

An argument for explicit rationing of health resources within the public-private mix in Brazil

Um argumento a favor da racionalização explícita de recursos de saúde no sistema misto público-privado no Brasil

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Three years ago, the forum on the rationing of health services ¹ provided an excellent starting point for discussing means of distributing healthcare resources more reasonably within Brazil. Recently, an overview of the Brazilian healthcare system concluded that the most sizeable barrier to securing the right of healthcare for every Brazilian is, in fact, political ². World Bank policy analysts have recommended the building of accountability for the improvement of poor performance in Brazilian public hospitals, which consume 70% of the nation's public spending on healthcare ³.

In this manuscript, building on the forum for the rationing of health services, we shall argue that, as a minimal requirement for the securing of the right of healthcare for all Brazilians, decision-makers must be accountable for the rationing of limited healthcare resources across the mixed public/private system, ensuring equitable access to essential health services for all citizens and engaging citizens in the determination of how this should be done. Explicit rationing will be required for building accountabilities within the public/private mix and for the ensurance of legitimate societal participation in the difficult task of distributing limited healthcare resources fairly and reasonably ⁴.

Rationing within the Brazilian public/private mix

The provision of universal and comprehensive healthcare is intangible, even in the world's wealthiest nations, including Brazil ⁵. Decision-makers who allocate resources are challenged with the high costs of evolving medical technology and competing with societal demands for a range of public goods, in addition to health care, such as energy, education, transport, infrastructure, etc. Rationing decisions occur at different levels of every healthcare system, implicitly or explicitly ^{4,6}. Mixed public/private healthcare systems present additional challenges to decision-makers, because there are marked differences in governance and accountability between the private and public systems. A recent analysis of the Supplementary (privately financed and delivered) system in Brazil suggested major discrepancies between the government's neoliberal approach towards the private healthcare sector and the actual focus on the private healthcare insurance companies ⁷. Evidence suggests that the two systems compete for limited health resources ^{8,9,10,11}. As a result, the Supplementary system draws human resources from the public system (Brazilian Unified National Health System – SUS), thus decision makers for SUS are left scrambling to staff their health services in a sustainable way.

Private health care accounts for more than 50% of health care expenditure in Brazil, although it serves only 25% percent of the population ¹². Brazilian children and youth have less access to the Supplementary healthcare system than do adults and the elderly (16.5% versus 24.3%) ¹². This difference is even more striking on a regional basis. For example, only 6.7% of Brazilian children and youth, from the North and Northeast, have access to the supplementary healthcare system, as compared to the 43.3% of adults and elderly of the state of São Paulo ¹². Interest groups and empowered citizens, who drive health policy changes in Brazil, generally have access to privately financed healthcare and are not used to waiting for medical services in the same line in which 75% of the population must wait. For 25% of Brazilians who have access to the Supplementary healthcare system, or who pay out of their own pockets for the same, healthcare services can be purchased as commodities of variable quality, just like cars or flat screen TV's. As such, the empowered civil society in Brazil doesn't see the problem of access to healthcare in their backyards. However, citizens who enjoy access to privately financed (and delivered) healthcare are exposed to inappropriate delivery of healthcare services in the form of, for example, unnecessary surgical procedures. Brazil's standing as the world record holder for cesarean deliveries ² is but a single example of this fact. National Health Conferences occur every four years at the municipal, state and federal levels in order to provide guidance for the implicit rationing of

the SUS, however, there is no parallel process that explicitly governs rationing in the Supplementary system¹³.

Principles for rationing healthcare resources

Ham & Coulter⁶ reviewed and compared explicit processes for rationing healthcare resources in diverse publicly funded healthcare systems. Distinct values and principles emerged in each priority setting process, such as individual right to healthcare, cost-effectiveness, efficiency, fairness, and dignity. International experience with explicit processes for the rationing of healthcare resources in the State of Oregon (USA), Scandinavian countries, the Netherlands and New Zealand suggest the need to focus on fair processes to facilitate societal learning on how to ration healthcare resources reasonably^{4,6}. Similarly, in Brazil, neither random citizens¹⁴ nor Brazilian bioethicists¹⁵ can agree on what constitutes reasonable allocation of healthcare resources. Nevertheless, building upon the forum for the rationing of healthcare services¹, we argue that the explicit rationing of healthcare resources, both in the public and Supplementary systems, must occur in order to enable societal education and legitimate participation in the shaping of modern societal values in Brazil regarding the financing and delivery of healthcare services.

Contributors

F. Ferri-de-Barros developed the argument and written manuscript. J. Gibson edited the manuscript for intellectual content. A. Howard revised the text for intellectual content.

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