HEALTH FINANCING PROFILE - BRAZIL

Over the last three decades, Brazil has made significant investments in social programs, including a comprehensive healthcare system. Since returning to democracy in 1985 and with the 1988 Constitution, quality healthcare has been explicitly identified as a right of citizenship and a responsibility of the government.[1] The Unified Health System (**SUS**) that provides free universal care for all Brazilians was instituted following a sustained push from civil society organizations.

With the subsequent declines in poverty that followed re-democratization, the country has also seen concomitant declines in under-five mortality and maternal mortality as well as increases in life expectancy.[2] Coverage for vaccinations and pre-natal care is almost universal.

Brazil's Primary Care Strategy (which includes the Family Health Strategy) marks a meaningful shift from curative hospital-based care to preventive ambulatory care with a strong pro-poor focus.[1] A highly decentralized system has led to complex patterns of funding and service provision with the Federal, State and Municipal governments involved.

Before formation of the **SUS**, Brazil's healthcare system was dominated by private organizations that received large government subsidies. Brazil's system remains highly privatized with the private sector receiving substantial funds from all levels of government.

Health Finance Snapshot

Total Health Expenditures (THE) per capita have increased steadily since 2003 with increased investment in resource-intensive social programs aimed in part at improving Brazil's primary health care system.

Though Brazil has a free and universal public health system, general government expenditure on health remains below 50% of THE. The combination of out of pocket and private insurance spending, at over 50% of **THE**, is among the highest levels of private spending on health in Latin America.

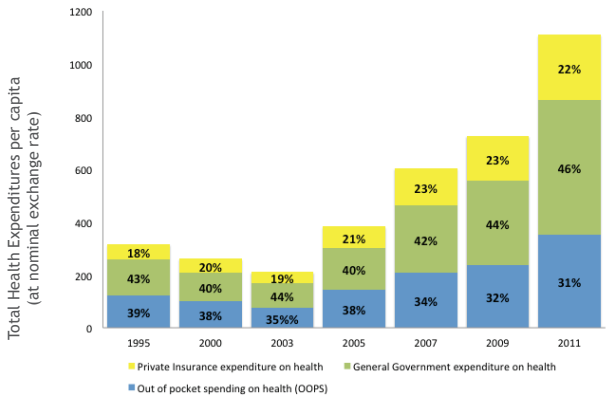
Table 1. Health Finance Indicators: Brazil

	1995	2000	2003	2005	2007	2009	2011
Population (thousands)	161,848	174,425	181,633	185,987	189,798	193,247	196,655
Total health expenditure (**THE**, in million current US$)	**51,153**	**46,189**	**38,806**	**72,060**	**115,775**	**141,824**	**220,363**
THE as % of **GDP**	7	7	7	8	8	9	9
THE per capita (USD at official exchange rate)	316	265	214	387	610	734	1,121
General government expenditure on health (**GGHE**) as % of **THE**	43	40	44	40	42	44	46
Out of pocket expenditure as % of **THE**	39	38	35	38	34	32	31
Private insurance as % of **THE**	18	20	19	21	23	23	22

Source: WHO, Global Health Expenditure Database; National Health Accounts, Brazil

- More than 1,500 private health insurance providers make up the **Supplementary Health System (SHS)**. The **SHS** serves close to one-quarter of Brazil's population, mainly through corporate health plans that companies offer their employees.[3] These beneficiaries often utilize free public facilities for complex tertiary care.
- **Out of pocket spending (OOPS)** as a share of **THE** fluctuates but has not varied substantially (Table 1, Figure 1):
  - OOPS does not include private insurance premiums
- **OOPS** as a percentage of income for households at the lower end of the income distribution remains lower than for wealthier households.[4]
- Only 2.2% of households in Brazil incur catastrophic health expenditures (30% threshold), one of the lowest levels in Latin America and the Caribbean.[1]

Figure 1. THE per capita by type of expenditure, Brazil



Source: WHO, Global Health Expenditure Database; National Health Accounts, Brazil

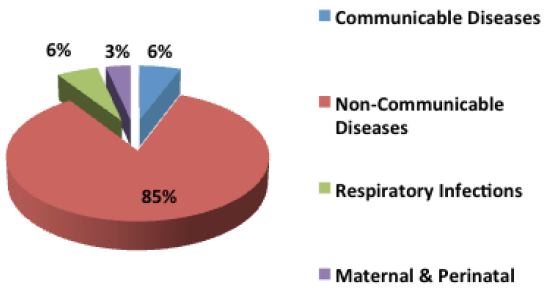
Health Status and the Demographic Transition

Brazil has experienced the epidemiological transition so that non-communicable diseases have supplanted communicable diseases as a leading cause of morbidity and mortality. Though the **total fertility rate (TFR)** has fallen from 4.1 in 1980 to 1.8 in 2012, we find that younger cohorts are still well represented relative to older cohorts for the time being (figure 3). By 2020, the proportion of the population of age to enter the labor market is expected to be larger than ever in Brazil's history.[5] However, this favorable population structure is not expected to last for more than a decade in light of Brazil's aging population and low fertility.

Epidemiological transition

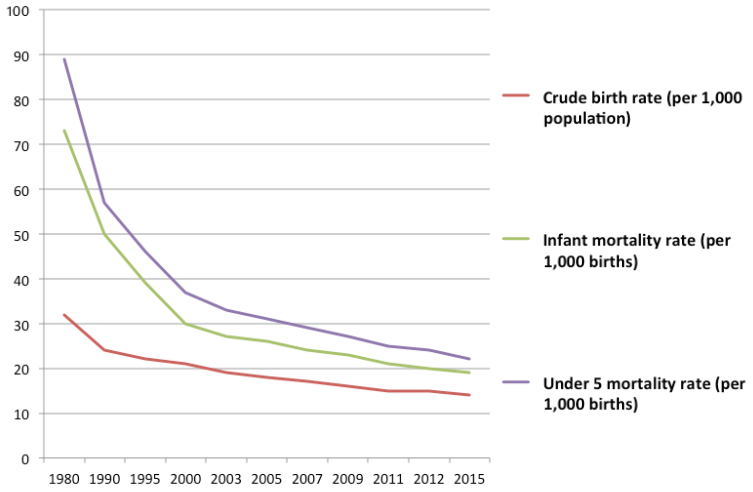
- Non-communicable (chronic) illnesses have far surpassed infectious diseases as major killers (Figures 4 and 5).

Figure 4. Mortality by Cause, 2008



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 2. Demographic Indicators: Brazil



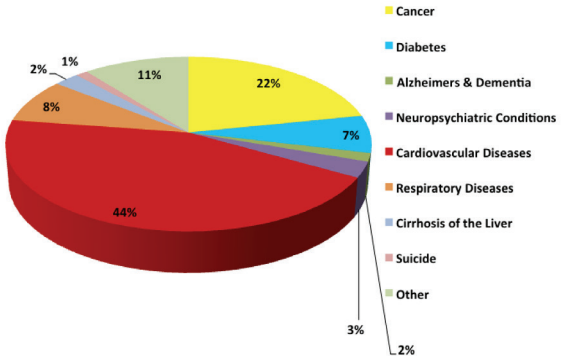
Source: United Nations Statistics Division and the Instituto Brasileiro de Geografia e Estatistica, Brazil.

Table 2. International Comparisons, health indicators

	Brazil	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US$)	3,593.3	1,899.0	89.2%
Prenatal service coverage	98.2	93.8	4.7%
Contraceptive coverage	80.3	80.5	-0.3%
Skilled birth coverage	97	98	-1%
Sanitation	79	73	8.2%
TB Success	72	86	-16.3%
Infant Mortality Rate	17.3	16.5	4.8%
<5 Mortality Rate	19.4%	19.6	-1.2%
Maternal Mortality Rate	56.0	53.2	5.2%
Life expectancy	73.1	72.8	1%
THE % of GDP	9.0	6.1	47.4%
GHE as % of THE	58.6	54.3	7.9%
Physician Density	1.8	1.7	4.4%
Hospital Bed Density	2.4	3.7	-34.5%

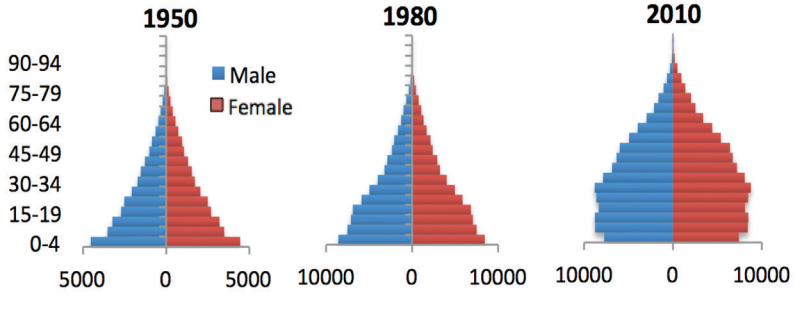
Source: Couttolenc and Dmytraczenko. "Brazil's Primary Care Strategy", World Bank, UNICO Series No. 2, 2013.

Figure 5. Non-Communicable Disease Mortality



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 3. Population Pyramids of Brazil



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

Health System Financing and Coverage

Brazil's 1988 constitution defined health as a right of citizenship. To this end, the **Unified Health System (Sistema Único de Saúde, SUS)** was created with the aim of unifying the many and fragmented systems that were in place before. Much of the health system was decentralized with responsibility passed to states and municipalities and minimum financial contributions for health at all three levels of government were eventually legislated.[1] The bias towards curative and hospital care is being transformed into a strengthened primary care system with a new focus on public health. Universal access targets are being supported by **results-based financing (RBF)** mechanisms primarily in relation to transfers from the federal government to municipalities.

Figure 6. Timeline of Brazil's Unified Health System (SUS)

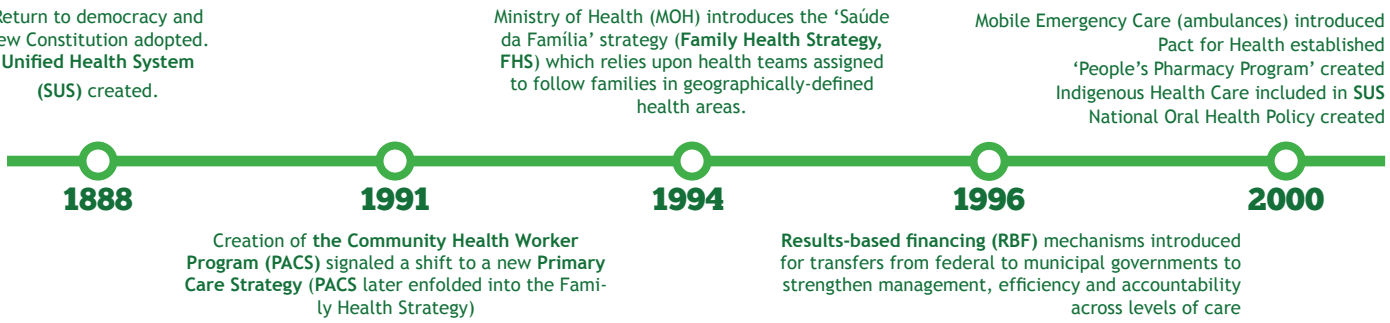


Table 3. SUS Financing after year 2000

	% Contribution of gross tax revenues
Federal Government	6-7%
State Governments	12%
Municipal Governments	15%

Financing for the **SUS** comes from all three levels of government (Federal, State and Municipal) with each making a mandatory minimum contribution of their tax revenues (table 3) and social contributions following a 2000 constitutional amendment.[1]

With the highly decentralized structure of Brazil's health system comes highly complex financial flows from higher to lower levels of government and from all levels of government directly to both public and private health facilities (table 4).

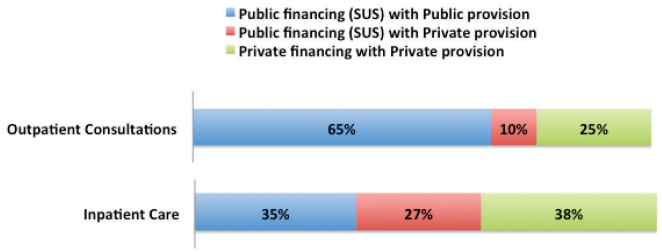
Table 4. SUS Decentralization and Funding Channels

Level of Care	Type of Service	Level of Government Responsible for Provision	Predominant Form of Service Provision	Funding Source(s)
Primary Medical (Básica)	General outpatient services (preventive, diagnostic and curative)	Municipalities	Public outpatient (ambulatory) facilities, often 'Family Health Clinics'	- Federal transfers (Capitation system and results-based transfers to municipalities) - State transfers to municipalities - Municipality's own funds
Secondary Medical (Média Complexidade)	Specialist outpatient and inpatient	- States and some larger municipalities - Federal Government	- Private sector facilities - MOH referral hospitals - Ministry of Education (MoE) teaching hospitals	- Federal transfers to states and municipalities - States and larger municipalities (using federal and own funds) contract with private facilities -Federal funds go directly to MOH and MOE hospitals
Tertiary Medical (Alta Complexidade)	Complex services: Organ transplants, HIV/AIDS treatment, hemodialysis, etc. Diagnostic: MRIs, CT scans, etc.	States Federal Government and States	Public hospitals - MOE teaching hospitals - Private facilities	-Federal transfers to States - State funding of public facilities using Federal and State own funds - Research grants & other private sources - Federal financing for MOE hospitals - Federal transfers to States -State contracts with private facilities (using Federal and state's own funds)

- Services under the public **SUS** system are available to all Brazilians without user fees, copayments or financial contributions, except for the People's Pharmacy Program where copayments are necessary.
- Approximately 67% of the Ministry of Health's budget for "Public Health Services and Actions" goes towards **SUS** (20% for primary care actions and 47% for secondary and tertiary actions defined as being of 'medium and high complexity').[6]
- The remaining 33% of the **MOH** budget goes towards Public Health Services such as health and epidemiological surveillance, assistance for nutritional deficiencies, human resources capacity within **SUS**, scientific and technological development of SUS institutions, production, procurement and distribution of pharmaceuticals, blood (and blood products), medical equipment, etc.[6]

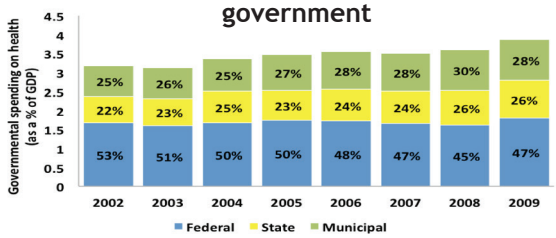
Private financing for private provision (i.e. outside of **SUS**) accounts for a large share of total financing: (figure 7)[1]:

Figure 7: Distribution of Care by Type and Subsystem



The Federal Government is the largest funder of **SUS**. With decentralization, its contribution has been declining since the early 1980s, from around 70% to less than 50% now. States and municipalities now contribute over 25% each of total **SUS** financing (figure 8).

Figure 8: SUS financing as share of GDP by level of government

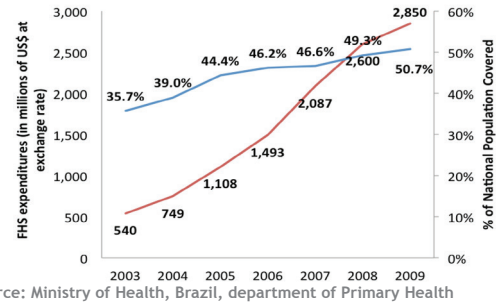


Source: Ministry of Health, Brazil, Sistema de Informações sobre Orçamentos Públicos em Saúde - SIOPS

Brazil's Family Health Strategy has become the flagship program of the **Primary Care Strategy (PCS)**. Family Health Teams (Equipes da Saúde) are considered key to **PCS** success.[7]

- Health Teams follow residents in an assigned geographic area (maximum of 4,000 inhabitants) and typically comprise a family physician, a nurse, a nurse's assistant and 6 community health workers (**PACS**).
- **FHS** are responsible for outreach, preventive and curative services as well as health promotion and referrals.
- In some areas, only **PACS** are present and are considered a transitional team, helping to usher in the **FHS** in stages
- A 10% increase in coverage of the **FHS** program has been associated with a statistically significant 4.5% fall in infant mortality.[8]

Figure 9. FHS Expenditures and Coverage 2003-2009



Source: Ministry of Health, Brazil, department of Primary Health

Since 1996, the **FHS** has been the focus of Brazil's efforts to increase efficiency and accountability through results-based financing:

- The variable **PAB** transfer is now results-based, offering incentives for the implementation of priority programs (primarily the **FHS**).
- In 1999, the variable **PAB** transfer was amended to be based on the Family Health Strategy's population coverage. **FHS** coverage quickly grew after introduction of this financing mechanism.

Emphasis has shifted away from curative care, towards primary care. The Primary Care Strategy (including the **FHS**) has had a pro-poor focus[1]:

- The number of public clinics and health posts has more than doubled since 1990, while the number of hospitals has not changed significantly.
- **FHS** first deployed in rural areas and poor urban areas of the Northeast and Northern regions.
- Federal transfers to municipalities for primary care (Piso da Atenção Básica or **PAB** transfers) have a "fixed" portion (fixed payment given per municipal resident) and a "variable" portion. As of 2012, municipalities with a higher percentage of their population either receiving the Bolsa Familia or classified as 'extremely poor' (whichever is lowest) receive a higher fixed **PAB** (i.e. higher per capita transfer amounts for poorer municipalities)[1].

Financial Sustainability[1]

- There are no explicit cost-containment approaches used for the **PCS**, apart from the availability of funds.
- No systematic cost-effectiveness analyses are performed with budgets often based on outdated estimates.
- **SUS** provides a full range of free services, not explicitly excluding any service from coverage.
- Overall public health financing of the **SUS** is considered inadequate while legislators find it difficult to increase its financing.
- The balance between public and private is challenging with considerable funds flowing from public coffers to private providers.

References

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