Interfarma (Pharmaceutical Research Industry Association) is an entity that unites the pharmaceutical plants installed in Brazil, responsible for promoting and encouraging research and development of new drugs. Founded in 1990, Interfarma unites 41 labs that represent 55% of the Brazilian drug market.

In September 2010, the association changed its Bylaws and started representing national companies and researchers.
A mind opening to a new idea will never return to its first size

ALBERT EINSTEIN
Presentation

This book addresses the greatest concern of Brazilians today: access to a health system that offers quality.

And, in view of such a serious problem, the publication seeks to, first of all, avoid the debate proposed herein through signed declarations and articles from being lost by a unilateral, sectarian or corporative view.

Experts and authorities were invited by Interfarma, which asked them a basic question: “How to face the greatest challenges of the health area in Brazil today?” Represented herein are the most varied segments, positions and interests in the fascinating debate on public health.

To the extent in which our guests present pluralist and democratic views on the theme, we provide aids for a reflection on the most recurrent errors in facing health issues in Brazil: having the participation of few, listening only to those who think like us or looking for culprits and not solutions.

The representativeness and quality of the signed declarations and articles allow us to state that this is a document that can be useful in studies and consultations, even if its intention is not to have an academic depth or pretension to exhaust the subject.

This publication is another contribution by Interfarma, amidst the extensive program of events and institutional actions aimed at bringing together leaders of the segment, the authorities and thinkers of public health in Brazil.

Enjoy your reading!

Eloi Bosio
Management Board President

Antônio Britto
Executive President
Health is priceless: to invest in the sector is to promote development

“Once the Federal Government, under the leadership of president Dilma Rousseff, has as a priority the eradication of poverty in Brazil, the SUS [Unified Health System] is undoubtedly a central instrument of justice and social inclusion”, says the minister Padilha

“On launching, right in the beginning of the second month of her government, the Saúde Não Tem Preço [Health Is Priceless] program, the president Dilma Rousseff restated the commitment assumed in her swearing in speech: health will occupy a central role in her government, contributing toward the goal of eradicating misery and taking Brazil to the position of fifth biggest economy of the planet during this decade still.

From the economic point of view, the health production sector has important contributions like inducer of development. With the work of about 10 million professionals, health answers for 8% of the Brazilian Gross Domestic Product (GDP), or 30% of the industrial GDP, and moves R$ 160 billion each year.

Therefore, we must increase investments in research and development and strengthen the industrial policy for the area, which encourages the creation of state-of-the-art technology and represents a great opportunity for foreign trade. Economic gains that are rendered in improvement in the quality of life of millions of Brazilians, to the extent in which the prices of drugs and procedures are reduced.

The options that managers, workers and universities assume in relation to the Unified Health System (SUS) directly influence the health chain of production, which since 2003 has received investments of R$ 6 billion in research and infrastructure.

On providing primary care to highly complex procedures, oftentimes unavailable in the private network, SUS has no equivalent in other developing countries. On the other hand, attaining a high level of coverage with a level of financing much inferior to that available in developed countries. After all, we are talking about the biggest public conductor of transplants worldwide. SUS also pays for 80% of oncologic procedures and 87% of dialysis in Brazil.

All the surveys regarding SUS’ operation show that users actually have more positive evaluations than those who do not resort to the public network. A study by Instituto de Pesquisa Econômica Aplicada (Ipea – Institute of Applied Economic Survey) showed that 72.4% of people who resort to SUS regard the service as regular, good or very good, an index that is 65.7% among those who do not make use of the public network. This perception was referenced by the last National Home Sampling Survey (PNAD), which showed that 86% of the public network users evaluate the service provided as satisfactory. On the other hand, the survey pointed out that the main complaint of the population refers to the time of waiting to be included in the system and be attended to, a challenge common to the national systems of other countries.

It is due to having chosen access as the central object of planning and agreement of all policies and transfers to the states and municipalities that we want to create a national indicator for assurance of quality access. This index will be of national dimension, but will take into account the regional peculiarities, to measure the progress of health policies and their impact on people’s lives.
SUS is already mature enough for us to draw a large national map that clearly establishes which equipments and services are offered. From this diagnosis, which will have to be rendered in a large map of Brazilian health, we will be able to conduct a debate on the standard of integrality for this health system, optimizing investments and identifying the real needs of each locality.

In health, the fact that we have a decentralized execution calls for continuous effort to improve the mechanisms used in defining the commitments among the Federal, state and municipal governments. I defend the idea of an inter-federative contract that foresees clear goals for each action and guarantees total transparency in its execution.

With the clarity on the use of SUS resources, we will be able to establish sustainable financing rules for health, making it clear what is actually investment in health and what is the role of each federated entity. Sustainable financing will only be attained if we show society the results of our efforts to improve the management and the destination given to available resources. This is a debate to be made by the society and the National Congress.

To create working conditions for professionals throughout the country is certainly a central issue in the conduction of this process. With our continental proportion and our diversity, we will not have a single, rigid alternative. It is with dialogue that we will define which are viable, for which contexts. However, we will not give up the right to have qualified professionals to attend to the Brazilian population, whether in the Amazon forest or in the suburbs of the big Brazilian cities.

We must discuss with the society, universities and with health entities the matter of professional formation, considering the universalization of care and redefinition of user demands. Brazil must build a strategic plan for the next 20 years, foreseeing the demands by specialists and the most sensitive localities for us to direct the professional formation policies and be able to advance in the use of technologies like telemedicine and distance learning.

All these strategies have as backbone our effort and commitment to the strengthening of SUS, whose service network is available to all Brazilians and which protects public health with an effective surveillance service that includes vaccine campaigns and immunization campaigns, fight against dengue fever and containment of public health risks like H1N1 influenza. “Once the Federal Government, under the leadership of president Dilma Rousseff, has as a priority the eradication of poverty in Brazil, the SUS is undoubtedly a central instrument of justice and social inclusion.”

“The lack of dialogue and the search for consensus are the biggest challenge of Brazilian public health”

It is not possible to solve all health issues in the SUS alone, since there is no system that can all by itself support all the complexity and size of the problem existing in Brazil, says Britto

“The first actions of the new government showed that there is an accurate understanding of the problems and challenges of health, mainly because the new team has given much priority to dialogue with the most varied segments, positions and ideas in terms of public health.
An encouraging stance since the lack of dialogue and the search for consensus are the biggest challenge of Brazilian public health. This problem precedes the lack of resources, which exists, and fragility of the management, which is another reality.

The lack of open dialogue with all led to false controversies. Many specialists and experts battle themselves and maintain closed stances on the causes of health problems in Brazil. One part ardently defends that the difficulties result from poor management and another believes, with the same fervor, that they result from underfunding. Health needs both – efficient and transparent management and more resources.

Another false controversy: does the SUS (Unified Health System) have to do everything or is it possible to have health without the SUS? The System is a hit, it is a success, but it is not all powerful. The SUS is a constitutional provision and is fundamental for basic health in the country. However, it is not possible to solve all health issues in the SUS alone, since there is no system that can all by itself support all the complexity and size of the problem existing in Brazil. The lack of private initiative is also impossible. The system is already public-private and there is no way of solving the deficiencies of health without using the entire existing structure.

Another controversy that is also false has to do with what should be the System’s priority: basic health or care of complex diseases. We must put an end to this sterile discussion because there are problems in both areas and both deserve care. The same also occurs when the debate is about whether the service provisioning in the sector should be conducted by national companies or just by internationalizing. This false controversy is also old. Brazil needs a national health project, but it cannot be isolated, without dialoguing with the science that exists worldwide.

What must be clear to all the segments involved with health is that Mrs. Maria and Mr. João, who live far from the main health centers of the country, are not very interested in knowing if health is federal, state or municipal, government supporter or oppositionist, public or private, national or global. The population wants to have access to at least a quality health, which will have to be constructed with the sum of efforts of all characters of the sector and the entire society.

Interfarma has assumed and defended the position that health deserves to undergo a process of seeking consensus that, without detriment to the diversity of opinions, leaves an outdated rhetorical dispute and tries to identify projects and partnerships that allowed the country to advance. This attitude in relation to health problems cannot be the responsibility of the federal government only, but it is surely the State that must take the first step in this direction.

Therefore, the first movements of president Dilma Rousseff’s government in the area of health have generated much hope. There is a visible concern with dialoguing with all segments in the search for consensus.”

Carlos Gadelha
SECRETARY OF C&T AND STRATEGIC INPUTS OF THE MINISTRY OF HEALTH

“The great challenge of the State is to articulate the development and innovation policies with that of health”

With the strategy of universalization of access, we notice an exponential growth of the commercial deficit in the production
segments of health, states the secretary of C&T and Strategic Inputs

“Since creation of the SUS, the history of the health policy has intermingled with the history of the Brazilian society guided by the democratic reconstruction and by the assurance of citizenship rights. In the concrete context of the implementation of these rights, the country is currently experiencing a decisive moment to increase access of the population to health. In addition to the policies directly related to the increase, structuring and modernization of the care, promotion and prevention network reinforces the need to establish an innovative agenda linked to the national development strategy. Today, health answers for 22% of the world expenditure with research and development, only 3% of this effort being in countries with low and medium per capita income, including Brazil. In the society of knowledge, this asymmetry makes national health policies extremely vulnerable.

With the strategy of universalization of access, we notice an exponential growth of the commercial deficit in the production segments of health (drugs, medications, equipment, medical materials, products for diagnosis, etc.), reflecting the need to link universal access to the development of the national production base. At present, as you can see in the graph below, the commercial deficit of the health complex is already dangerously close to the threshold of US$ 10 billion. Programs essential to health like those of oncology, AIDS and other transmissible diseases become susceptible to the international market, reflecting an unacceptable situation of dependence in a strategic area for the country.

It is in this perspective that the policy for strengthening the Health Production and Innovation Complex is inserted - which includes all health industrial and service segments, as a strategic pillar of the national health policy to reduce our vulnerability. Health currently represents 8.4% of the GDP and, with the strategy of increasing access, the demand for health actions and services should be increased greatly. There is therefore a clear need for access to become leverage to generate employment, income and strategic knowledge in health, involving biotechnology, new materials, genetic therapies, drug synthesis, information technologies and medical equipment and materials, in addition to new approaches for prevention and promotion.

The great challenge of the State is to articulate the health development and innovation policies, guiding them by the social needs. It is time for boldness to choose development of the production and innovation base in health as one of the great national priorities.

For such, there are the commitments to promote a qualitative transformation in the health regulatory framework, involving a strong expansion in the strategic use
of the purchasing power of the State, followed by a significant progress in the concrete initiatives for the health regulation and for the strengthening of partnerships with the production sector. The perspective is to make the encouragement of production and innovation and increase of access compatible with quality. The strategic products for the SUS essential to the national health programs, provide the concrete north for the transformation intended.

In institutional terms, the strengthening of the government articulation, started in the scope of the Health Industrial Complex Executive Group (GECIS), aims at an integrated action of great span able to articulate the purchasing power and regularization in health with long-term financing, strengthening of the technological infrastructure and incentives to production and innovation in the country. The great wager is to contribute decisively to a national development project that integrates the economic and social dimension and competitiveness and equity of access.”

José Gomes Temporão
Professor of Fundação Oswaldo Cruz & Former Minister of Health

“Private health sector grows and is strengthened at the expense of the Public System”

“Private health sector grows and is strengthened at the expense of the Public System,” states the former minister

“The Brazilian health system is a historical and complex process that does not end. However, the current moment has a dynamic very different from the one that existed when the SUS (Unified Health System) was conceived over 20 years ago. At the time, there was a consensus in the society that a public medicine, of quality, in a universal system, was what everybody wanted. Today, this is not so clear and Brazil is discussing, even if still shyly, the loss of public health’s hegemony. Private medicine grows and is strengthened due to a phenomenon that can be explained from some perspectives. The first is the chronic lack of resources from the public sector.

The SUS was born underfunded, a situation aggravated during its existence and that remains. An example of the damages caused by this underfunding are the hospitals of the former Inamps, in Rio de Janeiro, and which today belong to the Ministry of Health. Twenty years ago, they were the best in Brazil and are now far from being included in this ranking. Currently, the main Brazilian hospitals are private and located in the city of São Paulo. Without sufficient resources, the public sector lost quality and efficiency, making room for the advance of private medicine.

Another important and relevant issue that explains, from the political-ideological point of view, the loss of hegemony, is the current view of the society that having a health plan represents, in a certain way, a social ascension. It is a serious mistake to think that a private plan can solve all problems because, in the majority of times, this is not quite the case. The claim of the workers unions, of all categories, of health plans, is also included in this scenario. These unions, from the political and discourse point of view, say they support the Unified Health System, the public medicine for all, but they pragmatically prefer to choose the private sector in their bargaining agreements. Curiously, the public functionalism of the three powers is also part of this process and has private plans. A matter that is little discussed and confronted, and also very ironic, is that the public servants themselves who work in the SUS, and who defend
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the System, have private plans, which is a contradiction in itself.

Even more curious is that in all these cases, there is tax relief and direct and indirect subsidies from the government. Families and companies, for example, can reduce expenses with health in the Income Tax and about 50% of the cost of public functionality plans is paid by the State. This is a paradox. When we add up all this set of subsidies and tax relief, we have an estimate today of about R$ 15 billion per year. This means that R$ 15 billion is transferred from the SUS to the private system. It is as if with one hand the State placed subsidies from reimbursement of medical-hospital expenses of companies, middle class families, expenses with functionalism plans and with the other hand removed this resource from the public sector. What can be inferred from this is that the private health sector grows and is strengthened at the expense of the Public System, from tax relief and subsidies from the government.

Therefore, the relation between the public and private must be discussed, reconsidered, because Brazil can approach a dangerous situation, which would be the process of ‘Americanization’ of the health system. For example, the movement made by the American society in recent years until it culminated in the Barack Obama reform, which tries to correct some disastrous market trends in the health of the United States but that, even then, cannot be fully implemented by the president. This slow process of continuous degradation of the public system, of chronic underfunding, combined with this political-ideological issue of private medicine as a process of social ascension, leads Brazilian health to a model closer to that of the American and far from that of the European, which was its reference.

Darcísio Paulo Perondi
FEDERAL DEPUTY AND PRESIDENT OF FRENTE PARLAMENTAR DA SAÚDE
[PARLIAMENTARY HEALTH FRONT]

“The problem is financing and this is an emergency”

Brazil is among the countries that destine less resources to health, in relation to the percentage of the GDP. It is ranked 169th in a list of 198 countries, says deputy Perondi

“There is a phrase by former minister of health, José Gomes Temporão, pronounced in a meeting of the political board of the Lula government last year that summarizes this current picture of health well: ‘If the financing crisis of the SUS (Unified Health System) is not solved, the pile of cadavers will increase’. The SUS is one of the reforms with greatest result in the last 20 years. Its attendance figures are fantastic, incomparable worldwide. Summing up everything, from the removal of an ingrown nail to a heart surgery, there were over 4 billion procedures in 2009. There is however a bottleneck today and it is called financing. The money is not enough.

Constitutional Amendment 29, date 2000, established minimum expenses with health in relation to the revenues: of 12% for the states and 15% for municipalities. It also linked the federal contribution to the nominal GDP (Gross Domestic Product). Municipalities are already spending more than they are able. In relation to the states, half meet the results while the other 50% masked the results. The resources from the Federal Government are not enough. Constitutional Amendment 29 had to
be regulated four years later and 11 years have already passed.

Today, the public expenditure with health, adding all the spheres, does not exceed 3.4% of the GDP; and that of the federal government is 1.7%. How was it in 2000? Federal tax revenues have increased extraordinarily since them, but health’s share has not and it remained in the same percentage of 1.7% of 2000. The federal expenditure with the SUS reached almost 10% of the collection in 2000, today it is less than 7%. In 10 years, the population has grown, the social ills have not been solved and the technology that saves has advanced, but the participation of the National Treasury in the SUS has reduced by one third.

Brazil, according to data from the WHO (World Health Organization), is among the countries that destine fewer resources to health, in relation to the percentage of the GDP. It is raked 169th in a list of 198 countries. This explains the financing crisis in the federal area.

Two years ago, the home survey conducted by the IBGE (Brazilian Institute of Geography and Statistics) revealed that out of every R$ 100 spent by the Brazilian, R$ 62 are private expenses and only R$ 38 are public. In Europe, especially in countries where the system is universalized, like in Brazil, the opposite is the case. There, out of every 100 euros spent with health, 85 are public and 15 private.

Out of every R$ 100 in services and procedures that the SUS purchases from a hospital for instance Santa Casa, it pays only R$ 60. Except for some areas, like oncology and cardiology, it pays poorly. Readjustment of the tables with convention members was punctual in the last two years, in spite of efforts by Frente Parlamentar da Saúde [Parliamentary Health Front] to point out that the crisis is real. Profitable hospitals are quitting the conventions with the System. Doctors also because the entire human capital is remunerated very poorly.

More resources are needed, with efficient management. However, those who say that the problem is management were never doctors, directors of public health centers, managers of Santa Casa and much less ministers of health. With these resources, one can do miracles. A minister from the area of economics would not support one week in the Health portfolio or 24 hours directing a teaching hospital. Where there is more management, there is more quality, it is obvious. It is however a lack of knowledge of the reality to say that the problem is management. The problem is financing and this is an emergency.

The solution is to vote for the regulation of Constitutional Amendment 29. It ceases the deviations from the states, with consequent increase of these resources, and raises the financing of the Federal Government. For the federal government, it would establish a share equivalent to 10% of the revenues, or about R$ 20 billion more this year for the Ministry of Health, had it been approved in 2010. The funds of the states would rise by R$ 3 billion or R$ 4 billion more per year. Amendment 29 has been shelved since 2008 in the House of Representatives because the economic wing of the federal government has barred all actions aimed at taking it to the plenary.”

Giovanni Guido Cerri
SÃO PAULO STATE HEALTH SECRETARY

“There is a real need to guarantee more resources for the sector”

Secretary says that greater financing can be assured by the regulation of Constitutional Amendment 29 and through more efficient mechanisms to demand the attendances conducted by the SUS to health plan patients
“Public health is something dynamic and, although it has advanced in the last decade, the challenges are building up. There were doubtlessly many achievements obtained to date.

Today, the SUS (Unified Health System) guarantees vaccine against polio to heart transplant, free of charge, to all Brazilians. There are centers of excellence in public care that are regarded as state-of-the-art, like Instituto do Câncer do Estado de São Paulo, Hospital das Clínicas da FMUSP (Faculdade de Medicina da USP – University of São Paulo) and Instituto Emílio Ribas. There are however primordial issues for the SUS to actually be able to provide a universal service that is at the same time more efficient to all citizens.

One of them is the financing of health. There is a real need to guarantee more resources for the sector, but this should not come by means of taxes, rather, it should come through regulation of Amendment 29/00 and more efficient mechanisms to demand from health plan operators the attendances made to their clients in public hospitals. Another urgent need is to promote, more effectively, the rationalization of attendance flows among units of the SUS, with effective mechanisms of referral and counter-referral. Citizens must have the due access to primary care, which solves about 80% of their needs and, there being the need for clinical or hospital care, the unit of origin should see to the referral, through a computerized system, without the citizen having to roam the health services with a paper in hand.

These are the two main steps to reorganize the SUS and make its service more efficient. From the management point of view, it is also important to strengthen the partnership with the municipalities and the federal government, in order to have hierarchization of the system, preventing simple cases from ending up in hospitals of high complexity.

Brazil and São Paulo have advanced in several areas of public health. There are policies and strategies that can serve as reference to improve the system in general, like the successful program for the fight against AIDS, regarded as a model by the WHO; and the national immunization program, regarded as a benchmark for several countries due to its significant results, like eradication of polio and control of other transmissible diseases, among them measles and diphtheria. In São Paulo, there is the management model for public hospitals in partnership with nonprofit private entities, the Social Organizations, and the support foundation model, which proved to be very effective in promoting quality care with agile tools for the contracting of human resources, purchase of materials and, in case of the support foundations, promotion of scientific research.

One must sum up efforts for management of the SUS to be actually synergic. The federal, state and municipal programs cannot work in isolation, but integrated to the System, without political-party banners. This integration is as important as or more important than the issue of financing. In São Paulo, the aim is to work in this wise. Federal government and city governments are partnerships for health to function well. This strategy is starting through the Baixada Santista (South Coost), where the cities will work as a kind of consortium, with consultancy by the State through Dr. David Uip. The idea is to use the expertise of each one of the municipalities and the health resources installed in each one of them to improve assistance.”
Deputy proposes a global pact among governments, private health sector, civil society and industry to regulate the cost of new equipment and drugs

“Health is a gigantic frontier. What to do faced with this challenge? On one hand, it is important to have technological development, which helps detect and solve problems early. It helps prolong life. And this leads to an apparatus in terms of drugs and equipment that is increasingly more sophisticated and has a significant cost. On the other hand, there is the need to cover the areas of basic care. It is a challenge to have structures and teams in all towns and rural districts of the country.

A good family health team solves 80% to 90% of the problems of a certain locality, without the need to displace personnel. Brazil has advanced in this basic care, but there are queues in specialized care. This delay occurs because the remuneration of SUS (Unified Health System) does not encourage professionals to enter the System. There is also a deficit in the formation of doctors.

There is a bottleneck originating from a corporate control of the formation of specialists. In general, universities do not allow the formation of professionals in the number needed by the population because they are in a model closely associated with the industrial complex. Certain specialties are controlled by specialists from that area, not by the interest of the population. To solve this problem, there is need for a social pact, guided by the government, to increase the number of graduated specialists, according to the needs of the System, and that also contemplates negotiations of minimum values per procedure.

Career in SUS is important for the quality of care. Professionals would have to dedicate themselves exclusively, but the SUS has been only a temporary job when what is needed is an ‘army’ of professionals dedicated to the work and being well paid. There must be a career plan, with better salaries, that also encourage the professional to start through the interior of the states. And the good remuneration must be by meritocracy.

To encourage professionals for basic care and the formation of specialists are fundamental actions. However, to do this requires a greater amount of resources than that available to public health today. There must also be money for equipment and drugs because the population has right to new technologies, which have very high costs, oftentimes outside logic.

There would be the need to create a sector chamber that would unite the managers from various public levels of the System, administrators of the private health sector and representatives of civil society and of the industry to discuss values, benefits of certain technologies, what is actually spent on researches and the profit margin companies must have to continue investing and discovering new products.

A pact must be established, even in international scope, possibly headed by the WHO (World Organization Health) is the biggest social frontier worldwide and this requires management and resources. Today, management is gradually improving in the country. However, public resources cover only about 40% of the Brazilian citizen's expenses with health; 60% are private. The federal government answers for 45% of the total amount invested in health. States and municipalities represent the remaining 55%. The Federal Government however withholds 65% of the entire collection.

Federal financing would have to double to about R$ 120 billion. Presently, there is need to regulate Constitutional Amendment 29 for the System to have more adequate financing. It is likely that this alone will not solve the problem, but it would help greatly. Constitutional Amendment 29 tends to progressively raise the financing of health, to the extent in which the GDP (Gross Domestic Product) increases.”

We must set up an agreement, even at the international level, perhaps headed by the WHO (World Health Organization), to regulate the issue of costs of new technologies and medications, particularly the ones that do not face market competition. Otherwise, all resources will only be targeted at the incorporation of technologies. There will be no money left for anything else.
Rafael Guerra  
FORMER FEDERAL DEPUTY

“The federal government centralizes the collection, but contributes less to health

One of the main bottlenecks of the Brazilian society is the care of moderate complexity, which substantially compromises the constitutional commitment of the SUS, states Guerra

“The main difficulty and the source of all the other problems of Brazilian health is underfunding. The per capital expenditure in the country is less than in most other developing nations. In relation to the percentage of the GDP, the expenditure should be close to 8% in the three levels of the government and private initiative, but it does not reach 5%. The share of the public sector is less than 50% of the total and that of the federal government is even lower, about 48%. However, in the collection of taxes, the opposite is the case. The federal government stays with about 70% of the total and the states and municipalities with the rest. Which means that the federal government centralizes the collection, but contributes less with health, overburdening the others.

This explains the difficulties in obtaining efficiency in the management of public health. Any administrator must have the resources to perform his or her work, not just talent and qualification. In addition, the remuneration is low. Managers of the private initiative, of any sector, have remuneration much higher than that of hospital administrators.

Another problem is the increase in health legalization. The search in Court to obtain access to treatments is mostly due to the difficulties of the SUS (Unified Health System) in meeting the constitutional commitment of universalization, equity and integrality. To meet these commitments, resources are lacking and health suffers with a flood of judicial measures that guarantee beds in ICUs (Intensive Care Units), high-cost drugs, among other services and procedures, but that end up destabilizing the budgets even more.

There is another great (and serious) strangulation. The main bottleneck of the SUS, which completely compromises its constitutional commitment, is in the moderate complexity, in which the patient must have attendance such as, for example, an elective surgery, that is not urgent. The queues and delay in attendances are long. This however is starting to occur in the health plans themselves. There is a great repressed demand in Brazil for procedures of moderate complexity.

However, with all the difficulties and few resources, public health has advanced greatly in Brazil. The care of high complexity, in some sectors, is comparable to the best in developed countries. In the areas of vaccine and AIDS treatment, for example, the country is a world benchmark. Brazil has evolved with the implementation of generic drugs and the Popular Pharmacy program, which increased access to the population, mainly of the poorest, to drugs. The Family Health Program (PSF) also took health to a good slice of the population with lower purchasing power.

The SUS is the country’s biggest advancement in terms of implementation of partnerships, regionalization and federative pact. There are also disputes in the System, with each seeking to guarantee his slice, but it is the best experience. Proof of this is that it has already served as example for the Unified Welfare System, and a Unified Public Security System is not being discussed, following the articulation model of the SUS.
Within this model of universalization, public consortiums are a very important alternative to enable regionalization of health. Result of partnership among the municipalities, they can work in perfect articulation with the private initiative, which without doubt tends to improve the efficiency of healthcare. In the state of Minas Gerais, there are already 72 health consortiums, uniting more than 800 municipalities. Which is to say that the regionalization program reached about 90% of the State. In Brazil, they served as reference for the implementation of other types of public consortiums, each one with its purpose. Today, there are almost 800 health consortiums in the country and almost 5,000 consortiums from other areas."

"The Unified Health System (SUS) is today experiencing a scenario of extreme difficulty due to its underfunding. And when the SUS is not well, philanthropic hospitals, which are nonprofit private entities are also not well. By Law, they should destine 60% of their services to the Public System and, in 2009, they answered for 41% of all hospitalizations made by the SUS, in the 2.1 thousand hospitals that the 2.1 thousand philanthropic institutions have spread throughout Brazil."

There were 4.535 million hospitalizations conducted by the santa casas, out of a total of 11.128 million of the SUS. To provide this care, they had a cost of R$ 12.3 billion, but received only R$ 7.9 billion from the System. Therefore, they had a deficit of R$ 4.4 billion. Which means to say that with every R$ 100 spent with patients from the System, only R$ 65 was received. In addition, the readjustments in the tables were punctual in recent years. The most significant occurred in the end of 2005.

This survey was presented to the former minister of health, José Gomes Temporão, and will be shown to the current minister, Alexandre Padilha. And this is the result of underfunding of the health sector, this conclusion is a national unanimity and even president Dilma Rousseff admits it. There will be the need to inject much more money in the SUS for it to be able to remunerate the convention network adequately.

Philanthropic hospitals do not need profit, but they cannot suffer loss, which ends up being borne by a very expensive indebtedness. In 2003, they had a debt of R$ 1.9 billion with suppliers, labor liabilities and bank loans. They closed 2009 with an accumulated indebtedness of R$ 6 billion. The result is that philanthropic hospitals are delaying the payment to suppliers, which renders difficult good drug and hospital material price negotiations. And bad payers that lack resources to make down payments are subject to the market prices, that is, they pay more. The snowball has been formed.

The underfunding to which they are being subjected is causing a progressive impoverishment of the santa casas, which are selling part of their equities in properties, which assured a monthly income, to try to reduce debts. Another consequence is the lack of resources to purchase new technologies. The development of new products, that increasingly aid and speed up the processes of diagnostics and treatment, is very fast and this requires constant investment from the sector. However, the insti-
Institutions lack resources to accompany this renewal, which takes place annually, and operate with increasingly outdated equipment.

To complete this challenging scenario, hospitals are not being able to maintain their staffs. The leaner structure leads to the closing of beds and, as a result, the population has greater difficulty in accessing hospital services. The purpose of the santa casas is actually to attend to those who are most in need, to provide absolutely universalized access. However, to exercise this function with quality, it must have at least financial equilibrium. Without this, there is loss in the quality of care, reflecting directly on the quality of citizen health.

The federal government plans to build 500 Emergency Care Units (UPAs), but has it already guaranteed in the budget the money for this expense? To build is easy, what is difficult is to cover the expenses monthly. Philanthropic hospitals are too interiorized, 56% are located in municipalities with up to 30 thousand inhabitants, and they are usually the only services of the population. Therefore, we must make another question: instead of duplicating services, why not make a partnership with this network that is already structured, along the lines of the Public-Private Partnership? In Brazil, at the same time that there is a lack of resources, it is common to have duplication of services, that is, installation of equal services in regions that are very close to each other. A more structured partnership with the santas casas would lead the public sector to save the resources that would be applied in the new units.

Arlindo de Almeida
PRESIDENT OF THE BRAZILIAN GROUP MEDICINE ASSOCIATION

“The government can be more effective through partnerships”

Private health entities propose to president Dilma Rousseff the creation of a Public-Private Partnership to increase access by the Brazilian population to healthcare

“The Brazilian public health is an international reference in many areas and when it comes to high technology, it leaves nothing to be desired in several sectors. In the area of transplants, for example, whether heart, kidney, liver and lung, just to mention some coverage, one will hardly find a patient who is not fully satisfied with the results obtained. Those who have access, who are able to enter the SUS (Unified Health System) and who have the opportunity of receiving care in the teaching hospitals, which are centers of excellence, or in state-of-the-art public hospitals, usually have no complaints of the System. But there are deficiencies in attendance at the entrance doors. The first access takes a long time and, unfortunately, many people are often unable to enter the System.

Several representatives of private health organizations, including of the Brazilian Group Medicine Association (Abramge), had a meeting with president Dilma Rousseff, little before she assumed the Presidency, and exposed how much the private sector can contribute with
the federal government to increase the access by the Brazilian population to healthcare services. It is not just about members of health plans and health insurances, but about the population in general. The ideal would be to create an intelligent Public-Private Partnership (PPP), following the example of some state governments, that is: the companies would operate in areas where they have more expertise and the government would remain in the sectors in which it is better.

The private sector is very dynamic, compared to the public care, in access to visits and diagnostic tests and in areas of small and medium complexity, for example, which are the first steps toward entering any system. It is more agile due to its managerial organization, where the public sector is more restricted. With this, it is more effective and efficient. The SUS is based on an attendance in the municipal scope that depends greatly on the local political systems, which renders management, which should be independent, considerably difficult. It has city governments with exceptional care, which contribute effectively to the System, including with economic resources. But others do not.

In the private system, there is greater agility for purchases and the hiring of personnel is simpler. In the public, a public examination must be conducted to increase the workforce and biddings to acquire any input, which demands a lot of time. In addition, the private initiative has a very great installed capacity and, if a partnership is created with the government, it has conditions to quickly get ready to elevate the number of employees and units, in order to expand its structure for the increase in demand for care.

It is evident that the government would be the main owner of the decisions. It has the priority regarding the paths that the health of the population must follow, but it does not have to be the ‘doer’, rather it must be the ‘guarantor. The Constitution states that the government must guarantee the conditions for health to be accessible to the entire population. Which means that we are not necessarily the ones who must do so. The government can be more effective through partnerships with the private initiative.

To enable this PPP, an intelligent financial agreement would be required. It cannot be: ‘you do it and I’ll see if I pay’. Today, the resources transferred by the SUS to the convention network are not enough to cover costs. The santa casas, for instance, which destine 60% of the services to SUS, finance a third of their expenses with the System. The current remuneration is an affront and hospitals that depend on the government are practically bankrupt.”

Humberto Costa
Senator and former minister of health

“There is an indirect subsidy by the public system for the private sector”

There is no equality. People from the middle class have faster access to drugs and high-cost procedures than the poorer part of the population, says the former minister

“The country’s biggest challenge in health continues to be implementation of the SUS (Unified Health System) and, within this, Brazil has other great barriers to overcome, which are also great challenges. The first and foremost is financing. Whichever the criterion used to analyze the country’s expenditures with health, under whichever angle we see it, we reach the conclusion that few resources are destined to the area. From the total expenses with health in Brazil, the public sector answers for about 45%; and the private sector, the expenditure of people, with 55%.
For a system that is constitutionally defined as universal, the standard is quite below compared to other countries that have this same definition, where the share of the public sector in expenses with health is much greater, approximately 80%. Resources are not enough because service-provisioning increases by the day while financing does not. On the contrary, with the end of the CPMF [Provisional Contribution on Financial Transactions], health lost an average of R$ 40 billion per annum, in values of 2008.

The second challenge is that it is of no use to increase resources if there is no clear definition of the responsibilities of all the players of the health system. From the states, municipalities, federal government, to the service providers and professionals, very clear definitions are required in terms of the health responsibility of all. The country needs a legislation to define these responsibilities and that can be an instrument for charting and enforcing with regard to those who fail to comply with the Law.

The third, which in a way depends on the previous two, is the construction of a legitimacy of the System. The SUS, without doubt, is very advanced, one of the greatest public health systems worldwide, attending to more than 70% of the Brazilian population exclusively. It however has problems in the quality of attendance: there are queues and the conduction of certain procedures takes a long time.

Therefore, the System has no equity. People from the middle class have faster access to expensive drugs, transplants and several highly complex procedures because they have health plans and go to visits and tests faster than those who depend solely on the SUS. They also have economic power to go to court and obtain injunctions that guarantee faster access to services and procedures not covered by health plans. The expensive procedures all remain under the hat of the SUS. There is an indirect subsidy by the public system for the private sector. As a result of this, there is usually a lack of resources to meet the poorest segments of the population, including the care for chronic diseases.

Another relevant barrier is that of human resources. There is a lack of contracting mechanisms that give the manager greater flexibility to meet the needs of the System, including that of defining personnel remuneration. There is poor distribution and a dearth of professionals, especially of doctors. The model of contracting through public examination restricts the SUS and there is the firepower of the corporations, particularly medical, that built a market reserve over time.

The solution is to open new schools and direct resources for specialization in areas of interest to the SUS. The system of public universities grew a lot during the Lula government, including medicine courses. But the number of public schools or the number of vacancies in those existing can be increased for these future doctors to meet the demand of public health. To guarantee this, there is the need to establish the mandatory civil service, and not just for health, but for any area that has a dearth of professionals in the public services. Those who graduate from schools paid by the society must return this investment with their work, but well remunerated.

Jorge Solla
BAHIA STATE HEALTH SECRETARY

“Whoever says he or she does not use the SUS is being ignorant”

System does miracles with its resources: it spends little more than US$ 1 per capita per day to cover all the procedures and services, from the simplest to the most complex, says Solla
“There has been a significant evolution in health since creation of the SUS (Unified Health System) and the idea that it is treatment of the poor for the poor is a lie. Brazil has developed technologies and services that are benchmarks internationally. There were advancements in basic care and the Samu (Mobile Urgency Care Service) today attends to almost 110 million Brazilians and with quality, so as not to include only the most known cases, like immunization, STD/AIDS and transplants.

Whoever says he or she does not use the SUS is being ignorant. We all make use of the SUS when fighting dengue fever, during vaccination, inspection of foods, cleaning products, drugs and in the control of water quality, among other health surveillance activities. At the other end, about 97% of Brazilians with kidney failure are treated by the SUS. More than 90% of cancer treatments are conducted by the SUS and more than 90% of heart and hemodynamic surgeries as well. The latest technologies and most expensive treatments are in the SUS. Not to mention the realm of medicine.

All this is done with one of the lowest financings. If we add up all the public expenses, it was little more than U$ 1 (about R$ 2) per capita per day in 2010, and to do everything, from fighting the mosquito to transplants. In any Brazilian capital, it is more expensive to pay one bus fare, which costs R$ 2.20 to R$ 2.50, than to go to the doctor. The SUS does miracles with the few resources it has because the option that was made for a decentralized system that unites several public, private and philanthropic institutions, enhancing it and giving it a very great capillarity.

There is still difficulty of access and regional gaps that must be solved. There is a whole scenario needing advancements: the challenge of care in the suburbs of the big cities becomes more and more complex each day, as well as urgent and emergency care, which amasses a growing number of accident and violence victims and the population that is aging and suffers from chronic disease intercurrences.

To solve the issue of financing, mainly in the federal sphere, is fundamental to fill these gaps. The federal amount, in terms of percentages, is lower than it should be. There is need to regulate Constitutional Amendment 29 to solve this. In Bahia, for two years, we invested over 14%, more than 12% of the revenues foreseen by Constitutional Amendment 29 for the States.

There is also a great challenge in the area of human resources. The health system has grown a lot in Brazil and created a number of workstations greater than the number of doctors. In Bahia, in the last four years, 400 more new units of the Family Health Program were opened and 1.2 thousand beds in state public hospitals. ICU beds grew by 80%, Samu coverage was tripled and there are not enough doctors.

The deficit is great in almost all the specialties and Brazilian regions, including capitals and in the private sector, and the country wastes labor. England, more advanced from the economic-social point of view, imports drugs and Brazil has hundreds of professionals trained abroad without being able to practice here because they are unable to validate diploma.

There is the need to increase medical formation in the country and regularize the situation of those who graduate abroad. Another thing that must be discussed openly is the mandatory civil service. Someone who studied in a public institution can offer, in counterpart, his or her work – well remunerated, of course, to the public health system to compensate the society’s investments. Some countries did this with good results. Should Brazil adopt it, in a quick calculation, with public courses alone and undergoing civil service of three year, it would be possible to supply more than half of the workstations in basic care that are empty today.”
Francisco Batista Júnior  
FORMER PRESIDENT OF THE NATIONAL HEALTH COUNCIL (CNS)

“The financing of the System will always be insufficient because it is absolutely privatized”

The SUS is being implemented wrongly, which systematically violates its legislation and is almost leading it to insolvency, says Batista, adding that this explains the repressed demand.

“The SUS (Unified Health System) has performed real feats in the country. It is without doubt one of the main responsible for progress in the quality of life of the Brazilian in the last 15 years. However, the System is being implemented wrongly, which systematically violates its legislation and which is almost leading it to insolvency. Today, if it is not totally unviable, it is very difficult to manage the SUS due to the distortions that were created within it year after year. An example of this is that its current managers probably do not even know how many people in Brazil need specialized procedures and are unable to obtain them through the SUS.

There are thousands of people waiting in line and thousand others who quit and are dying slowly. Why the long queues? Why does the System have little money? Actually, the SUS is underfunded. This is absolutely unquestionable, but also unquestionable is the fact they established a logic in the System to prevent its full financing. Except for the resource destined for basic care, which should be the highest and is the lowest of the System, the financing of the SUS occurs by the conduction of procedures, like hospitalizations and tests.

This model, besides not meeting the real needs of the population, generates distortion in the service network structure. For example: Brazil is the country with the highest number of tomography devices worldwide, per capita. However, unfortunately, these tomograms are not in the public network, they are in the private network. All managers want this device in their network because they know they will be remunerated by the Ministry of Health per test. The financing must be defined according to the need of each population, from surveys and planning conducted by the municipalities.

There is a constitutional inversion that is being fatal to the SUS. To make possible in Brazil a universal and integral public health system, it would have to be, if not fully public, as in the case of Cuba, prioritarily public. Simply because it is impossible to enable a model like the one in the Constitution according to the market logic. The world has already shown this. The United States has already shown this. It is the country that spends the most with health worldwide and that has the most people excluded from the system – approximately 45 million North Americans.

The system has to be public, as in the Constitution, and it can buy from the private that service for which it temporarily lacks conditions to provide to the population. In these 20 years, there has been a wild process of inversion of this legal logic. Today, 95% of specialized, high cost procedures of the SUS are bought from the private sector. In the area of transplants, 97% are done through contracted private service. This is impossible to pay and explains the repressed demand that increases more and more. It would be much more economical to have a professional team in a public hospital, teaching hospital, being well remunerated and conducting as many procedures as are required.

The financing of the System will always be insufficient because it is absolutely privatized. Today, great part of the SUS’ professionals is outsourced. Not satisfied, ide-
ologists of this model advanced in the privatization of the administration itself of what is public. Since 1998, when São Paulo State started this process, private companies started to administer part of the System and at a cost that was impossible to finance.

If hard measures are not taken, there is no doubt that the SUS will fast become unfeasible. Among them, it is fundamental to have more resources and, therefore, the regulation of Constitutional Amendment 29 is important. It is imperative for each public service to have administrative, financial and budgetary autonomy. The management must be professionalized and the workforce encouraged to create the SUS career, so that the professional can dedicate himself or herself with exclusivity. The country also needs to implement the civil service in health: all graduates in health area courses will have to work in the SUS for at least one year, preferably in the location where they just graduated.

“Greater access and admission with quality are priorities of the Ministry of Health”

Surveys have shown that the Brazilian population complains of lack or delay in access to health services and one of the devices to face this problem will be the construction of 500 health regions in the country, says the secretary

“The great challenge of the Healthcare Secretariat (SAS) is to increase access to medical care, preventive actions and access to drugs, in addition to providing the admission of the patient in the System with greater quality. Which does not mean that the areas of promotion, health surveillance, epidemiology, among others in the scope of the SAS, will be abandoned. Greater access and admission with quality are priorities of the Ministry of Health because the SUS (Unified Health System) recorded an extraordinary growth during its more than 20 years of history and a greater dimension, in this magnitude acquired, with the growth of services and boldness to propose attendance to all Brazilians, always requires adjustments, mainly in quality.

Several surveys have shown that the Brazilian population claims a lack or delay in access to services. One of the devices to face this problem will be the construction of 500 health regions in the country, which are already well defined. These areas are being denominated by the Ministry of Health as 'Health Map' of the country because they will give a portrait of the needs and offer of services in each one of them, with indicators of health and production of the service.

The great instrument to increase access and quality of services is the organization of Healthcare Networks. From the survey of the needs, a set of services, and the great majority already exists, to be structured like a network, so as not to compete among themselves. Each one will have a clearly defined role, with menu of offers that cover from services to attendance times. With this structured network, there will be greater fluidity in the System, waiting time will be significantly reduced and the patient will no longer have to wander from one service to the other. The Family Health Program (PSF) will be one of the great commanders of this network.

Another priority will be to organize the thematic networks, like that of urgency and emergency, for example. Brazil can no longer live with crowded emergency rooms, lack of beds and insufficiency in the Samu (Mobile Urgency Care Service) in some regions. It also can no longer live with the possibility of not taking in a preg-
nant woman during her pregnancy or delivery time. The third priority network will be to face the addiction to crack and alcohol that is progressing among Brazilians. For this, the idea is to strengthen the current Mental Health Network.

In order to organize a gigantic system like the SUS in this manner, the National Health Card will have to be implemented for each user. Gradually, the clinical record of the patient will be articulated to this card and the entire System will have access to the data, which will prevent, for example, unnecessary repetition of tests. For this, of course, there will be need to implement an agile and robust computerized system. All the procedures are already well under way and the government will implement a great part of this plan in the next four years.

The SUS must delineate a quality standard and have an integrality standard debated with the other levels of management. In this wise, the relation between the Federal Government, states and municipalities will be greatly discussed and will be redone. The Ministry will formulate federative action contracts, an important legal and institutional innovation, that clearly foresees the role of each entity in the health regions. It is a movement to provide the health management with transparency.

The quality standard will also be demanded from complementary health because the majority of hospitals that attend to the private initiative also provide service to the SUS. The Ministry of Health is also concerned with reviewing the outdated method of financing of the convention network, in terms of values and models, and it has debated this with the aim of seeking more modern alternatives like, for example, financing by results and not by procedures. The payment by procedure does not mean quality and encourages the provisioning of certain services. But these are movements that cannot be sudden, since they can generate lack of attendance.

Currently, there are not enough resources for all this. The SUS is underfunded, everybody knows this, and there is need for the states to comply with Constitutional Amendment 29, and for it to also be regulated in order for public health to have more resources. However, the Ministry of Health is convinced that the society will mobilize itself for this to occur, to the extent in which this entire plan is implemented, because it will show that the public resources are being used well.”

José Agenor Álvares da Silva
DIRECTOR OF THE NATIONAL HEALTH SURVEILLANCE AGENCY (ANVISA) AND FORMER MINISTER OF HEALTH

“Those with greater social fragility are more exposed”

The public health system is being appropriated daily by parts of the population that have more resources and use injunctions obtained in Court to have access to more expensive technologies, says the director of Anvisa

“The SUS (Unified Health System) was approved in 1988 and regulated in 1990. However, it is not a finished product. It is dynamic, being in constant modification and this will always be so. The action of specialists, managers, of the Congress must be attentive to the technological, epidemiological and demographic changes to provide conditions for the sector to understand these transformations and be able to act forcefully. Today, there are two realities coexisting in Brazil: that of a poor country and that of a rich country. It has child mortality equal to that of the poorest countries and diseases resulting from modern life, predominant in richer countries, in addition to the regional differences. And the SUS must work with all these issues.

The System has three principles: universalization, integrality and equity. When discussing the universalization and integrality, there is a question that many specialists, jurists, academics make today: does the government have conditions to give everything to everyone in the
area of health? One must reflect on this and the answer, of course, should not restrain the right of anyone. It is however important for the society to answer, since it notices that the public health system is being appropriated daily by parts of the population that have little or no social fragility. Those with greater social fragility are more exposed.

It is at this point that the principle of equity comes in, which is something that the country is learning now: to treat equals with equality and unequals with inequality. Every technology provides a benefit in terms of cost. But in health, its incorporation does not presuppose cost reduction. The area’s inflation is always greater than that of the country because the new technology is expensive and increase the economic cost, even though it reduces the social cost. In the area of drugs, for example, the resources from the Ministry of Health available for free distribution of drugs should be about 8% to 10% of its total budget.

When someone goes to court to be able to obtain an expensive drug, which ofentimes does not even have its efficacy evidenced through studies and researches, thousands of people are penalized because the resource is finite. A part of the population will no longer receive the drug and those who were waiting in line for a more expensive drug see the same mess because a judge determined that another must receive it immediately, ahead of others.

In some aspects of the legalization of health, what we have are groups and segments of the population with little or no social fragility, like the middle, high middle and rich classes, with greater access to more expensive drugs, the so-called exceptional. This part of the population has greater access because it has more money to go to Court and obtain injunction. The confrontation of legalization is a challenge because it privileges the part of the population that has more resources, to the detriment of the more socially fragile, and causes a damage in the budget.

The SUS has had many advancements. Significant parts of the population that did not have access now have access. There are however other problems that are real challenges. One of them is the issue of financing of the public health system, which is one of the lowest compared to that of other countries. However, the financing cannot be discussed in isolation. One must first of all be clear as to which actions must be taken for this financing to be effective and efficient in the provisions of health services. Without this, it is useless to increase resources just to increase them.

The three spheres of the government, Congress, judiciary, specialists and the entire civil society must define an action strategy that solves great part of the problems and bottlenecks of health and an action plan to increase public financing, in order to support these actions.”

“In the Federal District, where the scenario is one of tragedy, another priority is to have sufficient number of doctors”

Brazil has advanced in the area in the last eight years, but the Federal District is very far from the development recorded in the period, says the new governor, who decreed state of emergency in health

“Public health in Brazil is still not in the ideal level, but important achievements were obtained by the Lula
government. The Federal District, however, due to the neglect of the former governments in recent years, did not accompany this process. On the first day that I assumed the government, I decreed a state of emergency in health. There was lack of drugs and hospital materials, very high expenses and hospitals full of problems. There is also a report from the Federal Government’s Audit Court (disseminated recently) pointing out that from 2008 to 2010, there was overpricing of drugs and deviation of resources, in about R$ 100 million.

I am a doctor, a public servant and I know the problems of the area in-depth. I am personally at the head of the Health management in my government. Resources exist and I will seek each possible cent from the Ministry of Health, in addition to our own, to supply the drug network and equip it properly. Since the beginning of the year, I have personally visited eight public hospitals and the Central Pharmacy of the Federal District. What is lacking is efficient management that is really committed to guaranteeing good care to the population. The first thing to be done is a survey of what is missing, of what is really needed, in what quantity, and to meet the most urgent demands.

To start tackling this issue, just apply already existing resources correctly and do not spend them in unnecessary contracts that even have, sometimes, suspicious values. Computerizing the network will also be important in this control of drug supply. It is inadmissible to have shortage of drugs, basic materials and for people to need injunctions in Court in order to guarantee ICU and drugs.

There are many important challenges in the area to be overcome. In the Federal District, where the scenario is one of tragedy, another priority is to have drugs in sufficient number. The Legislative Chamber approved in the beginning of February a package that will allow elimination of the current dearth of professionals to attend to the population. By 2014, almost 11 thousand servants will be hired, through public examinations, to the area, about six thousand this year alone.

Another current priority is financing. We are enabling resources for the area. We will repair hospitals, the places where drugs are stored and regularize supply of drugs and hospital materials. We are starting with the basic.

We must also act preventively in health, with basic care programs, in which people are taught the best habits, like the importance of a balance diet and physical exercises, to also prevent diseases and even control pre-existing conditions, such as, for example, cases of hypertension and diabetes. This stage is important for the well-being of each one as well as in order to ‘dehospitalize’ health, which means to attend in hospitals to really serious cases and to also reduce the time of patient hospitalization as much as possible, by means of an efficient attendance.

To attain this goal, the Emergency Care Units (UPAs) are fundamental. In them, patients receive the first cares and minor attendances. Only the serious cases are referred to hospitals. In the Federal District, we will put into operation, yet this year, 14 UPAs, in partnership with the federal government. Four should start working in the first 100 days of government.”

“Management is crucial, but provided one’s eyes are set on the people”

Sérgio Côrtes
STATE HEALTH & CIVIL DEFENSE SECRETARY OF RIO DE JANEIRO

SUS must provide users with services of good technical standard and qualified professionals to guarantee the binomial
of quality and increase access, opines the secretary of Rio de Janeiro

“The greatest challenge of the Unified Health System (SUS) is to provide users with services of good technical standard and with qualified professionals who are properly equipped, according to the type of care they provide, in addition to providing the population with the same quality found in high-standard health units. This is the path to be tread in order to build a system that guarantees the quality and increase binomial in access for the user. The search of the State Health Secretary of Rio de Janeiro will be very intense to attain these objectives in every type of service, whether own or convention.

To attain them, several actions and tools have been used. One of them was the implementation of a new system of electronic trading that enabled purchase of the best equipment and generated a savings of more than R$ 700 million. Another important decision for the State’s health policy, shared management, is a component to change the picture of Rio de Janeiro’s health, since it is possible to solve the equation of productivity increase with greater savings of public money. Provide the services of lab tests by hospitals and Emergency Care Units (UPAs) start being administered through shared management, in July 2007, the annual expenditure was R$ 135 million for less than R$ 42 million and the production was increased from 1.2 million lab tests per year to more than 9 million.

Management is crucial, but provided one’s eyes are set on the people. Not only users of services but also servants. This year, Rio will be conducting a public examination for health managers, who will join those approved last year for this position. The aim is to have State career professionals qualified for management, which is becoming more and more professionalized. The qualifications for emergency doctors will also continue this year and will be extended to nursing professionals.

Investing alone does not suffice. One must plan. The creation of the 24-hour UPAs is a mark and expresses the management model adopted by the government of the State, in 2007, to relieve the emergencies of big hospitals, overcrowded due to receiving patients who could be referred to emergency services that worked fulltime. Proof that the attendance model has been working and that it served as reference for the federal government to extend the idea to the entire country, crossing borders, with one Emergency Care Unit (UPA) being inaugurated in Buenos Aires and plans to inaugurate five others in the Argentinean capital and to extend it to other areas.

The UPA organizes the network, increases access and relieves the emergency of hospital units. It is important to note that the UPA was not considered to substitute anything but rather to comprise, together with other units, an organized health network. Today, it is more than proven that these Units are effective in the redefinition of flows. In the 41 UPAs of the State (and works are being concluded in 11 more this semester), the transfer rate is 0.6%, that is, more than 99% of cases that reach these units are solved, proving the high power of solution of the service.

Another important mark of Health management in Rio de Janeiro is the regionalization of services. Over the years, a wrong idea gained force that all the municipalities should provide health services in all the specialties. The SUS proposed an unprecedented challenge and we are implementing the Regionalization Program. By organizing the State in ‘health regions’, it will be possible to plan integral care to the patient better, starting with basic care. With this, health becomes closer to the people, while the actions needed to solve the problems will be resumed with great speed.”

Pietro Novellino

PRESIDENT OF THE NATIONAL MEDICINE ACADEMY (ACM)

“Brazil also needs to invest in science and technology”
In order to accompany the technological advancements of medicine, the Brazilian health system needs more resources because the new products have very high cost, says the president of ACM

“The greatest challenge is the endearing of healthcare, but this is a global problem resulting from the higher cost of technology. And there is no way. In order to accompany the technological advancements of medicine, Brazilian health system needs more resources. Diagnostic methods and technology are constantly advancing in their most varied aspects, but all this evolution is expensive, above the purchasing power of the public budgets.

Since medicine must be only one, attend to all, whether rich or poor, equally, this is not easy because the new technologies can consume great part of the System’s resources, which already operates with insufficient financing, even if it increases a little each year, to cover all need’ of the Brazilian population. Without money, it is difficult to make available all the drugs, equipment, devices, inputs and most advanced technologies that reach the market each day.

It isn’t long, for example, that surgery evolved considerably with techniques like video surgery, much less invasive and providing patients with very fast recovery. But now, the perspective is already robotic surgery, conducted by robots that follow the commands of a surgeon, who does not necessarily have to be in the surgical center. It is being experimented in prostate cancer and is regarded as a ‘gold’ standard procedure.

There is need to greatly increase investment in the System in order for it to, as a result, be able to apply more resources in technology and provide Brazilians with greater access and greater quality in care. Therefore, it is important for the House of Representatives to regulate Constitutional Amendment 29, shelved in the Congress for years, which foresees an increase in financing for the area, particularly in the federal scope and in the states.

In the longest term, Brazil also needs to invest in science, technology, in the generation of knowledge and in production structure for the health sector. Except for some centers of excellence, the country is late in this process, as shown by the data on patents. Compared to other countries, it has a very small number of registrations, that is, it innovates little in the area.

However, it is not only financing of health that must be greater. There is also need for better distribution of resources and greater control of expenses because there is a lot of wastage in hospitals and in other care units. In a country in which resources are limited, control of the structure must be doubled and can make the difference. President Dilma Rousseff is aware of these challenges and the area of health was one of the main banners she raised during her candidacy to the Presidency.

Note that the System has always been greatly concerned with the problems of medical care. Lately, however, the focus has been on prevention, the so-called primary healthcare. Which is very positive. Good health starts when a person is conceived in the mother’s womb. A good prenatal care, without doubt, will create a healthier person. The care provided to the child with up to two years of age is also fundamental for this.

Despite some deficiencies, mainly due to financing problems, Brazil has evolved greatly in providing care to the poorer population. The Family Health Program has obtained good results and the Emergency Care Units (UPAs) have guaranteed a significant gain in care. Brazil is not yet in the ideal level, but which country reaches the best in this area? In the United States, for example, one of the richest countries in the world, almost 40% of the population does not have right to health. But health does not obtain satisfactory results in any part of the world, if factors like basic cares with nutrition, feeding and education are not addressed.”
It is difficult to make medicine integral, which would prevent diseases in half of the population because it involves actions of infrastructure like basic sanitation, safe housing conditions and education, which are deficient in the country, states the professor from USP.

“Brazil has created a health system that is theoretically very suitable. The SUS (Unified Health System) has three important aspects: universalization, integrality and equity. It also foresees a hierarchization of health with a primary care system for the simpler problems; secondary, for medium-level diseases; tertiary, for the more complicated cases. It also foresees decentralization and promotes a social control over health. All this is important and is written in any journal of the SUS, but this is where the problems begin because nothing has left the paper.

The idea of promoting universalization, which says that everyone has right to health, is highly democratic. Integrality implies conducting prevention, health protection actions, education and the treatment of health per se. Equity is a very fair principle and from the social point of view is better than equality because it includes justice. In a country with the proportions of Brazil, decentralization means that all the decisions cannot be made entirely in Brasilia because this will not help a small city where they are requiring a health center and, suddenly, a hospital is built to perform heart surgery. Social control is a perfect mechanism because the society supervises and controls all these actions. But all the principles of the Unified Health System have been violated.

Brazil has three health systems: the public, which is responsible for 75% of attendances; the complementary, which are the health insurance companies that attend to 20% of the population; and the private system, which attends to 5%. The private and complementary systems often overburden the SUS, mainly with the more expensive procedures, with the excuse that the government must provide universal care. The complementary system is perverse because it charges high monthly fees and transfers the high-cost problems to the SUS. Universality ends up being unfair.

Integrality combines prevention and treatment, but epidemiologists say that 45% of the day-to-day diseases of the Brazilian population are avoidable, emerging due to lack of infrastructure, education, hygiene, precarious feeding. The other 55% are inevitable diseases in any nation, like cancer. To attend to the population well, actions are required in prevention and treatment. It is thus not difficult to have integral medicine, which would avoid diseases in half of the population, because it involves infrastructure actions like basic sanitation, drinking water, safe housing conditions, education, which are deficient in the country.

The federal government, however, destines less than 2% of the GDP (Gross Domestic Product) to health. In 2010, there were R$ 55 billion, while the United States invested 13% of the GDP of US$ 13 trillion, and even thus the American population complains. It is impossible to do anything with the Brazilian financing. The country has 9th world GDP, is regarded as one of the most developed nations in terms of GDP, but if we analyze the HDI (Human Development Index), it is in the 73rd position. This means that there is money, however, health, education and other basic rights of the population are being neglected.
The decentralization is very intelligent because the right thing would be for each small city to define its health needs to create a system. But it is disregarded because the government recentralized for political reasons. The last precept of the SUS that does not work is social control, for obvious reasons. The SUS establishes that each city must have a community health council formed by the citizens, but there was a political dominion of these councils. None of SUS’ precepts work.

Other actions would have to be adopted and one of them is to value the medical class. Almost 60% of Brazilian doctors have three or more jobs because they earn badly. Another measure is to improve medical formation. Brazil currently has 170 medical schools, while the United States, with a population that is 30% higher, has 120. It is not bad to have many schools, but they must have a minimum quality criterion to defend the society.”

“It is impossible to improve management without innovating”

“There is no manager that can obtain success in a bad structure and financing, which is essential, must be invested in agile and efficient structure”, states Belfort, who also defends the ‘dehospitalization’ of medicine

“The great challenge of the governments is to stop repeating that more financing and management is required. It is impossible to improve management without innovating. Brazil has tried to launch structures that do not work for tens of years, under different rulers. The excessive statizing, bureaucratic and inefficient mentality of the health system, where there is often the situation of ‘you pretend to pay me and I pretend to work’ is an example. It is not timesheets and harsh sheriffs that will improve health.

It is essential to move on to new management models, recalling that Brazil is very big. Territorially smaller countries have regional systems, according to their needs. Brazil should not, with its size and diversity, want to have a restricted ‘pattern’ to solve everything. We need greater freedom, including for the universities and philanthropic institutions to be able to innovate. And it is no use trying to innovate management without a radical structural change.

It is unfair to demonize the managers. No manager can be successful in a bad structure. Financing, which is essential, must be invested in agile structure. The model of Social Organization, management partnership between the government and philanthropic, private, nonprofit organizations, is an example of good results and innovation. The Social Organization, which administers the health unit or system according to the rules of the State and in observance of the principles of the SUS (Unified Health System) is much more efficient, also because it has autonomy, which guarantees greater agility in making decisions.

There are Social Organizations in Bahia, Pernambuco, Rio de Janeiro and other States – where different parties are in power, and which are obtaining results equal or better than those of São Paulo, their cradle. The innovation worked and there are new alternatives, like the Public-Private Partnerships (PPPs) of Health, implemented in Bahia and now suggested for the São Paulo capital. Fortunately the federal government itself, even if still shyly, is beginning to admit new possibilities, with different acronyms. It is not about choosing one, but courageously allowing several options and, accompanying their trajectories, perfecting the choices.
They all have the same nucleus: to propose, in an innovative manner, mechanisms of great administrative efficiency, without compromising the essence of health management, as duty and role of the State, which imposes the rules, inspect and exercises control; and it is up to the society to act, under direction of the State, to obtain success and greater efficiency, with transparency.

It is important to prioritize human resource, which represents more than 70% of the investment in health. In the last 50 years, almost all the countries failed in obtaining improvement and greater efficiency in the structuring of human resources in health. Among the ‘failures of the last century’ is the fragmented care in an increasingly greater number of professions, whose activities overlap or collide even.

One must rethink the device used in the training of processionals, its relation to the system and, mainly, the quality of health schools, and not each of each profession, to forge the professionals of the 21st century according to the reality of Brazil, more adapted to the different levels of social development. The current model is restricted, serving the corporate interests, and the sector is turning into a stage of disputes, where the fundamental concept, that of professionalism, is forgotten. And professionalism is to place the interest of the patient-citizen above one's own.

A fundamental aspect, also, is the need to order the incorporation of new technologies in the university-industry binomial. Formerly, the patient would run to the hospital, place where good medicine was practiced. This no longer works, and does not need to, cannot even, continue. More and more, medicine must get to where the patient is. There is a need to ‘dehospitalize’ and ingest in technology, increasing the power of resolution and of decision of the health professional who is in the field and in the peripheral units.”

“Healthcare in Brazil is conducted by the SUS (Unified Health System) and by the private plans, the so-called supplementary health, but there is no integration among the systems, says Vecina

“It is time to do what is different differently”

The Brazilian state must reform its managerial equipment. The world had undergone deep changes in the last 20 years due to the neoliberal process of the economy in which the State increasingly withdraws from a series of areas, transferring the management to the private initiative, starting to perform a more regulatory activity, that of guaranteeing delivery. And the country needs to advance more in this process. The State is necessarily very isonomic, which is a disaster in the operation of institutions that must have results. It is time to do what is different differently. It is time to be contemporary. Therefore, a great challenge is management. And not just that of health, but of the entire society.

There is also the problem of financing. If we make a comparison today between the per capita expenditure of the public sector and of the public initiative, the public does not reach half of the private expenditure. There is a lack of resources and ways to increase this financing must be discussed, which is a role of the Congress, which must provide solutions to the great problems of...
the country. Constitutional Amendment 29, shelved in the House of Representatives for years, must be regulated. Brazil has many cross subsidies that generate inequality. The Brazilian society is full of goodness, which must be discussed and reevaluated, like deductions in the Income Tax from expenses with health plans.

Healthcare in Brazil is conducted by the SUS (Unified Health System) and by the private plans, the so-called supplementary health, but there is no integration between the systems. An example of how they ignore each other is that of cities of the São Paulo ABC region, where coverage of the health plans reach an average of 70% of the population. According to the norms in effect, the municipal health secretariats must cover 100% of the population, if there was money. But in these cities, 70% have health plans and this is olympically ignored. One must rethink the System if a population can buy medical care, what can be done for this to have a minimum integration with the effort made by society to cover the rest of the population that has no plan? We can no longer view the private sector as if it offered only sophistication and lack of queues.

The country must also create systems to regulate health access, with correct scheduling and fast attendance, which does not occur today in the majority of services. All health systems worldwide have queues, but they must be reasonable and democratic. The delay in attendance is unacceptable, which can take more than a year. The area of transplants is able to organize absolutely democratic queues. São Paulo no longer has queues for corneal transplants. This is the fruit of management capacity and can serve as example to other sectors. It is possible to be more effective and efficient. Just look at what the country has done in the area of Aids treatment, immunization, among others. These are good examples that can be universalized.

It is estimated that 8% of the Brazilian GDP (Gross Domestic Product) is generated in the space of health, between service provisioning and industrial production of drugs and products for the area. This data shows the economic relevance of the sector. However, the commercial scale in this area is very imbalanced. The country must induce, using the various instrument of the State, the production of knowledge, technology, innovation and product development. In science, in the generation of knowledge, it is more advanced. But it is lagging behind in the transformation of science into something utilizable, which is technology, and into products, which is innovation. There is need to move the private sector to incorporate capacity to produce technology and innovation. The private sector must absorb people with capacity to do this, create centers of innovation, it must have doctors and apply in risks. And it is in the management of this risk that the public sector must use its inducing capacity more daringly.”

José Saraiva Felipe
FEDERAL DEPUTY AND FORMER HEALTH MINISTER

“The SUS is experiencing a dehydration of its credibility due to lack of resources”

In the opinion of deputy Saraiva Felipe, either we seek a suitable and stable financing for the System or we rediscuss the model of integral and universal care set forth in the Constitution.

“One of the crucial problems of the new president is the health area. The SUS (Unified Health System) is experiencing a dehydration of its credibility due to lack of resources. It was the country’s biggest social achievement in the 1988 Constitution, the most progressive and the most inclusive because the State assumed the responsi-
bility of universal and integral healthcare. However, the public budget, that of the Ministry of Health in particular, did not at all follow this magnanimous and extraordinary commitment assumed.

At the time of the Constituent, it was considered within the budget of social security, which involved social security, welfare and health. However, in 1994, this was changed because the resources of social security were insufficient even to pay retirements and pensions, and the Ministry of Health became dependent on the general budget of the Federal Government. This caused, over the years, a drastic reduction in resources. In current values, there would be about R$ 112 billion, in view of the R$ 68 billion foreseen for the Ministry of Health this year.

To worsen the scenario, the attributions increased. Before the Constitution, the public health service attended only to beneficiaries of the pension system. The attendance is now integral and for all the 190 million Brazilians. Currently, the SUS is living with R$ 1 per inhabitant/day, about R$ 360 per year. All this explains why it is the area in which the government will face the greatest pressure.

Either we rediscuss the concept of universality and integrality of the SUS, which is not ideal, or we seek a suitable financing, through a stable source to prevent it from dying from inanition. Health must be rethought to save and revitalize the SUS because there is the risk of regressing in this achievement, which without financing and management can be rejected politically.

The State must guarantee this right to the population. It must leave other areas and assume this as an essential political matter. A form of putting more money into the SUS is to regulate Constitutional Amendment 29, which would add R$ 10 billion to R$ 12 billion to the federal annual budget. The municipalities are already overburdened and many spend more than 15% of the income, as defined by Constitutional Amendment 29. However, majority of the States, in a survey conducted about two years ago, did not even invest 6% of their own budget, instead of the 12% defined by Constitutional Amendment 29, and they also masked the figures. But any attempt to find a new source cannot fall into the trap we have already experienced with the CPMF. It cannot be a substitutive source, it must be additional.

However, it is no use putting more resources if there is no more homogeneous and professionalized management. There are places where the SUS works perfectly, but in other places it is too improvised, with people with neither graduation nor proper experience. The way out would be to advance in the decentralization process, with the Ministry increasingly becoming a regulatory, financing agency with technical condition to conduct a follow-up of attainment of the goals by the states and municipalities. For this, it needs more professionalized managers. The positions of health secretaries are sometimes mere political bargaining positions.

Without new and stable sources of financing, an alternative is to restrict the care: the SUS would continue to be universal, but no longer integral, and would offer only a care package. The excess thereof would not be the responsibility of the State.

One must also consider that there is a great tax relief with the discounts in Income Tax for those who have health plans or insurances. This subsidy totals more than R$ 20 billion per annum. Therefore, another alternative is to, instead of viewing the complementary sector, which is a reality, as an adversary, which is baloney, to establish dialogue for it to actually become a partner of the SUS.
“It is in the municipality that health occurs and it is the one that is investing the most”

According to the president of Conasems, basic care must be strengthened and the Family Health Program, one of the great success of the System, must receive double the investment per team

“Health must be reaffirmed as a policy of economic development and thus guarantee all the constitutional precepts of social security in implementation of the SUS (Unified Health System). The priority commitment now for the three spheres of public management is to operationalize and concretize the pact for health by complementing, qualifying and consolidating social inclusion by the public health system. The challenge is to enforce the Law.

Were it easy to provide health, the country would have already overcome all the challenges. The problem, however, is not only financing, management, political will, structuring or computerization, but rather a sum of all. It is clear that more (stable) financing is needed for this integrated process and this is a great challenge of the three spheres of the government. However, the Ministry of Health and the federal government will have to advance more in the next four years until they obtain application of 10% of the GDP (Gross Domestic Product) in the area. For this, one must work politically in order for the Congress to regulate Constitutional Amendment 29, which assures sources of financing.

It is in the municipality that health occurs and it is the one that is investing the most. Siops (Health Public Budget Information System) informs that more than 95% of the municipalities comply with the rules of Constitutional Amendment 29 and, out of these, a great part applies even more: 20% to 22% in health, when the Constitutional Amendment establishes 15% of the revenues. Therefore, it is not difficult to state that health occurs in the municipal sphere. It is on the door of the mayor that the patient knocks, on the door of the municipal secretariat and on the door of the basic unit.

Conasems (National Council of Municipal Health Secretariats) has the premise of strengthening basic care and there is need for improvement, for example, in the financing of the Family Health Program (PSF). There would be need to double what the Ministry transfers today per team, recalling that Brazil is highly diversified. The health programs are tied, as if they were based on a cake recipe that could serve the entire country. Which is a mistake because each region has its own peculiarities. If there is no budget, it is difficult to propose a differentiated financing that meets the regional specificities.

More and well managed resources. This binomial cannot be dissociated as it promotes greater quality, greater admission in the entrance doors, greater supply or purchase of medium and high-complexity service. To qualify the management is a function of all and this has been occurring in recent years through the creation of teams and continuous education programs. The Health Work & Education Management Secretariat, set up by the Ministry in the previous government, made this logic of the qualification of management clear as a premise.

The managing teams must be independent from the mayor, secretary and political party. The pictures must remain to maintain the cognitive patrimony, we may call it, in order for health not to lose the thread of things. This is being done and it is a challenge to continue this construction.
Health also needs a system of structured information systems based on the user, to aid and qualify the management from concrete data on the actual needs of the individual, and establish the medical professionals to meet the System’s demand. Today, in addition to the remote areas, there is a shortage or doctors in capitals and in big metropolitan regions. The problem is serious: how can one think of producing health without a doctor?"
run the risk of dying of inanition. Either leave the SUS or close the doors.

In addition to the discrepancy in the table, another great problem is the tax burden. In average, one third of the amount paid for any product, equipment, treatment, drug, input and hospital material is made up of taxes. Even the consultations of professionals are taxed at rates incomparable even with those of developing countries. This is an incoherence because health is an essential area. In 2009, the tax collected over the sector was R$ 30.5 billion, among federal, state and municipal taxes.

The Federation knows that a leap of greater quality in Brazilian health depends on stable and suitable sources of financing. The budget suggested for public health this year is R$ 70.9 billion and, according to the municipal secretariats of the sector, more than R$ 100 billion would be required. It is therefore fundamental to quickly regulate Constitutional Amendment 29.

A current discussion in the international ambit is the manufacturing of biosimilar drugs and the country is already late to start local production of this type of drug, which has a high cost, states Kalil

“The administration of costs is a serious problem. The costs of medicine are increasing and public resources are not always enough to cover everything. Problems of high complexity related to heart diseases and cancer are real because the treatments are more expensive. To solve part of this issue, Brazil needs to produce more generic drugs. Besides being cheaper by legal determination, generic drugs cause a competition in the market that favors the reduction of prices and, consequently, of costs, mainly for the public system.

In the area of generic drugs, a current discussion that occurs in the country but also in the international ambit, is the manufacture of biosimilar drugs, and Brazil is already late in starting local production of this type of drug. Biological drugs are much used in rheumatic diseases and cancer treatments, for example, and all their patents are starting to expire. Which means that we can produce them in the country, significantly reducing our dependence on importation and public expenses with these products.

Despite representing a small volume of the total, with about 2%, biological drugs are responsible for 40% of the State's expenses with drugs. That is, they are very expensive and regulatory bodies must speed up the regulation of biosimilar drugs in Brazil, which is still pending. The entire public administration is very slow, despite there being a concern by managers in obtaining greater speed, but this delay can imply in loss of competitiveness for the country, in addition to maintenance of higher costs that could be reduced for both the government and the population.

China and India are investing in the production of biosimilar drugs and Brazil has conditions to manufacture them, since it already has technological know-how for this. Instituto Butantan, for example, produces biological drugs for the area of vaccine, technology that can be used in the production of other types of products used in this category, and there is also an entire area geared toward the production of monoclonal antibodies.
However, the great question that exists today, and is definitive for the implementation of national production, is how will biosimilar drugs be produced in the country. What will be the requirements for registering these drugs? If they must have the entire process documented, from the preclinical stage, through all the three clinical research phases, to local manufacturing, it will take a long time and Brazil will lose the competitive edge it would have by launching these products in the moment in which their reference drugs start to lose their patents.

What will be the regulation for registration of these drugs is unknown because there is a discussion in the scientific sphere as to whether a biological drug with the same function of another, that served as reference, is equal or if this would have to be proved clinically. Since it is a molecule and not a small synthetic substance, each one would be a little different from the other, but at the same time with similar functions and very clear biological parameters that would waive the conduction of all clinical tests.

In addition to regulatory issues, without doubt, financing incentives would be welcome for the pharmaceutical industry to adapt in order to develop technologies in this area, as well as for training of human resources. The public policies are what define this type of work and they are not occurring as they should and in the right time.

“The State must have a map of the regional needs of health”

The first and biggest challenge of the government is to increase access to health for the poorer population, which is far from the main care centers, says the president of Albert Einstein

“Health is a permanent challenge for any government and country. Epidemiological conditions change systematically, the aging of the population evidences other types of problems and new elements do not stop appearing that interfere and lead to different pictures of diseases. It is a challenge for health professionals to better understand all these changes, to diagnose the problems and treat them. It is evident that from this comes another challenge, that of sustainability. To assure access to all this, there must be economic resources.

Society allocates, and will always allocate, resources to health, but the financing will always be less than required due to new challenges that appear each day in terms of diseases and cost of new technologies. This is a global reality. Were it not true, the Barak Obama government would not be so preoccupied with finding tools to make health more universal in the North-American system. In Brazil, however, the first and biggest challenge of the government is to increase access to health for the poorest
population, which is far from the main care centers. This problem of access results, particularly, from the policy of homogeneous health implemented in the country, which has continental proportions.

To guarantee minimum access and to have a differentiated plan, the State must have a map of the regional health needs because the standards of diseases found in the North of the country are completely different from those in the South and so on. There is also the need to encourage professionals in order to be successful in a health regionalization plan. Professionals must be encouraged with opportunities for growth and more adequate remuneration, and today, the SUS (Unified Health System) is a highly restricted platform to make these changes.

The alternative is to encourage the private health sector, because it has advanced more than the public system in meritocratic growth, remuneration by meritocracy. If the country is able, without political 'localisms and within the logic of the citizen's need, to encourage the private initiative to be a partner that supports the public sector, there would be opportunity for a much greater gain in terms of access to health. The model of this partnership, of course, cannot have a national standard, it must be heterogeneous. It must be regionalized to meet the different realities and demands of both investment and needs existing in the country.

Brazil, however, is advancing in the area of health. Today, party interferences are less and we are increasingly realizing that solutions for the System's problems must be born in the technical and not in the political field. The financing, however, should be greater for the Unified Health System to evolve more. Note that the resources should also be allocated more adequately. There is a problem in the administration and distribution. The manner in which resources are distributed today within the tripartite system –federal, state and municipal government, does not assure that they will reach those who actually need it.

In the area of supplementary health, there is a great concern with the regulatory process. Today, big companies are verticalizing certain services, that is, insurance companies also assume the function of service providers. This is a situation in which there are directions and opportunities for gains that do not necessarily reflect a free market economy. There is a concern in the regulatory mark with verticalizing processes, which should be treated differently. The government must encourage the agency that regulates the complementary health sector to be more independent, to create mechanisms that guarantee that the institutions work within a market economy, but protecting the interests of the citizens.”

“Bureaucracy strips Brazil of its competitiveness”

To increase access to drugs, one must increase free distribution to those dependent on the SUS, promote reimbursements to patients of private health plans and insurances and reduce the tax burden, says Bosio

“Without doubt the public health system has undergone important advancements in recent years. Also without doubt is the fact that there is still much to be done to guarantee the constitutional right of the Brazilian population to full access to health. In the area of drugs, for example, to increase access, there is the need to increase free distribution to those dependent on the SUS (Unified Health System), promote reimbursements to patients of private health plans and insurances and reduce the tax burden.

The public system has various drug distribution programs, like Farmácia Popular, but they are not enough.
In the private initiative, there are few plans that offer any kind of reimbursement, a model that would be an alternative for the public sector also. The result is that patients will remain sick because they simply do not have resources to buy drugs. Those who can buy them compromise the family budget and many treatments are suspended before the term because one cannot maintain the investment in the time prescribed. Majority of the poorest population can only obtain effectiveness in their treatments when they are hospitalized.

The result of this situation is that patients undergo more visits and tests than necessary and end up overcrowding the emergency rooms. Since their health problems are not solved, they return many more times to the doctor, overburdening the attendance systems, or they end up in the emergencies when the diseases worsen. The social cost and waste of resources applied in the System due to these failures are incalculable.

The free dispensing program of the public system also has other serious failures. Since financing is short, the drug basket of the government usually contemplates older products, that are cheaper but less effective. From the list of products to treat hypertension of the Farmácia Popular Program, for example, few are really effective. Only 30% of hypertensive patients who use these drugs are able to control blood pressure accurately. Hypertension is one of the main causes of cardiovascular problems, which cause 300 thousand deaths per year in the country.

Another important challenge has to do with inclusion of new technologies for treatment of more complex and expensive diseases. The process is precarious and slow, which limits the number of patients treated. In the last five years, only seven products were included in the SUS list. The government established a series of regulatory barriers and the inclusions only occur once a year and according to certain conditions. This limitation is certainly the fruit of the low budget of public health. The government recognizes that the new technologies are the best treatment options, but due to restricted resources, ends up limiting inclusion with delayed approval.

A delay that cannot be explained, however, is approval of the protocols for Brazilian research centers to take part in international clinical trials. The multinationals want to increase partnerships in clinical research here, but the bureaucracy strips Brazil of its competitiveness before the other countries. Although investments in clinical researches have increased in recent years, the potential would be three to five times greater were the regulatory bodies to be more agile. The participation of a greater number of multicenter studies, besides generating more knowledge for local scientists, would also be a way of encouraging the admission of new technologies and greater investments in Brazil.

Another serious problem is taxation. In a country under development like Brazil, with millions of people still living in conditions of absolute poverty, it is at least shameful that the tax burden on drugs reaches 30% of the final price, in averaged, while on various superfluous products there are lower tax rates, sometimes reaching zero. In drugs, the rate is higher, for example, than for many foods, veterinary products and even diamonds.”

“Approximately 70% of doctors are in the South and Southeast region, which shows that the distribution is very faulty in Brazil”
There are also serious conflicts in complementary health. Companies have presented enviable profitability, compared to other sectors. All are doing well, except for the clientele and service providers, states d’Avila

“A situation that significantly deteriorates public health in Brazil is the lack of a State career and adequate remuneration for doctors. In the Family Health Program (PSF), for example, except for some cities that offer better salaries, the contracts are precarious, without labor rights, like vacations and 13th salary, and there is no functional progression. Majority of doctors from the PSF regard the work as a temporary job while better opportunities do not appear in the job market. In many states, especially in the Northeast, professionals are also leaving the public service. Nobody wants to work in the emergencies of hospitals being remunerated badly and in adverse working conditions.

The Federal Medicine Board (CFM) delivered a letter to both president Dilma Rousseff and to the minister of health, Alexandre Padilha, claiming a career plan similar to that of the Judiciary Power and Justice Department. It also does not suffice to place a doctor with a stethoscope hanging from the neck in the interior of the states to solve the problem. The professional must have a complete team and attendance structure.

Another challenge is medical formation. Brazil has 181 medicine schools today and did not have more than 90 ten years ago. There was a great increase in the number of schools without any social necessity. The birthrate of doctors in the country is four times higher than the birthrate of the population. More doctors are born in Brazil than people. On the other hand, there are no vacancies for medical residency in sufficient number. While 15 thousand doctors are graduating each year, only 7.8 thousand residency vacancies are offered. Thus, each year the country records a great contingent of doctors who are unable to specialize.

Approximately 70% of doctors are in the South and Southeast region, which shows that the distribution is very faulty in Brazil. In Sergipe, for example, 93% are in Aracaju. There is lack of a public policy for interiorization of healthcare that considers the valuation of health professionals.

There are also serious conflicts in complementary health. Companies have presented highly positive balances and an enviable profitability, compared to other sectors. All are doing well, except for the clientele and service providers. Patients are dissatisfied, mainly due to the long time of waiting to be attended. And doctors are leaving the system due to feeling absolutely devalued.

Operators that remunerate better pay R$ 50 per visit. There are already some grassroots movements in some specialties against this abuse. In a period of 10 years, operators increased by 140% the value of the monthly dues and doctors had readjustment of 60%, while the inflation was 100%. Associação Paulista de Medicina [São Paulo State Medicine Association] has a calculation that shows that for a visit of R$ 35 paid to an operator, the doctor receives, in average, R$ 8.65, minus expenses of the consulting room, taxes, among others.

From this situation, we have a very perverse scenario: the doctor increases the number of daily attendances and, as a result, reduces the time of attendance to patients. In some specialties, there are doctors scheduling visits every 15 minutes. The CFM has alerted the National Supplementary Health Agency (ANS) and the Ministry of Health about this issue and the need to have adequate regulation to standardize the relation between operators and doctors.

However, the main challenge in the area of Brazilian public health is financing, which lacks a suitable and stable source. Perhaps this is why there are most of the other problems. It is very difficult to have efficient and quality health if there are no more resources, particularly in view of the difficult and population dimensions of Brazil. The worst is that Constitutional Amendment 29, which foresees a greater injection of public funds in the System, has been awaiting regulation for more than 10 years, due to absolute lack of political will. Approval of this Amendment would not immediately solve all the problems of public health financing, but it would meet a great part.”
The democracy of health lacks advancements

The Brazilian associations of patients are following the world trend “Nothing about us without us”, which means that they want to take part more in discussions and implementation of solutions for the sector’s problems, says Altenfelder.

“The structural problems of health are great and not exclusive to the country. Issues like financing, access to health, adaptation of drugs to the local realities, quality of management of public systems are global contexts and Brazil is inserted in this panorama. There are great challenges in this area because forecasts show that the world population will increase from 6 billion inhabitants in 2000 to 9 billion in 2050, and majority of this growth will come from developing countries, like Brazil. Most of these people, similar to what is today, use the public health system. It is too fast a growth for the public service to accompany.

The Brazilian population will also become more and more urban, with many living in centers of little development, that is, in the suburbs, highly dependent on public services. In view of this long-term context, how can health take part in the solving issues of local development and how it can meet the new needs of the area, from basic care to the most complex? On observing this panorama, the relationship with the interested parties is the great challenge because the government does not work alone, since it does not own the solution alone. Neither will implementation of the solution occur from the point of view of the government.

The government needs labs, medical societies, academies, associations of patients. There must be a very big spirit of cooperation because nobody can implement alone a solution and the relationship among the interested parties is highly strategic. It can help a lot in solving problems. And this has been a deficiency. Despite the regime in the country being democratic, the democracy of health lacks advancements. For it to actually exist, there is need for access, availability, and information. The information system in Brazilian health has deficiencies: the card of the SUS (Unified Health System) has not been implemented to date and it would be a kind of patient ID card.

The social dialogue, however, must be collaborative. Each part must see what it can contribute so as not to overlap the others. And the question of relationship, from the side of the patients, must follow the global trend of ‘Nothing about us without us’. This is a model that comes from outside, following the line of democracy ‘Nothing about us without us’. Patient associations are being shaped to assume this role, which means that they want to take part in discussing the problem, the solution and implementation of the solution.

Health organizations are seeking support to improve the quality of management, social mobilization projects, information campaigns for the population and to develop a more effective influence in public policies in the municipal, state and federal ambit. They are seeking better quality of funding and strategic view. A few have reached this level, but they have more effective operations. In São Paulo, for example, the NGOs are fundamental for implementation of the Antismoking Law.

With this paradigm of ‘Nothing about us without us’, they form a very clear line of operation. This occurs in Canada, Australia, England and other countries of Europe. It is a movement that implies a more comprehensive operation. And they can contribute greatly toward social cost, an information of high added value much closer to them due to the intense contact they have with the patients.
The associations linked to health are generally 10% to 15% of the total organizations, as indicated by studies conducted in some Latin American countries. Supposing that this data applies to Brazil, there are at least 28 thousand in health. These associations provide essential services to the population that the State is often unable to.

"Brazil depends a lot on imported medical products"

The new technologies are important, effective instrument and speed up the diagnostic and treatment process, but the incorporation is slow due to the high cost, says professor Jatene

"The incorporation of new technologies (whether drugs, devices or equipment) of good quality, at low cost and in real time has been one of the great deficiencies of Brazilian health. These technologies (usually imported) are effective instruments and speed up diagnostic and treatment processes, but it is not rare for the country’s health centers to have access to them only when they are already outdated due to their new generations, always being behind in relation to other health systems worldwide.

Good part of this problem results from the high cost of purchasing these new technologies, mainly when compared to the financing power of Brazil, whether private or public. Even those who are in the Brazilian supplementary health have per capita investment much less than the average in developed countries. And the per capital expenditure in Brazilian private health for people who have health or insurance plans is approximately four times greater than that of public health because the government’s problems of financing are real.

Budget restrictions, however, cannot be the reason for everything. There is need to create the concept that the new technologies can and should coexist with primary medical procedure, with simpler, more basic solutions of healthcare. They have to walk in parallel. There is no need to adopt a highly expensive technology to the detriment of basic care, but also one cannot ignore development because it is expensive, modern, an advancement. Brazil can try to incorporate new products intelligently and in optimized fashion. They do not have to be available everywhere, but in reference centers, in places with good geographical distribution so that a greater number of people can have access. One must seek paths for this.

Brazil depends a lot on imported medical products, ranging from drugs to inputs and diagnostic devices, like those of magnetic resonance. Taking part more intensely in the research and development of new drugs can help assure fast admission in the country, and without costs for the centers that will be part of the studies, of the most advanced drugs being produced in the world. However, approval of research protocols by regulatory authorities of the health system takes too long. The commissions are slow, delay in decision making and oftentimes the researches are concluded and Brazilian hospital centers do not even know if the answer was yes or no. The way out is to buy the equipment when there are resources.

A more active participation in the product research and development process would also be important for a long-term and more definitive solution to the problem: nationalization of part of these new technologies, which would make them from accessible from the economic point of view. Local development requires know-how and expertise, guaranteed by the studies. In the area of equipment, in addition to the cost reduction promoting a greater insertion of new products in health, the
national production also facilitates the replacement of parts, maintenance and technical assistance.

In order for nationalization to occur, however, public incentives are welcome in many aspects. The industry, whenever it proposes to do something, is implicit that it needs return on investment, even for the company's survival. It spends, but it must sell and profit in order to continue to develop. And one of the problems is exactly this. Sometimes, the equipment are for a restricted market, which usually does not encourage companies to invest. There is no magic formula to solve such issues, but one must certainly look at such problems with greater attention."

José Camargo
MEDICAL DIRECTOR OF THE TRANSPLANT CENTER OF SANTA CASA DE PORTO ALEGRE, PIONEER IN LUNG TRANSPLANT IN LATIN AMERICA.

"The public system is poorly administrated and is not concerned with being efficient"

The municipalization of health, idealized to better control public funds, created difficulties for access of the Brazilian population to the System, says Camargo

“Bureaucracy is the biggest hindrance in the Brazilian public sector. The SUS (Unified Health System), biggest public health system in the world, has a manner of administering that is little efficient. The municipalization of health, idealized for better control of public money, created great difficulties for access by people. A patient from the SUS with cancer, for example, has to cover a very long path between health centered and secretariats, after papers, authorizations and passwords, who on arriving at the hospital that can solve his or her problem, is usually at such an advanced stage of the disease that the treatments are little effective.

Those who use the SUS know that the journey to obtain treatment takes months, a precious time that makes the difference in maintaining the lives of patients. The municipalization of health created another injustice. For example, two brothers live in Rio Grande do Sul, one in the interior and another in the capital. The one who lives in the interior knows that only his vote is equal to that of someone who lives in the capital because in health he is doing very badly. If he ends up having a complicated health problem, he will die before he reaches the big city.

The bureaucracy is so insane that it obliges, in another real example, a patient admitted for heart surgery and who discovers he has cancer to be discharged and return to his or her heath center, in his or her city of origin, restarting the entire 'via crucis' to obtain treatment for the newly-discovered problem. Before, this would be resolved with the so-called inter-consultations, within the hospital itself. The impression one has is that the system was planned with this bureaucracy to make people quit treatment.

Health has another problem that must be equated: the demographic explosion. The growth of the population is still out of control. All the strategies in this area are very incipient. Brazil grows by one Uruguay per year. This deregulated increase without criterion occurs predominantly in poor families that, in 95% of cases, are completely dependent on the SUS. A basic action of planning in the area of health is control of birth. There is no way of multiplying resources to cover the population's multiplication.

An interesting proposal is the adoption of a model in effect in Chile, in which the State assumes all the costs of the more expensive health procedures, like chemotherapy, radiotherapy, transplants and highly complex
surgeries and thus health plans are able to offer lower monthly dues accessible to a higher percentage of the population. Thus, the SUS would be less overburdened and would give more qualified care to those who depend on it, those who actually need it.

In the case of transplants, there is another aberration: 35% of Brazilians have health plans, but only 5% of transplants made in Brazil are paid by them, that is, 95% of transplants are paid by the SUS. This is due to the fact that the National Health Regulatory Agency (ANSS) only determines that the health plans pay for kidney, corneal and bone marrow transplants. Anyone who has a health plan and must undergo another type of transplant will have to resort to the SUS. This is not fair to hospitals that transplant and receive derisive values, with patients who pay private plans and go to the nursery wards of the SUS, and to the SUS itself.

The public system is poorly administrated and is not concerned with being efficient. Therefore, there are several ‘brazils’ within Brazil. The country has medical areas that are real islands of excellence, renown internationally. However, the whole set is at a low level, and this disparity is reflected in technological qualification. There are transplant centers in the country compared with the most developed worldwide. But they are isolated centers and do not represent the mean of national medical care quality.

Brazil has completely unprotected areas. It is not possible to affirm that every Brazilian can undergo transplant by the SUS. This affirmation would be a lie. The population living in the North and Northeast has minimal chances of obtaining transplant through the SUS, unless it has money to migrate and obtain treatment in other areas. In these regions, transplants are not performed and the patient who needs one and does not leave will die. The distribution is very unfair.

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Paulo Hoff
DIRECTOR OF INSTITUTO DO CÂNCER AND EXECUTIVE DIRECTOR OF THE ONCOLOGY CENTER OF HOSPITAL SIRO-LIBANÉS

“It is society that must determine the ideal financing for the sector”

The incorporation of new technologies must be in the agenda of the federal government because Brazil depends greatly on imported inputs and equipment, says Hoff

“The guarantee of financing for health is a very great challenge for all the System’s administrators. Brazil has one of the lowest public expenses per capita with health in Latin America, which is a paradox considering all the level of development of the country currently. The Brazilian government invests less, for example, than the Mexican, whose system is similar. It is however the society that must determine the ideal financing for the sector, because the whole world is noticing the complexity of health and that there are no limits to supply all its needs. The solution, of course, also passes through a political decision of transforming health into a priority.

The delay in access to health in great part of the national territory results from the few resources. A difficulty that becomes more complicated as health problems increase due to lack of care, placing at risk the quality of life of the population. Another situation arising from underfunding is the quality of services. It is not because the care is free in the SUS (Unified Health System) that one should
not demand the same quality given to patients who have private services.

Today, one must think of a methodology for quality control of doctors who are graduating. There was a very great increase in the setting up of faculties of medicine in the country due to the perception that the number of doctors was insufficient to attend to the population. Brazil, however, currently has more faculties of medicine than the United States, whose population is 30% bigger. There are 180 schools here, while in the United States they hardly exceed 100.

It does not suffice to open schools; there must be quality and this still needs to be perfected in Brazil through assessments. The country has great doctors, but it also has professionals who do not correspond in quality to what is expected by the population. The poor formation of doctors is also due to the few residency vacancies. São Paulo State owns 30% to 40% of all the vacancies, but it does not have this same percentage of the Brazilian population.

Today, the graduate must have this complementation in his or her training to be able to actually work as a doctor because the practice of medicine is becoming more and more sophisticated. To improve access and the quality of public service, the remuneration must also increase so that the medical professional can dedicate himself or herself and avoid extenuating triple workdays.

The low incorporation of new technologies in the country is also the result of financing. They have a high cost, but Brazil can have creative solutions to speed up the implementation process. The system of research control in Brazil takes longer than in other countries, which in the longer term renders difficult the incorporation and also the development of national technologies. This subject must be in the agenda of the federal government because Brazil depends a lot on imported medical inputs and equipment, area in which there is a great deficit in the trade balance.

There is need to encourage the creation of a Brazilian medical-industrial complex geared toward innovation for the country to develop patents and be able to sell products abroad, competing in the international market. Of all the BRICs, Brazil is the one that has a less advanced industry in this area. China is famous for the production of diagnostic imaging equipment at lost cost and of good quality. India has a gigantic pharmaceutical industry and exports raw material to the whole world. There is already a medical-industrial complex in Brazil, but it must be encouraged to grow. The country, with a well outlined policy, can attract foreign industries to set up research centers and develop technologies patented here.”

José Luiz Gomes do Amaral
DOCTOR AND PRESIDENT OF THE BRAZILIAN MEDICAL ASSOCIATION - AMB

Dialogue in search for solutions for health

There is the need, within the apparatus of the State, to limit the power of influence of the various poetical parties whose interests are, almost always, not in line with the Government policies

“On mentioning the critical issue of healthcare of the Brazilian population today, we immediately refer to the corners of the country and the inaccessible and remote areas. We forget, or simply do not realize, that care in the suburb of the big urban centers is also disorganized and distant, maybe not geographically, but technically. Dismantling is a serious problem of the public health system in Brazil, but it is not the only one. The governance is compromised and fragmented and there is no fluidity in the dialogue in search for solutions.

The financing of health is essential, but before discussing how to seek more resources for health, there is need
to, within the apparatus of the State, limit the power of influence of the various political parties whose interests are almost always not in line with the Government policies in order for management to be more efficient.

To make the attendance network more efficient so that it meets the constitutional principles of equality through the country requires infrastructure and investment. The hiring of doctors and other health professionals is only one of the items.

However, we should not deceive ourselves with these and theories whose main argument is to relate improvement in healthcare of the population to increase in the number of doctors in the network of SUS (Unified Health System). We have enough doctors in the country and if the majority is in the private initiative, it is because the public system is very little attractive.

Were we to place today the 340 thousand doctors in activity to attend to the system throughout Brazil, the budget of the Ministry of Health, the highest of the Esplanade, would not be enough.

In order for the doctor to feel attracted to work outside the big centers, one must consider at the same time important aspects of what is being called "search for a positive work environment", which includes resolvability, accurate equipment for diagnoses, therapeutic resources, career plan, interaction with the local community and professional development. Recent studies show that Medicine is renewed by 50% every four years and recycling of knowledge and skills of the professional is not solved through the internet and telemedicine alone.

Admitting that the SUS today needs more doctors to balance the level of care throughout Brazil, a system of monthly rotation that allows taking to remote regions doctors of essential specialties can mean improvements in care of the population without the need to establish a professional. These doctors must have suitable formation and enough experience to face the challenges of caring for and treating patients in inhospitable areas.

Despite the challenges, there is from our part a great expectation and at the same time a frank dose of optimism in relation to the future. The minister Alexandre Padilha is an expert in dialogue, sensitive to the problems of the portfolio and of the public health system, and he knows the clinical practice. He can help a lot because the minister’s mission goes beyond the technical aspects. It requires courage and political will for the solutions provided to be long-lasting and adjusted to the Brazilian reality."
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