%</td>
</tr>
<tr>
<td>United States</td>
<td>28.4%</td>
<td>12.6%</td>
<td>15.8%</td>
<td>2.1%</td>
<td>13.7%</td>
</tr>
<tr>
<td>France</td>
<td>42.3%</td>
<td>18.9%</td>
<td>23.4%</td>
<td>2.5%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Greece</td>
<td>31.6%</td>
<td>18.5%</td>
<td>13.1%</td>
<td>0.1%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Hungary</td>
<td>39.9%</td>
<td>16.9%</td>
<td>23.0%</td>
<td>5.0%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Ireland</td>
<td>30.8%</td>
<td>10.3%</td>
<td>20.5%</td>
<td>-4.6%</td>
<td>25.1%</td>
</tr>
<tr>
<td>Italy</td>
<td>42.5%</td>
<td>18.6%</td>
<td>23.9%</td>
<td>4.5%</td>
<td>19.4%</td>
</tr>
<tr>
<td>Japan</td>
<td>28.1%</td>
<td>12.1%</td>
<td>16.6%</td>
<td>0.7%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Norway</td>
<td>42.0%</td>
<td>13.5%</td>
<td>28.5%</td>
<td>-13.3%</td>
<td>41.8%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>36.5%</td>
<td>10.5%</td>
<td>26.0%</td>
<td>-0.9%</td>
<td>26.9%</td>
</tr>
<tr>
<td>Poland</td>
<td>34.1%</td>
<td>14.9%</td>
<td>19.3%</td>
<td>1.6%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Portugal</td>
<td>36.5%</td>
<td>16.8%</td>
<td>19.7%</td>
<td>2.9%</td>
<td>16.8%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>36.5%</td>
<td>13.8%</td>
<td>22.7%</td>
<td>1.8%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Sweden</td>
<td>46.8%</td>
<td>16.5%</td>
<td>30.3%</td>
<td>2.6%</td>
<td>27.7%</td>
</tr>
</tbody>
</table>

rather significant observations to contextualize each society’s commitment to its population’s health.

In most health spending indicators, Brazil only occupies intermediate positions. In share of total health spending in GDP, Brazil is ranked 57th, whereas in public spending on health in the GDP (3.6%), it is only ranked 89th.

The unfortunately negative highlight is that Brazil is ranked 151st in share of government spending on health in relation to total government spending (7.2%). Thus, private spending on health in relation to total spending on health is high. In that item, the country is ranked 28th.

Data confirm the criticism by specialists, both public and private, that public spending on health is still insufficient. In Brazil, total spending on health is about 7.5% of Gross Domestic Product (GDP). But the share of public spending is only 3.6% of GDP, which creates a disproportionate onus for the needy population due to the unequal concentration of income and regressive tax load.

Greater government participation

An analysis of national health systems reveals an interesting fact: the government is increasingly occupying more space, as a service provider or as market regulator or service financer. The recent American experience is a good example, according to a document from the Institute of Supplementary Health Studies (IESS). Until 1965, health care was the responsibility of the American citizen, who contracted the service directly in the private sector. In 1965, the government began to guarantee access to health care for the elderly and poor, paying the service providers directly.

In the 1970s, a public fund was instituted to subsidize part of the private plans for those unable to pay. However, the high costs forced the government to reform the system. In 1990, health spending was US$ 713 billion and rose to US$ 2.3 trillion in 2008, committing 16% of GDP. And now it has become obligatory to contract health insurance and the government will subsidize contracting private plans so people’s income is not compromised by this cost.

Increasing health costs are a global phenomenon. Spain saw its spending on health grow fivefold from 1960 to 2006. The country, which in 1960 spent the least on health, 1.5% of GDP, saw it rise to 8.1% in 2006.

In Canada, the health system is structured on five axes: universality, integrality, accessibility, public management and transferability – federal funds are transferred to province governments, which handle the care to the population. About 70% of Canada’s health system financing is guaranteed by public funds from fiscal revenues. The provinces and territories prioritize, on average, more than 30% of their budgets on finance health services.

In France, copayment, a system where the government subsidizes part of the cost, is made according to the therapeutic classes and pathologies. Discounts reach 100% for serious disease medications, 65% for the most consumed medications and 35% for the rest. In Portugal, the medications included in the copayment program are divided into levels. Those classified as “A” have discounts of 100% and represent those indispensable for patient survival or those used in treating chronic disease. Level “B” includes

International Models

In an international comparison, Brazil's total spending on health (7.5% of GDP) is below the world average (9.7% of GDP). But the fact that calls most attention is the low public share in total spending. Public spending on financing health (48% of the total) equals 3.6% of GDP, which is not compatible with a health system that intends to be universal and have full care. In these conditions, private funding is needed to complement the remaining 52% of total spending, that is, 3.9% of GDP. With the population's own resources. Given the unequal income distribution and regressive tax burden, the smaller participation by the government strongly penalizes the least favored classes. Paradoxically, and considering the scale of income, the relative participations of public and private spending is similar to those seen in the United States, a country considered a paradigm for private health care.
essential medications used for treating serious diseases or that are for prolonged use, with discounts of 70%. Those classified as level “C” have discounts of 40%.

Brazil needs greater commitment from the government with public spending on health

Despite recent improvements, our country’s health indicators are still bad when compared, for example, with Organization for Economic Cooperation and Development (OECD) countries, and even some countries in Latin America, such as Argentina, Chile and Costa Rica. With a still very low per capita spending level (around US$ 630 per annum), no doubt there is still plenty of room for more investments in the Brazilian health system.

In order to reach the international average for health spending (9.7%), additional public investments of 2.2% of Gross Domestic Product would be necessary. This increase would also permit reaching the international average of 60% in public spending and 40% in private spending.

Some studies indicate that this greater investment could have higher returns than those estimated for developed countries, considering that, after a certain level, marginal returns for spending per capita in health can become descending. Thus, countries with lower spending and worse health indicators can expect more additional benefits for each additional monetary unit of spending on health than countries that spend a lot and have better indicators.

Brazil is still far from reaching a stage where it can argue the existence of a sufficient level of spending, the existence of adequate infrastructure or a satisfactory performance of its health system. Insufficient public resources join insufficient spending on health, which is recognized by analysts both in and outside the Single Health System. But although it is necessary to persistently and permanently try to increase efficiency, this does not presuppose accepting the argument that generally pops up in the dispute for budget resources, that health must always “do more with the already available resources”. The simultaneousness of the problem cannot be disregarded: that it is necessary to spend more, at least initially (for example, invest in the qualification of managers at all three levels, create procedures, improve health information systems and their interoperability, correct related price distor-

---

tions in the system, remunerate human resources fairly and make SUS attractive for the entry of professionals from other areas), to thus spend more efficiently.

Spending on medication

Public spending on medication in Brazil represents 0.33% of Gross Domestic Product, whereas the average sum of public spending in OECD countries is 0.92% of GDP. Due to this low participation, more than 45% of health care spending by the group of the 40% poorest families is spent on medication. If the government does not decide to significantly expand copayment type programs to cover this access gap, it could at least exonerate those taxes that fall on medication. Value-added taxes on medication in Brazil reach 27.5%, a true international record.

The federal government has strived in recent years to exonerate the Social Integration Program (PIS) and the Tax for Social Security Financing (Cofins), an expressive portion of the market, but the states must also contribute decisively in reducing or exempting ICMS (Value-Added Tax on Sales and Services) on medication. Clause X of Law no. 10.742, of October 6, 2003 permits the Medication Market Regulation Chamber (CMED) to ensure the actual transfer of any tax load change to medication prices. In the case of ICMS exonation for medication, there is therefore a guarantee that this tax load reduction will be transferred to the consumer.

Scenario of inequalities

A population of more than 130 million Brazilians does not have sufficient income to have access to medication, a situation worsened by low public investment

Per capita investment by the Single Health System (SUS) is insufficient for responding to the challenges of health universality. In 2009, investments by the three levels of government resulted in spending of nearly R$ 550 per inhabitant, whereas a private health plan for the same service proposed by SUS totaled spending of R$ 5 thousand say federal deputy Marcos Pestana. Former Secretary of Health of Minas Gerais, Pestana says that these numbers put the public manager in a dilemma: complying with the duty of guaranteeing health services to the population and facing daily budget restrictions.

“The constitutional framework was extremely generous, and a freer reading of the law makes it possible to imagine access is unrestricted: everything for everyone. But
Families spend more

A survey by the Brazilian Institute of Geography and Statistics (IBGE) called the Satellite Health Accounts analyzed the sector’s performance from 2005 to 2007 with data on production, consumption and foreign trade of goods and services related to health and job market and income information.

In detailing family expenses, spending on medications is the most representative, as per a survey by the Institute of Supplementary Health Studies (IESS), based on the IBGE survey. In 2007, they represented 35% of all health care consumption, that is, R$ 44.78 billion, a growth of almost 10% compared to the R$ 40.9 billion in 2005. In 2007, on the same item, the public sector spent only one-tenth, in absolute numbers, of Brazilian family consumption: R$ 4.72 billion, also about a 10% increase compared to 2005. In relation to total public spending, medication only represented 5%, indicates the IESS.

Despite the government’s low participation in health care spending, the numbers point to a tendency of growth in the sector’s importance as a whole in Brazilian economic activity. In 2005, health care added R$ 100.97 billion to the economy. In relation to the total added by all segments, health represented 5.5%. “The valued added measures how much value each activity adds to the economy. Operationally, they are the revenues from selling products or services minus the sum of input purchases – or intermediate consumption. The sum of added value and taxes on production determines the GDP (Gross Domestic Product) for the sector,” explains the study. In 2007, sector GDP increased and stayed at 6% of the Brazilian total, with R$ 137.85 billion.

According to an IBGE survey, total family consumption spending on health goods and services reached R$ 128.9 billion, 4.8% of GDP; public administration spending was R$ 93.4 billion, 3.5% of GDP; and non-profit institution spending for families totaled R$ 2.3 billion, 0.1% of GDP. “Thus the consumption of health goods and services this year represented 8.4% of GDP,” affirmed the study.
medications and access is unequal. Those in need and without resources do not have medications, and that population certainly has a higher mortality rate,” endorses public health physician Gonzalo Vecina Neto, corporate superintendent of Hospital Sírio-Libanês, and former president of the National Health Surveillance Agency.

The “Analysis of the Medication Sector in Brazil, 2004-2007”, published by Interfarma, analyzes the size of this inequality. In 2006, class A, with income of more than 20 minimum wages, spent on average R$ 32.80, of their own resources, per capita per month on medications, totaling R$ 2.2 billion per annum. Class B, with income of ten to twenty minimum wages, the monthly commitment was R$ 20.60 per capita, totaling R$ 3.1 billion per year. In Class C, from five to ten minimum wages, R$ 14.70 was spent per capita per month, with annual spending of R$ 5.5 billion. In Class D, from two to five minimum wages, 71 million people spent R$ 9.60 per capita, per month; and, in class E, with income of up to two minimum wages, the average monthly sum spent was R$ 6.80 – equal to 2.5 bus fares in the city of São Paulo – representing an annual outlay of R$ 4.9 billion (see figure 7).

The sums express a large difference in access to medication in accordance with social class. In order to reduce this gap and bring Classes C, D and E to the consumption level of Class, R$ 18.2 billion per year would be needed. The volume of resources needed to included Classes D and E in the same consumption level as Class C would total R$ 9.4 billion.

The Interfarma Study also reveals that when the population’s earning increase, per capita sales of medication also grow. Pharmaceutical sales depend on the behavior of the economy and on income, underscores the study. Between 1997 and 2003, average earnings for the Brazilian population fell 3.8% while average per capita consumption of units of medication fell 5%.

However, between 2004 and 2007, when the country recorded a 2.9% growth in average income, consumption per capita rose 1.3%. “The calculation is that for every percentage point of increase in GDP, spending on medication increases 1.27; totals spending on health grows 0.88 and other health spending rises 0.94, says the Study.

Investing in medication costs less

It is cheaper to set aside resources for medication than for admissions, exams and repeated doctor visits.

Medication is one of the fundamental components due to its preventive and therapeutic power. Promoting the population’s access to medications is one of the ways to meet a constitutional precept for promoting, protecting and recovering health.

“From diagnosis to therapy, the least costly phase for society is medication. It is a priority,” says ophthalmologist and president of Hospital Israelita Albert Einstein, Claudio Luiz Lottenberg.

When comparing doctor visits, exams, hospital admissions, the “patients’ pilgrimage” through hospitals and clinics, which translates into a loss of productive time and quality of life in general, spending in medication is the lowest cost in the chain, explains Lottenberg. Thus, public policies have been designed specifically for pharmaceutical assistance. In 1998, the government published the National Policy on Medication, and six years later, the National Policy on Pharmaceutical Assistance. After that, some definitions structured the policy for access to medication, but the budgetary restriction is still a roadblock for fully serving the population. “It is easier for the individual to recover, but unfortunately, he doesn’t always have access,” says the president of Albert Einstein.

In 2008, federal spending on medications was R$ 5.86 billion, varying little in 2009, when it reached R$ 5.89 billion. Last year, 460 types of medication were offered free-of-charge to the population through the Single Health System (SUS). Altogether, the Ministry of Health centralized the purchase of 80 and it transferred R$ 2.7 billion to the states for purchasing other medications. However, dividing the sums by the number of inhabitants, spending fell, given population growth over the same period. It was R$ 30.93 per capita in 2009, and R$ 30.70 the following year, as shown in data from the Brazilian Institute of Geography and Statistics (IBGE).
“Guaranteeing access to medication, whether public or private, may be the country’s Achilles Heel,” says public health physician Gonzalo Vecina Neto, corporate superintendent of Hospital Sírio-Libanês, for whom medication is not guaranteed to the entire population, mainly affecting the low-income population. “Access is unequal in Brazil.” According to Vecina, access to medication must be considered access to health care and treatment. “Integrality in health care must be vertical and horizontal, and medication is part of that. It is vital. However, we historically disdain that.”

Timid action

“Health’s industrial complex has played a very interesting role in the sense of expanding Brazil’s capacity in basic medication and vaccines. However, a really efficient equation has yet to be found to take it a step higher,” says Antônio Britto, CEO of Interfarma. According to Britto, this step higher would involve a defined project for the medication area to reach more pathologies. Therefore, a project integrated with what is being done in the world. “No one is able to run innovation and the search for new medications in a single country or company. Because today the cost of innovation, from a financial perspective, is around US$ 800 million to US$ 900 million per new medication. And Brazil has a certain difficulty because the institutional model for seeking partnerships is still very insufficient,” he says.

Incorporation of new technologies

The government’s effort, which increased the sum destined for purchasing exceptional medications 5.13 times between 2002 and 2009, and 6.27 times the volume of units prescribed, is acknowledged by specialists, who, however, have some reservations. The main one is the Ministry of Health’s Commission for the Incorporation of Technologies (Citec) slowness in approving new drugs for inclusion on the list of specialized components.
“There is an inexplicable delay in approval. The studies that evidence the benefits are sent all complete, but there’s no answer and that is harmful to society,” says Jorge Kalil, head professor of clinical immunology and allergies at the College of Medicine at the University of São Paulo and director of the Instituto do Coração (InCor) immunology lab. Between 2002 and 2009, only six new medications entered the list of specialized components, which this year adds another 40, totaling 147.

Sérgio Simon, oncologist and direct of the Paulista Oncology Center (CPO) and executive director of the Brazilian Group for Clinical Studies in Breast Cancer (GBE-CAM), is one of the critics of the Single Health System’s (SUS) slowness in incorporating new medications. According to the oncologist, this delay separates the population: one well-treated one and another with unmet needs. “For us, medical professionals, it is frustrating to care for a patient who receives one medication in the morning and, that same day, to care for another patient with the same disease and prescribe another medication because it wasn’t authorized by SUS,” he explains. Simon says the gap in treatment financed by the private and the public sectors is not sustainable and society will force the change in the system. The government’s justification for barring industry innovations is the high cost, which, says Simon, is a false and near-sighted view. “It is necessary to change access to medication because we are still treating patients in the public network with outdated drugs that have no effect. That is a high cost for society.”

Waiting List

“There is a list of around 130 exceptional medications waiting for analysis, waiting for a definition of whether they will be inserted in the government’s program, or not,” says Devaney Baccarin, responsible for Interfarma’s Access Commission. “In Brazilian pharmacopeia, incorporation is already mediocre when compared to other more developed countries, but at SUS it is even slower. We would like the process to be more accelerated,” affirms director of strategy at the Oncology Center of Hospital Sírio-Libanés, Paulo Hoff, for whom public financial limitations hinder “having everything for everyone”. “It truly is not possible to have everything, but nor is it possible not to. For example, in my area, new medications still don’t cure cancer, but they increase life expectancy.”

This low incorporation of new technologies is a way to control spending since an important part of the drugs is excluded in government purchases. Another subterfuge is the delay in analysis for inclusion in the list. Senator Flavio Arns (PSDB) leads a front to establish a time period for public administration to analyze requests for incorporating medications to SUS’ list. “The request cannot await analysis indefinitely. I think 180 days is sufficient for the government to give an answer,” says Arns, author of a bill that limits postponing this analysis.

Medicine and prevention

Access to medication increases adherence to treatments, reduces public spending and avoids the proliferation of lawsuits in Courts against the government, affirm specialists

The government’s decision to offer free medication to patients with diabetes revealed an unmet need. “By creating a national program and incorporating medications to the Single Health System (SUS) list, the number of people served jumped from 3 million in 2001, to 14 million in 2010”, explains endocrinologist Fadlo Fraige Filho, exemplifying the importance of a policy for access to medication. The specialist underscores that this care was seen in a reduction of admissions and also in the demand for more expensive medication for treating complications resulting from an evolution in the disease. The lack of accompaniment of glucose and insulin doses can lead to, among other serious problems, retinal detachment and loss of sight, high blood pressure, circulatory alterations with vessel obstruction, loss of kidney functions and acute paralysis of facial, eye and extremity nerves.

An important victory for diabetics was approval of the law that makes the distribution of medication and material for applying and monitoring glycaemia free-of-charge for patients enrolled in education programs for diabetics. “When it becomes law, patients can sue for it
be executed. It is another guarantee of access to medication," observes the endocrinologist. Fraige says that argument is used when health managers are not aware of the rights guaranteed to patients with diabetes. But, despite the advances and achievements, the gap in relation to new medications is worrisome. “The public sector is behind in relation to market supply, because it opts for the cheapest.” And the program for diabetes care is one of the few structured programs at SUS.

Sérgio Metzger, director of institutional relations at the Juvenile Diabetes Association (ADJ), uses SUS and is one of its militants. Organization and mobilization of patients and the medical class permitted the incorporation of medication and inputs for monitoring the disease. “Society needs to pressure to show that it knows its rights,” says Metzger. The insulin available at SUS is still basic, a kind discovered 30 years ago, and which serves 80% of the patients. The group is pressing to open access to insulin analogs for children and the elderly. It costs ten times more, but the benefit for the patient is faster and greater. “There are 93 products for diabetics with their request for incorporation to SUS’s list filed, but we know there are no resources,” he says. That’s why one of the association’s banners is to pressure National Congress to approve regulation of Constitutional Amendment (EC) 29 and set the minimum percentage of 10% for investing Union revenues in health.

Impacts on life

The impacts of a lack of an efficient health care and pharmaceutical policy go beyond costs with doctor visits, treatments, admissions or medications. Indirect factors

Below average life expectancy

Advances in science and research and improvements in the general conditions of the population had a considerable impact on the Brazilian’s life expectancy at birth. In 1940, the average did not exceed 46 years of age, and in 2008 it has reached nearly 73. The average projection for 2050 is 81. Another evolution is the reduction in the infant mortality rate. For every one thousand liveborn in 1998, 33 did not reach one year of age. Ten years later, this index has fallen to 23, as per the Brazilian Institute of Geography and Statistics (IBGE). The positive data show the country has an increasingly healthier population. However, they are far from placing the country in a prominent position in the global health scene.

Life expectancy in Brazil is high compared to several countries, but below average for the Americas, where it is around 76, according to the World Health Organization (WHO). Other worrisome data indicate the country has one of the highest mortality rates between 15 and 65 years of age compared to others in the Americas, also according to WHO surveys. After dropping from 212 deaths per one thousand inhabitants, in 1990, to 176 in 2006, general mortality in Brazil is still higher than, for example, Argentina, with 124 deaths; Mexico, 122; United States, 109; Costa Rica, 95; Chile, 91; and Canada, with 72 deaths per one thousand inhabitants in the same year analyzed.

Public health physician Gonzalo Vecina Neto, corporate superintendent of Hospital Sírio-Libanês, says there are some reasons for Brazil’s lower life expectancy: infant mortality was drastically reduced in the country, but when compared to other more developed countries we see that it is still double digit compared to single digit rates in the others; the homicide epidemic among men between 15 and 45 year of age; and finally, the worsening of improperly treated diseases, such as hypertension and diabetes, due to a lack of access to health care and medication, which is increasingly responsible for the number of deaths, “If studies show that 10% of the population has diabetes and 20% hypertension, no doubt we have an important problem from a mortality perspective if there is no firm action in promoting health care and control for these diseases,” says Vecina.
must be included, such as lost work days and even early retirement. This perspective is analyzed by pharmaco-economics, a subject that describes and analyzes the costs and benefits of pharmacotherapy for the health system and society. Cardiologist Denizar Vianna, assistant professor of the Department of Internal Medicine at the Rio de Janeiro State University (UERJ) explains that it is necessary to know the impacts and risks of treatment in the natural history of the disease for making decisions, especially when resources are limited.

Vianna says financing access policy is a critical issue and it shows that, in this case, the lack of medications was the main reason for hospital admissions with even higher costs. When calculated, total cost with each patient was R$ 444,445.20, almost half related to indirect costs, such as early retirement and absenteeism. “These costs must be considered by public managers, but unfortunately they are disregarded because they are related to another area of the government,” explains the cardiologist.

Patients in courts

From 2003 to 2009, the Ministry of Health claims it responded to 5,323 lawsuits related to medication requests alone, which represented spending of R$ 159.03 million in the period. The number of lawsuits grew over the

Deciding in favor

Health area lawsuits in court gained such importance and space that they led to a public hearing in the Supreme Court (STF) in 2009. The discussions required six days of debate and more than 50 presentations with different points of view: attorneys, scholars, public defenders, district attorneys and attorney generals, judges, public managers, health care professionals, civil society and users of the Single Health System. The testimony guided the ruling on several lawsuits before the STF since then.

In the first one, after holding the public hearing, Minister Gilmar Mendes concluded that the Union, the state of Ceará and the municipality of Fortaleza should provide medication for treating a patient with Type C Niemann-Pick. He also determined the supply of medication by the state of Paraná to a patient with Type VI mucopolysaccharidosis. The Minister’s understanding was based on the fact that legal decisions deal with providing a health service already determined in policies formulated by SUS. “In most cases, judicial intervention does not occur due to absolute omission in terms of public policies geared towards protecting the right to health care, but also taking into account a necessary judicial determination for complying with already established policies,” he argued in his vote.

Without contradiction

In the cases of treatments still not incorporated by SUS, the Minister underscored the need to evaluate case by case to avoid harming the administrative order and compromising the system. On the other hand, the appreciation of new therapy indications by government bureaucracy is slow and it can deny public network patients treatment already offered by the private network. In both cases, Gilmar Mendes stressed the importance of registering medications at the National Health Surveillance Agency (ANVISA) and the fact that public administration does not verify the impropriety of requested drugs. With these considerations, the Minister concluded that the high cost of medication could not be a reason for denying supply because the Policy for Dispensing Exceptional Medications was created precisely to consider patients with rare diseases.
years, from 8 in 2003 to 2,273 in 2008, dropping to 1780 in 2009, informs the Ministry of Health. José Miguel Nascimento Junior, director of pharmaceutical assistance at the Ministry of Health, says judicialization is not only a budget issue. “There is a lot of irrationality on the prescription side. In the Brazilian market, there are more than 18 thousand medications and SUS will never offer all of them. There are also doctors who prescribe drugs that are still experimental, that is, they are not even on the industry’s production line yet,” says Nascimento, recognizing, however, that there are many cases of management problems.

In Rio Grande do Sul, around 30 thousand active patients currently receive medications due to judicial rulings. This volume demanded the creation of a special purchasing and logistics structure in the state just to meet these cases, because they involve nearly 3.5 thousand medication presentations for 65 thousand different types of treatment in the 496 municipalities. “Today, there are nearly one thousand new lawsuits per month,” says Bruno Naundorf legal advisory coordinator for the Secretary of Health of Rio Grande do Sul, for whom the lack of regulation, clarity in the laws and delimitations in the right to health care encourage an increase in the number of lawsuits. Naundorf says that of the current total, 76% of the cases are not part of state government jurisdiction, which, however, is obliged to incur the expenses because of judicial rulings.

Vera Valente, director of Interfarma Access and Innovations says “the judicialization of health is bad for everyone: for the patient who receives the medication with delays, for the company that does not serve the real market, and yes, punctual demands, and most especially, it is bad for the manager, who disorganizes his purchases and pays more expensive for the medication.” Vera underscores that the solution is for the government to define criteria for frequently updating the list of SUS medications. The Interfarma director recognizes that resources are limited, but she defends the participation of laboratories in the discussion to help find a solution to the matter.

The case of the state of Paraná ruled on by Minister Gilmar Mendes concerned a patient of the geneticist and president of the Brazilian Medical Genetics Society (SBGM), Salmo Raskin. The patient won the right to receive medication from the Secretary of Paraná for treating type VI mucopolysaccaridosis, because he was already present deformities in the skeleton and problems in the cornea, among other symptoms. “For five years now we have been trying to implement genetic disease care at SUS and the government resists diagnosing the pathologies because that will represent high treatment costs,” says Raskin. SUS’ lack of systematization and prioritization of who should receive treatment increases the cost. “The success rate for those who file a lawsuit in Court is greater than 90%, and requested treatment is offered without an evaluation of the general scenario for priorities,” he adds. Salmo Raskin lives this contraction on a daily basis. Because he specifically treats rare diseases, with high costs for medications, the geneticist instructs his patients regarding available therapies, regardless of any ties to SUS or health insurance plans. “I believe my role is to clearly tell the patient what is available in the market and to seek his well-being and quality of life. And I have encouraged patients to seek their rights.” Raskin says medical community pressure forced the National Health Surveillance Agency (ANVISA) to recognized nearly ten medications for treating genetic diseases, and that after great bureaucracy.

Rare diseases

The case of the state of Paraná ruled on by Minister Gilmar Mendes concerned a patient of the geneticist and president of the Brazilian Medical Genetics Society (SBGM), Salmo Raskin. The patient won the right to receive medication from the Secretary of Paraná for treating type VI mucopolysaccaridosis, because he was already present deformities in the skeleton and problems in the cornea, among other symptoms. “For five years now we have been trying to implement genetic disease care at SUS and the government resists diagnosing the pathologies because that will represent high treatment costs,” says Raskin.

SUS’ lack of systematization and prioritization of who should receive treatment increases the cost. “The success rate for those who file a lawsuit in Court is greater than 90%, and requested treatment is offered without an evaluation of the general scenario for priorities,” he adds. Salmo Raskin lives this contraction on a daily basis. Because he specifically treats rare diseases, with high costs for medications, the geneticist instructs his patients regarding available therapies, regardless of any ties to SUS or health insurance plans. “I believe my role is to clearly tell the patient what is available in the market and to seek his well-being and quality of life. And I have encouraged patients to seek their rights.” Raskin says medical community pressure forced the National Health Surveillance Agency (ANVISA) to recognized nearly ten medications for treating genetic diseases, and that after great bureaucracy.
Private care is the alternative for those with money

Study shows that 81.2% of Brazilians with income higher than 20 minimum wages have private health plans compared to only 3.4% of those earning up to one minimum wage.

In Brazil, the private sector became responsible for the supplementary coverage of health care services since the government has been unable to provide integral, free and universal care. But, despite this additional care nature, today nearly 42 million Brazilians are ensured by the private sector. Most especially, employees of companies that offer health plans and insurance are in private care, most with some financial contribution by the employees, and the higher income population, which can thus avoid the long waiting lines of public care. For most of the low-income population, private services are a distant reality. The “Analysis of the Medication Sector in Brazil”, published by Interfarma in 2009, shows that only 3.4% of the population earning under one minimum wage has private coverage, while the national average is 21.1% of the population. In the poorest regions of the country, the scenario repeats itself. In the North of Brazil, for example, there is less private coverage, reaching nearly 7.6% of the population, and only 9.2% of northeastersners have a private plan.

The same study, with data for March 2008, reveals that 81.2% of those earning more than 20 minimum wages have private plans in the Midwest, South and Southeast, where private enterprise reaches 13.2%, 19.2% and 33.2%, respectively. "Private medicine here is called supplementary, but I consider it complementary because there are cross subsidies. Those with health insurance plans can deduct part of their expense from their Income Tax, so it cannot be considered supplementary medicine," says public health physician Gonzalo Vecina Neto, corporate superintendent of Hospital Sírio-Libanés. Furthermore, some specialists point out that many private enterprise patients end up resorting to the public system in cases of medication prescriptions, exams, admissions, surgeries, among other procedures often not covered by private plans and insurance.

With regard to spending on medications, there is no coverage in the private sector, but there are some reduced price initiatives for members through their own pharmacy chains or partnerships with member drugstores. Maria Stella Gregori, attorney and former inspection director at the National Supplementary Health Agency (ANS), says the regulators do not oblige the inclusion of pharmaceutical care by private enterprise, except in cases of admissions. “There should be some regulation in that sense, not an obligation, but something optional,” she says, observing that there are bills before Congress in this sense.

Recipe for good health

More resources, better management, lower tax burden, regulations and clear and defined policies are prescribed by specialists to guarantee more quality to the Brazilian system.

The conception of the Brazilian health system, based on the concept of integrality, universality and being free, is advanced, and there are few health specialists who defend a radical change in face of the country’s low per capita income. A large part agrees that the system has problems because it is still under construction, and like any other project, it only needs corrections in route. Among the major challenges to be overcome to improve the country’s health are the low resources destined to cover what is determined in the Constitution for the sector, a consequence of the Union’s low budget for basic areas; management problems; excess tax burden; non-existence of an efficient health policy; and the lack of clear regulations. “The laws must define integrality because the resources are finite. The government does not have the conditions to give everything to everyone. This universality that says everything can, everything has, cannot be sustained,” says public health physician Gonzalo Vecina Neto.
Secretary of Science, Technology and Strategic Inputs at the Ministry of Health, Reinaldo Guimarães, suggests the next government must pay attention to the financial demand that would put the health system on a healthy path: it would at least be necessary to double the Ministry’s budget for it to fully exercise its function as projected in the first texts of the Constitution, he says.

Cardiologist and former Minister of Health Adib Jatene has already made the calculations and he says the Union only has about 10% of the budget to invest in health, education, infrastructure projects and housing and funding. In other words, the former Minister means it is necessary to create new sources of financing for health. One of those who idealized the extinct Provisional Contribution on Financial Transactions (CPMF), the so-called “health tax”, the former Minister is alone in defending its return.

Former Anvisa president Gonzalo Vecina also suggests that private health plans should also contribute by implementing more encompassing policies of pharmaceutical care, with discounts and reimbursements. Professor of clinical immunology and allergies at the College of Medicine of the University of São Paulo (USP) and director of the immunology laboratory at the Heart Institute (InCor), Jorge Kalil says the health plan could be more expensive, but it would be a benefit that mainly members of collective plans could have. “If the companies so wish, they can buy directly, and with volume, making it cheaper for everyone.”

Even in face of some many variables and difficulties to finalize the health equation, it is possible to obtain significant advances if each one makes their contribution. It is a consensus among specialists, doctors and scientists, private enterprise executives and representatives of public authorities that the solution for the deficiencies in access to health care and medications in Brazil is the responsibility of every level of society. “Everyone needs to make their contribution. Society will have to contribute increasing resources for health care; the government by reducing taxes; and industry by dialoguing and negotiating prices. And if there is a constructive, rational debate, I think this matter needs to be solved,” affirms Antônio Britto, CEO of Interfarma.

Britto is optimistic in relation to a solution to the problem, because he believes that whoever the next president is, the subject will be a priority. “Because health today is the greatest demand of the Brazilian population. This subject has ceased being socially important and has also become a politically decisive matter. As Brazil solves old problems, such as inflation and income distribution, the health problem becomes more and more scandalous, because in the other issues we are proving competence in solving them as a country, so we cannot say we are only incompetent in some aspects of public health,” affirms Antônio Britto.
Ad on the next page is a summary of Interfarma’s thought concerning the country’s political moment and what the entity expects as a solution to Brazil’s health issues. The text was published in a special supplement to the Valor Econômico newspaper on June 9, 2010, concerning the result of the “Paths for Financing for and Access to Health Care” seminar. The debate was promoted by Interfarma in partnership with Valor Econômico.
A victory for the Health Party

By gathering authorities and specialists in human health, renowned scientists, business leaders, sector leaders, scholars and researchers at the “Paths for financing for and access to health care” seminar in São Paulo, Interfarma – Pharmaceutical Research Industry Association – fulfilled its missions to propose an ample debate on public health in Brazil during this important year of presidential elections.

Over the past 25 years, there have been countless advances in health care and basic care for the Brazilian population. The drop in infant mortality and the eradication of diseases like polio, thanks to the excellent National Immunization Program, demonstrate that Brazil has overcome obstacles once thought insurmountable.

The creation of SUS – Single Health System – permitted such advances, but the specialists present at the seminar, before an audience of nearly 300 people, agreed there was much to do. Some believe the problem is in the lack of resources and they defend that pre-candidates to President of the Republic should include the destination of resources to health in their government platforms; other specialists say more resources need to be allocated to health. Furthermore, the debate registered criticism to the business environment, the bureaucracy in processes and the delay in protocol approval, especially in clinical research.

Interfarma believes the solution begins first with a rational dialogue geared towards the future in which the government, patients, industry and service providers can discuss the solutions for health without bias.

It was with this spirit the entity, in partnership with Valor Econômico newspaper, proposed the debate on a sensitive issue that concerns Brazilians, the authorities and which should mainly call the attention of the future governors of this country. The proposals suggested in the debate shall be forwarded to all Presidential candidates, state governors and the National Congress.

By suggesting the construction of an open and frank dialogue with the participation of all players involved, Interfama believes this initiative is already a victory for the health party.