Public – private mix in the Brazilian health system: regulation, financing, and interests compromising equity

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Introduction

In this paper, we aim to analyze some constraints of the public –private mix in the Brazilian health care system, and how they may impact equity in access to health.

The classical definition of Whitehead (1992) considers equity in health as the condition where all individuals have the opportunity to develop their health potential, for which should be reduced or eliminated disadvantages avoidable and unfair. In Whitehead words *"ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential if it can be avoided. The aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those that result from factors considered to be both avoidable and unfair."*

One of those unfair factors, according to Whitehead, is the inadequate access to health services, as so as to other essential public services, linked to a broad range of social needs.

As argued by Ottersen et al. *"the deep causes of health inequity cannot be diagnosed and remedied with technical solutions, or by the health sector alone, because the causes of health inequity are tied to fairness in the distribution of power and resources rather than to biological variance."*(2014:7). In countries with massive inequalities like Brazil, there are numerous social conditions 'external' to health needs that are out of the range of health systems, although impact in health. If those social conditions limit the role of health systems, the system itself can have a high impact on their reducing. And will do so as more equity in access it can guarantee, which depends on elements that go from the type of funding to the model of medical care.

Universality, funding from fiscal resources and integrality are proved to be the best macro conditions combination to health systems address equity. That is the logic of universal public systems. On the contrary, equity is compromised where unexpected expenses on families and individuals, ability to pay and limits to health needs prevail. That is usually

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the logic of private or hybrid systems, where the public system is not universal, and the segmentation of coverage predominates.

Brazil has a unique health system with a universal and national public subsystem (the Unified Health System - Sistema Único de Saúde – **SUS**), financed by the State, and a large private subsystem **(PS)**, funded by companies and families, that serves 25% of the population. For medical care, SUS relies heavily on private providers, mainly for intermediary and high levels of care. The same providers serve SUS and the private subsystem.

The dynamics of Brazilian health care system has, therefore, two major types of public – private mix. One mix within the public system – SUS, with its contracted private providers. Another one between the public system - SUS and the private subsystem, formally separated.

Concerning equity, the core issue of the inner SUS mix is the fragile regulation and planning upon private providers to balance upper-cost services with low or middle-cost ones, usually the most needed by the population. The preference of private providers to best-paid services contracts prevails. As SUS has been underfinanced, the high-cost services (and medicines) tend to consume governments budgets, compromising access to services according to health needs, new investments in public owned services, health prevention, and health promotion. The combination of a fragile planning and regulation is complemented, or even caused by a complex, well known but yet scarcely investigated network of local interests that per pass the whole system.

The SUS – PS (private subsystem) mix, in turn, also compromises equity. Either when private health plans refuse attendance to patients, overloading SUS, or when health plans' patients are forward to SUS in units with contracts with both subsystems. Also, health plan expenses are deductible from income tax.

While pre-paid health plans offered by the private subsystem cover the middle and upper class, SUS is universal, free and covers around 150 million inhabitants, most of them poor or of low income.

The complexity and concurrent constraints of the public-private mix in Brazil can be attributed to fragile regulation, underfinancing of the public subsystem, and private interests with privileged access to government decisions. To explore these elements, we use recent data and research results on health services in Brazil.

Public- private 'mixes' in health

In Brazil, the deep imbrication between the public and private sectors in shaping the health services system predates the establishment of the Unified Health System (SUS). As Paim et al. (2011: 1781) state, "the Brazilian health system consists of a variety of public and private organizations that are set up in different historical periods," generating deep inequities in access and use of services.

Various studies (Oliveira and Teixeira, Andreazzi, Bahia) have addressed the interpenetration of public and private interests as one of the central features of the Brazilian health system throughout its historical trajectory, analyzing how The public-private mix was structured in the provision of health services at different times. During the years of the Military Dictatorship (1964-1985), the private sector was privileged, mainly through public financing for the construction of private hospital institutions, with the subsequent purchase by the State of the services offered by these same institutions. The implantation of SUS, from the end of the 1980s, did not break the imbrication between public and private. Rather, private sector starts to compete with the state for leadership in the dynamics of the area of health, mainly through the expansion of health insurance market.

Indeed, the power of influence of the private sector with the federal Executive and Legislative branches set an important veto point for the proposals of the reformist agenda of the health movement in the Federal Constitution of 1988. As a result of this process, the constitutional text assumed a Beveridgean conception for SUS, with the prevalence of the notion of health as a universal right under public responsibility. At the same time, however, in affirming the complementary nature of the private sector, the Magna Carta allowed different health business segments to act in defense of their interests, with repercussions for financing, management, provision and access to health care.

It can be affirmed that what has been established in Brazil is a duplicated coverage (Santos, 2011), in which SUS is a public health subsystem alongside with a vigorous private one. The implementation of SUS promoted a significant expansion of coverage of health services, especially in Primary Health Care (Paim et al., 2011; Porto et al., 2006) and to historically unattended areas such as the North and Northeast regions of the country.

On the other hand, hospital attention is mostly controlled by private units contracted by SUS (63% of the total beds in December 2016). Many of these units, as well as diagnostic and therapeutic support services simultaneously attend patients financed by SUS and by private health plans, forming a permanent source of conflicts and contradictions. This duplicity has been considered to generate inequalities in access, use and quality of health services as it produces financing arrangements and care networks that make it difficult to regulate the system (Santos 2011).

Secondary level is the bottleneck of SUS, with a low offer, difficult for scheduling services, no choice of professionals and long waiting lists (Porto et al. 2006). It is precisely at this level of care that private health plans are better and attract beneficiaries.

Victora et al. (2011) identify that providers who attend SUS and non-SUS patients offer a different menu of care according to the amounts paid, what influence the choice of procedure and the material used, affecting the quality of care and possibly generating adverse health outcomes. The authors conclude that this mix is an important constraint to the right to health.

The private subsystem has differentiated prices, differentiated controls, and differential medical logic. In Brazil, different from the US case, health plans did not introduce the concepts of managed care. The relationship between health plan companies and providers is still based on the extensive control over fee-for-service procedures, with constant conflicts due to denial of payment and recurring audits (Ribeiro et al., 2008).

In hospitals that cover double SUS and PS health plans, there is a constant exchange of patients who are admitted as beneficiaries of plans and are forwarded to SUS' beds, depending on the price + severity of the case. The private subsystem regulation agency – (National Agency for Supplementary Health – ANS), instituted in 1998 the obligation that health plan companies reimburse SUS for services used by patients covered by the private health plans. That has generated numerous lawsuits by corporations, which claim that being SUS universal, the reimbursement is illegal. Although the charge was considered legal, companies use various features to avoid payment. The fragility of the regulatory agency to collect this debt helps. From 2000 until 2016, only 46% of the debt was paid (ANS, 2017).

Changes have been taking place in the private subsystem in recent years, tending to the control of the market by big corporations, with a concentration of beneficiaries in a few. In December 2007, health plan companies and associations were 1,168, having fallen to 780 in December 2016 (ANS, 2017ª). The average annual growth of this market in the period from December 2007 to December 2014 was 2.8%. However, the tendency of increase has been diminishing since 2015, due to the economic crisis.

The number of beneficiaries, in March 2017, was 47,740,783, equivalent to 24.5% of the Brazilian population. The coverage varies more than 30% in the states of the Southeast and the national capital, and between 5 and 10% in some states of the North and Northeast regions. The health plans market is concentrated in the most economically developed parts of the country, where the segments with the highest payment capacity reside. At the same time, 80% of the plans are collective and, of these, 81% are contracted by companies for their employees, which implies shrinkage and loss of coverage in contexts of unemployment. ANS information indicates a reduction of 1,4 million beneficiaries in 2016.

These trends are associated with the fact, highlighted by Victora et al. (2011), that the overall price of health plans grow at a higher rate than inflation, while most of them do not cover higher-cost procedures. As a consequence, we have what Connil et al. (2008) called Hood Robin effect, where health plans beneficiaries can (and do) use SUS for high-cost procedures and drugs, while the poor population only has access to SUS. That represents a major distortion of the system. Examining the therapeutic itineraries of health

plan beneficiaries in the city of Florianópolis for various areas of care (cardiovascular, oncological, mental and obstetric health), the same authors identified that it is precisely in the high-cost procedures where there is a combined use of SUS and private subsystem (Connil et al., 2008).

Heterogeneity is a hallmark of the medical business within the private sector (BAHIA, 1999), but this is not a barrier to the organization of the sector. On the contrary, private health sector has outstanding performance with the Executive and Legislative powers, exerting massive lobbying in defense of their interests. Scheffer and Bahia (2013) identified a significant presence of health plan companies in the finance of candidates from different political parties and ideological matrices in 2010 general elections. Officially, candidates were funded in almost R$12 million (nearly U$ 4 million).

Among those candidates, were elected 38 members of the National Congress, 26 for state assemblies, five senators, five state governors and the president. Although the authors did not analyze the performance of these politicians in the interests of specific health plans, they argue the possible support or initiative of candidates present bills, reports, opinions, and votes for private health plan companies' interests, as so as vetoing propositions that contradict those same interests. Two specific points of interest have been the contracting of health plans for civil servants and the support for naming appointments to positions at the regulation Agency (ANS).

A recent good example was a Law including an amnesty for penalties applied to health plan companies, calculated in R$ 2 billion (near US$ 625 million). It passed both houses of parliament but was vetoed by Presidente Dilma Rousseff. For Filipon (2015) this may have already been a consequence of a strengthening of the lobbying of health plan companies arising from the opening of the national healthcare market to Foreign Direct Investment capital, also approved under the government of former President Dilma Rousseff.

According to the Inter-Union Department of Parliamentary Assistance (DIAP), the composition of the health bench in the national congress is composed of three distinct groups. One that defends the SUS and the responsibility of the state to guarantee the universal and public right to health; another that sponsors for-profit private sector interests, including health plan companies and, a third group that supports and defends the nonprofit sector, represented by non-profit hospitals. The disputes are intense among these three groups, but all have a consensus on regard to the increase of public resources for health. The health bench supported the law that decided for the allocation of part of the pre-Salt oil reserves revenues for health and education. That would have represented a significant increase in the SUS budget, but this measure has already been modified by the government that replaced former president Dilma Roussef.

Within SUS, local and state governments are important arenas of dispute with private providers, either regarding public funding or for the occupation of strategic positions in health secretariats, that control contracts.

One of the innovations carried out by SUS was the principle of decentralization, in which states and especially the municipalities started assuming a set of responsibilities in the provision and management of health services public health actions. The scope of this decentralization was unprecedented in the country and unparalleled in the international experience. The defense of decentralization went through the criticism of the state-society relationship pattern consolidated in the years of the Brazilian Military Dictatorship, profoundly marked by authoritarianism, centralization, and bureaucracy.

Viana et al. (2010) emphasize that decentralization of health was stimulated in the 1980s by the redemocratization agenda, therefore caring a strong political meaning. In the 1990s, in turn, decentralization was dependent on economic stabilization measures, which took little or no attention to planning and development policies that could include the health sector. In fact, decentralization in health took the path of the federative design, with difficulties to build schemes appropriated to the health dynamics. As a consequence, the results of decentralization were diverse and quite dependent on local previous conditions, which, far from overcoming existing inequalities, eventually reinforced them.

Despite that, decentralization contributed to the expansion of public coverage of health services and induced states and municipalities to increase their share of SUS funding. Piola et al. (2016) analyzed SUS expenditure from 2000 to 2010 and showed the growth of state and municipalities participation on SUS funding. The growth is more sensible and regular after the Constitutional Amendment (EC) 29 - which defined a minimum percentage of national, state and municipal budget to be spent in health –, and some stability on funding could be guaranteed. Official data show the share of municipalities in SUS funding rose from 21.7% in 2000 to 28.5% in 2010. Concerning States participation, it increased from 18, 6% in 2000 to 26,4% in 2010. However, the central government share decreased from 59,8% to 45,1% in the same period (Piola et al., 2016).

As a consequence of the economic crisis, public health expenditures fell after 2013. In 2014, the per capita per day public expenditure in health was of R $ 3.89 (near US$1,5). According to the WHO Brazil is below the average of health expenditure in the Americas. Taking 2013, while the annual per capita expenditure average in the Americas was US$ 1.816, in Brazil, it was 70% less, or US$ 523 (Abrasco, 2017). In comparison with countries with public and universal systems, Brazil public expenditure in health was 3.65% of GDP in 2010, against the average of 6,5% of those countries.

Decentralization and a regular increase in expenditures did not impact inter-regional disparities. The majority of municipalities depend on central government transfers, even allocating the mandatory minimum of their budget. But federal government transfer policy is not based on redistributive criteria; rather it has prioritized national programs which do not necessarily meet local needs.

Municipalities have constitutional autonomy to allocate health resources and may decide to buy services directly from private providers or invest in public provision. That is a core issue for understanding constraints within SUS. Besides little funding and an insufficient network of health services, most municipalities (they are 5570 in Brazil) have low

technical capacity to manage their local systems, which compromises planning and regulation. Moreover, local private interests influence the decisions of health managers, being through their control over the offer of health services or for political local parties interests, or both.

Many cities have 2 or 3 doctors that work for SUS and run private clinics or head small local or regional hospitals. It is common that doctors who have to work 6 or 8 hours a day for SUS, work only 3 or 4. Patients are forward informally to private offices, being charged for a consultation. A similar path occurs with specialists or therapeutic and diagnostic procedures, facilitated by the insufficient offer of these services in SUS. Curiously, this practice increased along with the growth of income experienced during the work's party governments. People, even the poor, sometimes prefer to pay than try public service. It has grown the offer of cheap health plans in small cities, a practice previously common on the impoverished peripheries of the large cities. This plans - which are informal because do not fill the regulation if the ANS -, offer a very limited basket of services, usually only consultations, and work as an extra stimulus for people to pay for exams, second level specialists and so on.

The idea that SUS 'does not work' is a powerful anathema spread out by the media, the middle class entitled to private health plans and even by SUS professionals. It is reasonable to consider that it represents the ideological side of the dispute. An ideology that joins economic interests to symbolic and cultural aspects, one feeding each other. Brazil is a strongly hierarchical society and aimed to build this without having to formally institutionalize the differences. An egalitarian system of healthcare will not be easily implemented.

Many local doctors or health entrepreneurs also head municipal or state health secretaries. It is prohibited to managed private institutions being in a public office, but the resignation to the position in the private system do not necessarily change the private interests. This chain of interests is well known but still scarcely studied at local and state levels. The investigations on corruption being carried out in Brazil have shown the chain of politicians and companies at the big players' scenario. Local mechanisms of interest mediation are not necessarily corruption. Rather they represent the country's historical characteristic of mixing public and private, with prejudice to the first.

According to Mancuso (2007), there are few studies in Brazil on the corporate action before the Executive, Legislative and Judicial powers at the state and local levels.

> *"Thus, there is still a lot to be done with state governments and city halls (be it at the top of government, secretariats, foundations, municipalities, public corporations and mixed-economy societies, or in lower-level civil servants) ; Legislative assemblies and city councils (at the level of the Presidency, the Presiding Board, the College of Leaders, the permanent and temporary committees, the parliamentarians and the functionalists of the houses) and to the judges located in the states and municipalities"* (Mancuso, 2007, p 139) (free translation by the paper's authors).

Final considerations

Concerning access to health care on public-private subsystems, it can be affirmed that after SUS there was a significant expansion of primary health care, which covers already 175 million people with tremendous impact on maternal and child mortality. On hospital care and diagnostic and therapeutic services, SUS depends heavily on private providers. This dependence compromises equity because 1)states and municipalities have autonomy to decide on contracts of private providers, but the majority of municipalities have small technical and regulatory capacity; 2) private providers have a high capacity for interfering in government choices, either because they control services, or because they control political capital 3) the public system is underfinanced, restricting investment and planning.

Regarding the SUS -private subsystem mix, it compromises equity as access to, and utilization of services in private health plans depend on income. Private companies are concentrated in the richest regions, the South and Southeast. The majority of beneficiaries are entitled through their employers, and health plans are very expensive for families and individuals. The regulation of the private subsystem is still weak and could not solve the major problems of this market, which are the mandatory reimbursement to SUS for services used by their beneficiaries and the reduction of consumers complaints due to denials of attendance and abusive prices. The use of the same providers of the public system allows arrangements to forward patients between the two subsystems, overloading SUS. Private subsystem count on public incentive as health plans can be tax deducted, while SUS is underfinanced.

Recent measures can intensify conflicts between the public and private subsystems, jeopardizing SUS. The government that assumed the presidency after the deposition of President Dilma Rousseff is actively pró-market. The Minister of Health is an engineer with no prior experience in health and had financial support from a health plan entrepreneur for his campaign to the National Congress (Folha de São Paulo, 2016). As soon as he took office, the Minister defended a ‘revision’ in the size of SUS. Recently announced the closure of the units of the public free drug distribution program. The program remains, but now only through private pharmacies and with a smaller list of medicines. SUS patients continue to have access to them at health facilities.

Another controversial measure was the reduction of the Mais Médicos (more doctors) Program. Former President Dilma Rousseff created the Program that hired about 18 thousand doctors to work in primary care in remote municipalities with difficulties to pay and fix professionals. The program was severely criticized by the medical corporation, for hiring foreign doctors, many Cubans, through an agreement with PAHO.

The Program has become the showcase of the Dilma government and has expanded basic care to more than 60 million people. Given its success, the current administration has maintained the Program, but will not expand it as planned. The Program also envisaged the expansion of medical schools to areas with a low rate of physicians per capita, a major problem of human resources in the country.

The most important proposal of the current Ministry of Health, still under study, is the creation of affordable health plans with reduced coverage. According to the Minister, this aims to 'unburden' the SUS. But can be interpreted as a clear incentive to the health insurance market. Experts have heavily criticized the initiative since the low effectiveness of the private health plans with reduced coverage was what led to the establishment of the regulatory agency (ANS) in 1998. The greatest gain of regulation was precisely the protection of users by defining a minimum mandatory basket of services.

The measure with the most significant impact on health, already approved by Law, is the limit to government spending for the next 20 years. For SUS, which has been suffering from low funding, is a critical blow. The National Health Council estimates a loss of R$ 424 billion (near US$ 135 billion) in the twenty years (G1, 2016). For education, the loss is estimated in R$ 25,5 billion (near US$7,8 billion) a year. Social policies will be hardest hit.

Two other reforms of broad impact in the social area are being discussed in the National Congress. The pension reform, which changes various aspects of legislation, such as age, time of contribution and tightens the rules of access to non-contributory benefits. The other reform is in labor protection laws, which significantly changes labor relations, making hiring rules more flexible. These two reforms have the opposition of unions and a significant part of public opinion. But they have the support of the market, which bets on its approval for the balance of public accounts.

Unfortunately, it seems that Brazil has entered the trajectory opposite to the evidence, which shows that in situations of economic crisis social investments can better the economic conditions. Quoting a Correspondence to the Lancet:

> *'Since only the state can mandate progressive payments and ensure that benefits are allocated according to need, only public financing systems can achieve the combination of universality, equity, and financial protection needed for UHC. Many of the governments that have learned these lessons are now the ones leading the charge for UHC to be included in the post-2015 agenda. ... These countries represent the new consensus on health financing: universal coverage can only be accomplished through public financing systems in which the state plays a leading part in raising revenues, pooling funds, and purchasing services.'*

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