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11. THE CASE OF BRAZIL

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I INTRODUCTION

According to the 1988 Constitution of Brazil, health care is an obligation for the State and a right for the citizens (Article 196). Therefore, since 1988 the health care system has been universalized and covers the entire Brazilian population in both urban and rural areas (Sistema Único de Saúde - SUS). The Federal Government bears more than 70 per cent of the global costs of the public health system, the States account for around 15 per cent, while the municipalities bear about 12 per cent. Since the 1980s, however, the trend has been towards an increase in the contributions of municipalities and a decrease in Federal contributions. The main source of revenue to finance the system is social contributions (Orçamento da Seguridade Social) and tax revenues. The latter are playing an increasingly crucial role, while social contributions are being devoted more to supporting pension funds than the health system.

In 1996 public health expenditures (including contributions at federal, state and municipality level) per capita in Brazil were around US$120, while global health expenditures (public sector plus private initiatives) were around US$ 300 per capita, corresponding to 3.5 per cent of GDP. In 1995 the budget of the Ministry of Health amounted to US$ 15 billion (R$ 15.8 billion) which

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fell to US$ 13.6 billion (R$ 14.1 billion) in 1996 and rose to US$ 18.7 billion (R$ 20.2 billion) in 1997. Brazil is among the countries in Latin America with the lowest investment rate in the health sector. In 1996 Argentina's global expenditure in the health sector reached US$ 600 per capita, corresponding to approximately 6 per cent of the GDP[2]. However, considering that public health expenditure per capita in Brazil was as low as US$ 88 in 1993, considerable, though not sufficient, improvement has taken place.

In order to increase the amount of resources available to the public health system, a tax applying to all bank transactions (Contribução Provisória Sobre Movimentação Financeira - CPMF) was established in January 1997. The tax, which corresponds to 0.20 per cent of all bank transactions, was supposed to remain in force for 13 months only. However, its application has been extended until the end of 1998. In 1997 the CPMF raised revenues of around US$ 6.4 billion (R$ 6.9 billion), which amounted to 6.1 per cent of total tax revenues and represented 30 per cent of the federal health budget[3]. The tax is not expected to solve the problem of lack of sufficient resources for the public health system, but only to provide temporary relief. Doubts have been expressed, however, regarding the actual destination of the revenues collected through the CPMF: some have speculated that revenues were also used for financing activities outside the health sector, while others claim that CPMF revenues were used to replace other federal contributions instead of being added to them.

The public health system is at present managed by three different authorities: (i) the Federal Government - which is in charge of policy development and planning at the federal level, scientific and technological development, rule setting and coordination and cooperation with the states and the municipalities; (ii) the states - which are responsible for policy development and planning at state level, technical and financial cooperation with the municipalities and coordination of their activities, and health education; and (iii) the municipalities - which are in charge of policy development and planning at local level, implementation of health activities, evaluation and control of health services, and health education at local level. The municipalities are expected, however, to assume a more significant role in the actual management of health services, with a consequent streamlining of operations and cost savings. On 1 January 1998, a new plan was put into action (Piso da Atenção Básica à Saúde - PAB). Under it, municipalities will receive from the Federal Government US$ 8.3 (R$ 10) per inhabitant to provide basic health services such as vaccinations and ambulatory consultations (the former system was based on ex-post reimbursement). This will allow municipalities to plan their health services better, to enhance controls and, it is hoped, to reduce fraud[4].

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[2] "Gasto per capita da saúde cai 7,6% em 96". *Folha de São Paulo*, 6 January 1997.

[3] Source: Secretaria da Receita Federal.

[4] " Em operação o Plano de Atenção Basica à Saúde". *Gazeta Mercantil*, 13 January 1998.

In general, the Brazilian public health system is regarded as inadequate to fulfil the role it has been given by the Constitution, mainly because of lack of adequate financing. Several factors have contributed to make the resources available insufficient, namely the emergence of new diseases - such as AIDS - which need long and expensive treatments; the re-emergence of diseases - such as cholera - which were supposed to have been eradicated; the persistence of other diseases - such as malaria, yellow fever and tuberculosis; longer life expectancy; the ageing of the population (in 1970 only 5 per cent of the population were more than 60 years' old; at present 11 per cent of the population are over 60[5]); the so-called "globalization of illness" due to domestic and international migration; the extensive and cumulative use of technology; and the need to face serious sanitation problems. The fact that the system has become universal, while undoubtedly representing a positive step towards the achievement of the goals of the 1988 Constitution, has placed a further burden on the public health budget, thus contributing to the deterioration of the system.

Along with insufficient financing, however, the problem of lack of good management and of appropriate controls is increasingly mentioned as one of the main reasons for the collapse of the public health system An audit carried out in 1997 by the Ministry of Health showed that at least US$ 557 million (R$ 600 million) belonging to the federal health budget go missing every year. Most states seem to be unable to supervise the activities carried out by public hospitals and ambulatories and to ensure compliance with the rules laid down at federal level to prevent abuses[6].

Parallel to the deterioration of the public health system, a private health system has emerged, which at present covers around 41 million people - corresponding to 25.6 per cent of the Brazilian population - and which raises about US$ 13.3 billion per year (R$ 16 billion), corresponding to 1.6 per cent of GDP. The private sector has expanded rapidly: the number of people who have joined a private health scheme/insurance increased by around 38 per cent between 1987 and 1995. According to some estimates, by the year 2000, 57 million people are expected to be members of a private health scheme/insurance. The disparity between the public and private sectors is striking: the private sector - which has to serve only one quarter of the population - can offer around 4,300 hospitals, more than 370,000 beds and 120,000 doctors. On the other hand, the public service - which has to provide full health care for the remaining three quarters of the population and for those under private health plans/insurances for

[5] Source: Instituto Brasileiro de Economia da Fundação Gétulio Varga, October 1997.

[6] "Governo muda saúde em ano de campanha eleitoral". *Jornal do Brasil*, 28 December 1997.

treatment which is not covered by those schemes - has fewer than 7,000 hospitals, around 565,000 beds and 70,000 doctors[7].

The private health system includes several types of arrangement: health maintenance organizations (HMOs) where the patients have access to a certain number of hospitals, clinics and doctors which are members of the HMO (medicina de grupo); health cooperatives (such as UNIMED); self-management systems, which provide health care to the employees of large firms (Auto gestão); administrations, which are health systems directly managed by large firms (Administração), and health insurances. These different systems have approximately the following shares of the Brazilian private health market: HMOs around 42 per cent; health cooperatives around 25 per cent; self-management systems around 17 per cent; administrations around 5 per cent; and health insurances around 11 per cent. Among the different systems, health insurances are enjoying particularly rapid growth[8].

Private health plans (excluding insurances) are, for the time being, subject to virtually no rules, so that, for example, the minimum coverage of the health plans, the maximum premium increase which can be charged according to the age of the patient, the minimum capital necessary to start activity, the places where new hospitals and clinics can be established, minimum requirements relating to the quality of the services provided and other similar crucial points are subject to no discipline at present. It is most probably because of this lack of regulation that the Brazilian Association for Consumer Protection ranks private health plans among the activities which cause the largest number of complaints. On the other hand, health insurances are subject to the general rules that apply to all kinds of insurance (e.g. economic-financial reserves amounting to 50 per cent of turnover).

However, some major changes may come about. In early 1998, Congress was discussing a draft law which, if approved, would bring many changes to the sector, the main thrust being to establish clear rules according to which private health plans should operate and to open the Brazilian market to foreign companies also in this field. The expected result would be a fairer and more competitive market[9]. However, the draft law, which was approved by the Chamber of Deputies in October 1997, has little chance of being approved by

[7] "Setor tem 50 mil médicos a mais que o SUS". *Gazeta Mercantil*, 22 September 1997.

[8] *Gazeta Mercantil*, 22 September 1997.

[9] Among the main provisions included in the draft text are the following: the activity of private health plans would be strictly regulated (they would be obliged to offer a "reference plan" - plano-referência - which would cover all illnesses classified by the World Health Organization, plus three additional less expensive plans with more limited coverage). The premium increase related to the ageing of the members would be regulated and contracts would be automatically renewed. No time limitations for hospitalization would be allowed. The coverage for retirees and unemployed would also be regulated. "Em busca da cura paga". *Veja*, 22 October 1997.

the Senate. Both medical and consumer associations were lobbying, for different reasons, against the law. However, the delay in adopting and implementing appropriate rules for health plans does not seem to serve the interest of Brazilian citizens.

The relationship between the public and private health systems is somewhat disaccordant. In particular, the private sector tends to believe that the public sector is unable to fulfil its obligations of providing health care to the whole population. Therefore, it would prefer to see it concentrating on the basic health needs of the country, such as vaccinations, prevention campaigns, actions against epidemic diseases, sanitation, and provision of health care only to that segment of the population which is unable to join any private health plan. In other words, the private sector would like to see the public health system reducing its role as direct supplier of health services, while increasing that of rule-maker. In particular, most feel that there is a need for clearer rules in the market, which could ensure fair competition.

On the other hand, the public health system is very attached to the role it was given by the 1988 Constitution; therefore it is reluctant to accept privatization of the health system and commercial exploitation of health care. According to it, the privatization of health care would lead to further marginalization of the rural areas and would be of no benefit to the majority of the Brazilian population who have to rely on the public health system.

II TEMPORARY MOVEMENT OF CONSUMERS

Care of foreign patients

Despite the high quality of health treatment that a number of Brazilian hospitals can provide, the very good image that some of them have (for instance some Brazilian hospitals have already been granted the ISO 9002 certificate on quality management), and the luxury accommodation they can offer, the presence of foreign patients in Brazil is very sporadic.

Usually, foreign patients are either visitors who are in Brazil for working purposes or tourism and who happen to need health care, or foreigners who live in Brazil. The case of foreigners who go to Brazil looking for health care is rare. In most cases these patients come from other South American countries and are relatives or friends of doctors who have studied in Brazil and are still in touch with their former professors and colleagues. In other cases, foreign patients are sent to Brazil to receive health treatment which is not available in their home country. In these cases, the health insurance of the patient usually pays for the treatment. However, when the foreign insurance refuses to pay and the patient cannot afford the cost of the treatment, the SUS bears the cost.

The general lack of interest by potential foreign patients in the health care provided by Brazil stems from the fact that those hospitals which would appeal to them are usually very expensive private hospitals. In Sao Paulo, for instance, the best hospitals charge fees which are sometimes higher than those charged by

well-known hospitals in the United States. Some health insurances are even offering Brazilian patients the option of receiving health care in the United States, since in certain cases the costs of treatment in the United States and transportation are lower than the cost of the same treatment in São Paulo. Amil, an HMO, has included in its network of health institutions a number of hospitals in the United States. It is also offering, through Amil International Health Corporation (based in Miami), assistance to its Brazilian clients who choose to be treated in the United States (e.g. translation, interpretation, transportation from the airport to the hospital)[10]. Transmédico, another company based in Florida, was set up in 1993 also to help Brazilians who wish to obtain medical treatment in the United States[11]. Several large hospitals in the United States are also targeting the Brazilian market by recruiting doctors and administrators who are able to speak Portuguese, by sending brochures to Brazil, and by offering preliminary consultations by fax[12].

The main reason for this situation is the lack of sufficient health infrastructure in the country: even though the number of those who can afford to pay for health treatment in a private structure is limited, it nevertheless exceeds the facilities available. Therefore, the best Brazilian hospitals can charge fees equivalent to or higher than those charged in most developed countries, knowing that they will have enough patients (in the best Brazilian hospitals the occupancy rate is around 85 per cent). Because of the high occupancy rate, in general private hospitals have not developed any strategy aimed at attracting foreign patients.

As far as the public system is concerned, the shortage of facilities for the local population has made it impossible to think of developing a strategy to attract foreign patients, even though some of the public hospitals are in a position to provide highly advanced health treatments.

There are, however, some exceptions. In Rio de Janeiro, for instance, a famous plastic surgeon attracts a substantial number of foreign patients (40 per cent of his patients are foreigners), and has greatly contributed to establishing the good reputation of Brazilian plastic surgeons in general.

Foreign students in the health profession

Some of the most prestigious Brazilian hospitals - usually those linked with the best universities - receive a number of foreign doctors, especially from other South American countries, who are usually interested in postgraduate courses. However, Brazil has never tried to make it a profitable activity: foreign

[10] "Mercado global da saúde, uma realidade lá fora". *O Globo*, 13 July 1997.

[11] The company helps Brazilian patients to find the right doctors and hospitals and takes care of bureaucratic formalities. It is reported that, on average, Transmédico takes care of 1000 Brazilian patients per year.

[12] "Tratamento mais barato é a nova atração do exterior". *O Globo*, 13 July 1997.

doctors are charged at the same level as local doctors attending the same specialization courses. Doctors from Portuguese-speaking African countries usually benefit from scholarships in the framework of technical cooperation agreements.

III TEMPORARY MOVEMENT OF HEALTH PERSONNEL

Even though a number of Brazilian doctors go abroad for postgraduate qualifications (especially to the United States and some European countries), they usually return to Brazil at the end of their studies. A foreign diploma or a period of training abroad may facilitate their career and provide them with access to better working opportunities.

A specific case is the migration of Brazilian dentists to Portugal during the 1980s. This was, however, linked to particular circumstances, namely, the economic crisis that Brazil faced in the 1980s; the fact that at that time immigration laws in Portugal were quite favourable to Brazilian citizens; the shortage of dentists in the Portuguese market; the special nature of the dentistry profession in Brazil, where, unlike in Portugal, a dentist does not need to be a doctor, since the two professions are quite separate; and cultural affinities.

Brazil faces a shortage of nurses, especially highly qualified ones, therefore the phenomenon of nurses moving abroad has not occurred. On the other hand, Brazil is not attracting foreign nurses, since the working conditions and salaries are not competitive.

Foreign doctors have difficulties in establishing themselves in Brazil, since procedures for assessing the equivalency of diplomas are rather complicated. Additional conditions may be requested by the professional associations, for example, foreign health professionals have to pass very strict qualification tests. Like several other large countries, Brazil faces the problem of a shortage of health professionals in rural and remote areas, but it does not appear that this shortage will be overcome by foreign professionals.

In the framework of MERCOSUR, a committee has been established to deal with the health sector. One of the issues it is supposed to address is the free circulation of doctors among the four Member countries of the group (Argentina, Brazil, Paraguay and Uruguay). However, this seems to be a particularly difficult subject, especially since the professional associations also have their own position, which does not always coincide with the government's. Therefore it seems that the Committee is giving priority to other questions where the chance of reaching agreement is higher. In December 1997, the four countries of the group signed a framework agreement which envisages the liberalization of trade in services within the bloc, to be negotiated in successive rounds of offers (including exceptions). However, at present it is not known how health services will be handled within this context.

The same Committee is also discussing the issue of reimbursement of health treatment for citizens of a MERCOSUR country receiving health care in another country of the group. According to the proposal under discussion, an

agreement should be set up among the public health systems of the four countries, allowing citizens of one country to receive health care in another on the same conditions as at home. At the end of each year the national health systems of the four countries would calculate the costs that they have borne of providing health care to foreign citizens and, if necessary, ask for compensation. The main obstacle to implementation of this proposal is the lack of similarity among the four national health systems. On the other hand, it seems that in the framework of private health plans, in particular medical cooperatives, some initiatives are being taken to allow patients enrolled in a medical cooperative in one country to be treated in another country by a "sister" medical cooperative.

IV FOREIGN COMMERCIAL PRESENCE

Under the 1988 Constitution, foreign firms and foreign capital were not allowed in the health sector, unless there was an "interest of the Brazilian Government" or, in specific cases, as regulated by law (Article 199,3°of the Constitution and Article 52 of the Transitional Provisions).

This situation changed in May 1996, when the Minister of Finance asked the President of the Republic to open the Brazilian market to foreign capital and companies in the field of health insurance. The main justification for this request was the commitment of the Government to give consumers further protection by raising the quality of the services offered, lowering their prices and establishing a fair level of competition in the market.

As already mentioned, the private health system in Brazil has evolved in a rather particular way. While the number of people interested in participating in the private system has increased at a very fast rate, the supply of health insurances and other kinds of private health plans has not been expanding at the same speed, thereby generating lack of competition, high prices and rather inefficient management.

In May 1996, the President of the Republic authorized the opening of the market to foreign firms and capital in the field of health insurance, although it is still closed to foreign participation as far as private health plans are concerned. This means that at the moment only around 11 per cent of the private health market is open to foreign competition. The market of hospitals and clinics is also closed to foreign participation.

Since the health insurance market has been opened, around 20 transnational corporations have established themselves in Brazil, either through joint ventures or acquisitions[13]. North American insurance companies seem to be the most successful in penetrating the Brazilian market, probably because of their expertise in the sector. European insurance companies, which have less experience in the health sector, are nevertheless showing interest in the Brazilian

[13] "Golden Cross recebe US$ 200 mi". *Gazeta Mercantil*, 17 December 1997.

market, especially because if they start activities in the health sector they are also allowed to operate in the areas of life insurance and pension funds.

It seems that the presence of foreign insurance companies has already produced some improvement in the Brazilian market, namely, companies are already offering insurance packages which provide better coverage and are beginning to save on administrative costs. However, prices are not going down as expected. The main reason seems to be the fact that foreign insurance companies are still not allowed to invest in hospitals, clinics, and so on. Therefore they have to operate in a market characterized by a shortage of health infrastructure and very limited competition.

As mentioned above, there are no specific rules applying to health insurances: they have to follow the general rules that apply to insurances in any other field. On the other hand, until the above-mentioned draft law is approved, there are virtually no rules applying to private health schemes.

V CROSS- BORDER TRADE

The best public and private hospitals have established links with each other and with hospitals, laboratories and universities abroad. The availability of technological communication tools is of great importance in a vast country like Brazil, where there are still areas of difficult access, with very scanty health infrastructure. However, at the moment only the best and largest hospitals are able to benefit from improved communication facilities. Hence, trade through this mode of supply has not really evolved in Brazil.

VI CONCLUSION

Brazil is facing several problems in the area of health care. The public health system has not sufficient resources to meet the needs of the population, therefore it is offering a service which in most cases is not adequate from either a quantitative or a qualitative point of view. Deterioration of the public system and improvement of the economic conditions of a (limited) number of the population have led to the development of a parallel private health system. Coexistence of the two systems is not easy. However, it is clear that there is no alternative to it, since those who can afford to join a private health scheme/insurance will continue to do so, because they do not trust the public health system. On the other hand, a large proportion of the Brazilian population does not have the means to participate in any private health initiative and therefore has to rely on the services offered by the SUS. Moreover, a number of areas such as prevention campaigns, sanitation, vaccinations - which are very relevant for the country - clearly fall under the responsibility of the public health system. In 1996, the Government decided to start opening the Brazilian health market to foreign investments in order to cut costs and improve quality; for the time being, however, the opening is limited to health insurances. Discussions are

proceeding on the possible opening of the market also in the segment of private health schemes.

The challenge is, therefore, how the public and private sectors can coexist, benefiting from each other's presence, bearing in mind that, whereas for the public sector, the ultimate goal is to protect citizens' health by ensuring equitable access to health services and appropriate quality, for the private sector, the final goal is profit.

The lack of a sufficient number of hospitals in the country has led to a situation where patients in the public sector frequently have to remain on long waiting lists before receiving the treatment they need, with all the risks that this implies. Patients in the private sector, on the other hand, have to pay extremely high fees to obtain access to the private infrastructure, while the real beneficiaries of the situation seem to be the private hospitals and private health plans which operate in a situation of virtually no competition (partly owing to the fact that the Brazilian market is still closed to foreign investment in these fields) and in the absence of rules.

The fact that all the best public and private hospitals have an average occupancy rate of around 85 per cent and charge high fees makes Brazil completely unattractive to potential foreign patients. This happens despite the fact that Brazilian hospitals are among the best in South America and, in some cases, from a technological point of view they are as advanced as the well-known hospitals in Europe and the United States.

There could be an interest in exploring the option of further opening of the Brazilian market to foreign firms and capital. The presence of foreign-owned hospitals might alleviate the problem of bed shortage and increase competition in the market, resulting in a decrease in prices and an improvement in quality. More affordable prices could both make the private health structure accessible to a number of people who cannot afford it at the moment - reducing the pressure on the public health system - and attract foreign patients who, for the time being, may find prices in most developed countries more attractive than in Brazil.

The public sector would therefore also benefit from this new situation. Part of the population would shift towards the private structure, leaving more human and financial resources available for those who stayed with the public health system. Moreover, if public hospitals were under less pressure, they could sell some of their services for profit.

This phenomenon, even though on a small scale, is already occurring in some prestigious public hospitals. Even though they are public, and in principle cannot devote part of their facilities to private patients, they still do so. The fees they charge to private patients serve to pay part of the costs that cannot be borne by the traditional financing of the public system. Thus, those public hospitals can guarantee high-quality treatment, attract prestigious doctors and benefit from advanced technology, despite the very scant resources made available to them by the public health system. The challenge is to find the right balance between the number of facilities to be offered to the private sector in order to generate extra financial resources and the need to have a sufficient number of beds,

doctors, equipment and so forth, available to public patients. At the moment this balance is very difficult to find, considering the pressure under which public hospitals operate. However, the situation could improve if there were more hospitals available in the country and fewer patients who relied on the public system. At this point, public hospitals could also start thinking about a strategy to attract foreign patients to Brazil.

Future opening of the market to foreigners in the field of health schemes (as opposed to health insurances) and the setting-up of clear rules in this sector might also be beneficial to the country. Foreign competition would most likely encourage private health schemes to become more efficient and offer competitive packages, while regulations would oblige them to include fairer conditions in their proposals in regard to coverage, premium increase, renewal of contracts and contractual conditions for the elderly and the unemployed. In particular, broader coverage would have the effect both of encouraging customers to join private health schemes and allowing them to use the private infrastructure for virtually all their health needs; as a consequence, the public system would have more room for those patients who have access to it alone.

However, the likelihood of further opening of the Brazilian health services market to foreign companies and capital being beneficial to the local population has more chance of materializing if this process were accompanied by the setting of appropriate rules. Regulations might establish minimum criteria for the entry of foreign companies into the Brazilian market, indicate the minimal coverage that private plans and insurances should offer, and include some conditionalities on the presence of foreign firms in Brazil. In other words, if Brazil wishes to open its market further to foreign competition, it needs to provide an adequate framework. Large firms and transnational corporations operating in the areas of hospitals, insurances and health plans may abuse market power and take advantage of the lack of rules. To ensure that the process of increasing competition and fairness in the market is carried out in the most efficient way, the State may consider the option of playing a less crucial role as health services provider and as a source of financing, while expanding its role as rule maker. The law which Parliament was discussing in 1997/98 would go some way towards solving this problem. This would be in line with the reform of the State undertaken since the mid-1990s which envisages the withdrawal of the State from the role of goods and services provider in many sectors (leaving space for private suppliers) in favour of strengthening its role as regulator (although the State would keep a key role as services provider in the health sector, unlike the case for some utilities). Given the economic, social and political complexity of such a process, however, the disengagement aspect of this reform has been privileged, while the process of setting up regulatory bodies and institutions has in many cases lagged behind. These features can also be observed in the field of health services.