

## Foreign capital and the privatization of the Brazilian health system

O capital estrangeiro e a privatização do sistema de saúde brasileiro

El capital extranjero y la privatización del sistema de salud brasileño

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The political and economic bases of the Brazilian Unified National Health System (SUS) were shaken early in 2015, with the approval of the *Amendment to the Constitution n. 86* (EC 86), that makes clear the underfinancing of the SUS, and of *Law n. 13,097*, that allows participation, directly or indirectly, of foreign capital, in health-related actions and care.

By imposing on the Federal Government the financing of individual parliamentary amendments, and by binding federal expenditures on health to the net current revenues, EC 86 will decrease the amount allocated by the current legislation, which is already too restricted.

Thus, the legal regulation enhances the financial constraints of the SUS, which include lack of compliance with the *Federal Constitution* that earmarked at least 30% of the Social Welfare budget to the health area; the removal of the Social Pension Fund from the resource calculation base; the distortion of the Provisional Contribution on Financial Transactions (CPMF), among other reductions.

To make things worse, EC 86 makes politically unfeasible, at least in the short term, the Popular Initiative Project *Saúde+10*, signed by more than two million Brazilians, that would have a more reasonable budget if at least 10% of the federal government's net current revenues were allocated in the health area.

The presence of foreign capital in the health area – from multinational companies in case of investments and trade, from major banks in case of financing, and from pension funds that operate with speculative capital <sup>1</sup> – was banned by the Brazilian *Federal Constitution* and the Health Act, with the exception of loans from international bodies, or technical cooperation, or connection with the United Nations.

However, since 1998, the *Health Plans Act* has allowed foreign capital in supplementary health care enterprises, leading to the understanding that even health-care companies that owned hospitals could benefit from foreign investments.

Health care was, therefore, partially open to international investors who became shareholders of health-care companies of hospital organizations related to them. Foreign resources had also been allocated to diagnostic test labs, in this case with the consent, not the authorization, of government bodies.

The General-Counsel of the Union (AGU) deemed this law unconstitutional, and recommended that the comprehensive permission of foreign capital in general and specialized hospitals and clinics, even in those non-for-profit, be vetoed, but no heed was paid.

Direct Unconstitutionality Suits brought before the Brazilian Supreme Court (STF) by civil society organizations stressed the constitutional

provision that expressly bans foreign capital in the health area, and raise an awkward situation: the original text of the SUS law is kept, but, after the addition of a comma, an opposing text is included. In practice, there is the possibility of foreign capital to be allocated in each and any health act and service, as now the Brazilian health legislation has two opposing policies in the same rule.

Beyond the legal controversy, the public underfinancing of health established in the Constitution, combined with the unrestricted opening of the health area for foreign capital, should foster privatization, as leaders of the private sector state their immediate goals of expanding the established capacity of beds and services for health-plan clients.

Privatization implies transferring functions and responsibilities, in full or partially, from the public to the private sector<sup>2</sup>. There is also an interest in active privatization<sup>3</sup>, i.e., the process through which the government makes political decisions that actively encourage the increase of private participation in the health area.

In the midst of a number of directives and lack of actions that have resulted in the breakdown of the SUS, the wide opening of the health system to foreign capital occurred without its actual motivations being known, or its consequences being openly discussed by the Brazilian Congress or assessed by social participation forums.

It was a victory of private hospitals, pharmaceutical companies and health maintenance organizations that advocate the entry of foreign capital and intend to increase the role of the private sector in the formulation of national health policies<sup>4</sup>, expansion of the private sector, and to secure tax relief and reduction.

The foreign funding serves as an alibi to justify a reduction of public expenditures in health in a time of fiscal consolidation and the permanence of SUS underfinancing.

The Federal Government is the main guarantor of foreign capital in the health area, both by deregulating and encouraging the growth of the health-plan market, which will benefit directly from the private hospital and diagnostic units that were expanded with foreign resources, and by procuring these services to mitigate the insufficiency of the SUS's provision of semi-complex care. Perhaps this is the driving force behind the *More Specialties* program, defined in the electoral campaign of 2014 as "a network of clinics with specialists and diagnostic tests".

The experience in education is enlightening. International funds have been attracted to invest in mergers and acquisitions in the higher-education market because of the credits

from the Higher-Education Student Financing Fund (FIES), and the University for All Program (PROUNI), which led to an excess of private undergraduate courses without the minimum quality requirements.

As they are volatile and speculative, foreign investments will select beds, tests and procedures that generate high financial returns, particularly services delivered according to private values and preferences, in a negative selection that avoids care of populations that live in distant areas, away from health care resources, older people, severe chronic patients, patients with mental disorders, and other patients that require ongoing care.

The expansion of a private healthcare network as such will increase the individualization of demands, direct payment in popular clinics, and the procurement of health plans cheaper in price, but with contractual traps and major coverage restrictions. Once again, the SUS, the public fund, will be used as guarantor, and re-insurer of private operations.

As private expenditures replace public expenses, the obstacles for justice and equity increase. Whenever private providers ensure the selling of their services per delivery, without commitment to health outcomes, the risks of wasting resources and of skyrocketing health system costs are tremendous.

Capital intended to generate returns will hardly be committed to healthcare needs, which require policies focusing on the reduction of diseases and deaths, and acting on the social determinants of health.

The universal system, a single system for rich and poor alike, based on health as a right, on the redistribution of wealth, financed by society as a whole by means of taxes and social contributions, thus gives way to a segmented system, unable to ensure access to all levels of care, in all regions of the country, including gaps in public health and in care of vulnerable, neglected populations, where and for whom the private sector has no interest in providing services.

The private health sector in emerging markets offers attractive returns for investors<sup>5</sup>. However, foreign investments in private health structures of mid- and low-income countries provided targeted improvements in the quality of highly specialized hospital services, accessible to a limited clientele, but they were also accountable for a predatory dispute for human resources, making the lack of doctors and other health professionals in public facilities and in remote areas even worse<sup>6</sup>. In Brazil, current standards already suggest that the excessive use of the private health services competes unfairly with the

public sector, draining human and financial resources from the SUS<sup>7</sup>.

Foreign capital advocates are the same that finance electoral campaigns, and have media networks to construct the myth of the private sector being more effective, and to promote the theory that the universal system is not sustainable. They use the word privatization as little as possible, and it is attenuated by words and expressions such as public-private partnerships, competition, quality, efficiency. They count on a quiet opposition by the public health movement, the cornering of health councils and conferences, the silence of unions and organized workers, and the omission of political parties that, in an electoral year, eliminated from the candidates' agenda any mention to foreign capital in the health area.

The modalities of health financing express the values of a society<sup>8</sup>. The principle of equality of people in face of disease and death, regardless of their social status and origins, is shared by republican, ethical and humanitarian ideals.

With the underfinancing of the SUS, and the suppression of barriers to the entry of foreign capital, Brazil follows the opposite path, the path of iniquities, generated by having health as a commodity and its conversion into merchandise. Citizens who have rights become clients; health services that could be assured in the universal system are transformed into competing companies.

Foreign capital in health care is an issue little addressed in the international literature, as the presence of American funds and companies, both in health-care insurance and delivery of hospital care, diagnostic services and therapy could not cross national borders until the 2000s. This issue is also left out in writings on global health. However, there are references about foreign investments related to medical tourism in developing countries<sup>9</sup>.

Brazil emerges as a country that is mobilizing private resources from commercial banks and international funds to expand health care services to those who can, directly or indirectly, afford them.

It is urgent to develop a national research agenda to provide the basis to track the impact of foreign capital in the privatization process of the different components of the health system: health financing, service delivery, management and investments.

Without the development of new knowledge that matches the complexity of the current health scenario in Brazil, and without the democratic engagement (yet to be aroused and developed) in the firm defense of the universal system established in the *Federal Constitution* more than 20 years ago, one can passively watch the downturn that leads the SUS to conditions that undermine its legitimacy more and more.

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