

Private health expenditures in Brazil

Gasto privado em saúde no Brasil

El gasto privado en salud en Brasil

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Introduction

The *Brazilian Federal Constitution* of 1988 established that health is “*a duty of the State*” and “*a right of the citizen*”. According to the law, every citizen is entitled to use the Brazilian Unified National Health System (Sistema Único de Saúde – SUS), in line with their social needs, regardless of their ability to pay, occupational status or health conditions. To ensure universal care, the State should have targeted its efforts to improve health equity and quality over the past 25 years. Health, however, is open to the private sector, and the Health Maintenance Organizations, which are very stringent in selecting their risks, received considerable governmental incentives, whose subsidies largely favored the use of private goods and services ¹.

For public health specialists, it is not easy to deal with this discrepancy. The distortion of this “system” tends to segment SUS’s public character, and the increase of private expenditure and the economic power corrode the sustainability of state funding, leading to a vicious circle characterized by the relative drop in payments and direct investments by the government. In addition, the regulation of a duplicate system is more complex for the State, as the private sector also provides services covered by the public sector.

Differently from the Beveridgian system and similarly to the American model, once the National Institute for Medical Care of the Social Welfare system (Instituto Nacional de Assistência Médica da Previdência Social – INAMPS) ended, the Brazilian system became a travesty comprising a mix of parallel and replicated actions, with the private sector establishing a parasitic relationship with the public health system (SUS) and the public funding standard. Even worse, in the current historical framework, with no power to support a strategic project that opposes the expansion of the neoliberal hegemony, a fiscalist perspective that advocates the development of the private health-plan market as a pragmatic solution to disencumber the public finances is advocated by economist sectors of the State and of society.

The market grows by leaps and bounds

We must think over why it has not yet been possible to fulfill the constitutional mandate of the SUS or significantly expand the regulatory mechanisms of the Brazilian National Agency for Supplementary Health (Agência Nacional de Saúde Suplementar – ANS) and the Brazilian National Agency for Sanitary Surveillance (Agência Nacio-

nal de Vigilância Sanitária – ANVISA). After all, in a particular way, for quite some time now, a process of Americanization of the Brazilian health system has been in place ².

The total health expenditure corresponds to 9% of the Gross Domestic Product, but only 47% related to public expenses, which is discrepant from the proportion seen in countries with universal health systems. In the composition of private expenses, health plans account for 40.4%, and make direct disbursement the more significant portion ³. Considering their “non-elastic” nature, expenses with plans tend to grow – even though compensated by government incentives, and despite free-medication distribution programs and the popular pharmacy program, low-income workers disburse a higher proportion of the household income for medication than families better off ⁴.

Despite the underfinancing, in addition to providing low- and high-cost services, since its creation the SUS has been, overall, successful in expanding primary care services (health promotion and prevention), in the coverage of chronic diseases, in decreasing expenditures of the population at the base of the social structure, and in decreasing exposure risk of catastrophic expenditures typically associated with high technological complexity. In fact, public expenditure is low, and a good portion of management problems are due to budgetary limitations, in such a way that tax relief, being key in the economic replication of the health plan market deserves better heed by government authorities, if one wishes to concurrently consolidate the SUS and decrease expenditures of families and employers for private goods and services.

In this scenario, the core contradiction of such a subsidy lies in decreasing the expenses of the upper income social strata and employers and, at the same time, taking out resources that could be allocated to the SUS, which reinforces the iniquity of the Brazilian system, as it worsens the distribution of the per capita public expenditure for the lower and intermediate income strata. This becomes more serious, as the subsidies do not entirely lessen the burden on SUS’s medical and hospital services, as private health plan clients also use the public services (vaccination, urgent and emergency services, blood bank, transplantation, hemodialysis, high-cost and high technological complexity services). Thus, paradoxically, SUS ends up by facing part of the costs of HMOs, and has to litigate to be reimbursed.

Subsidies: the Achilles heel of SUS

It is not advisable to make renunciation something natural, and to place it apart from values, rules and practices that enable government control under the SUS framework. This may cause such regressive situation from the perspective of public finances, by favoring the upper-income strata and the private health plan market, that some countries have established ceilings or designed policies to decrease or target its incidence.

An acceptable justification for the Brazilian Ministry of Health to fill such a regulatory gap is the suspicion that the tax relief could negatively affect the funding of SUS and the equity of the health system, particularly if one considers its positive effect on income de-concentration. However, if the federal government decides on a radical approach to the Constitution concerning health care universality and comprehensiveness, other assumptions should be taken into account, considering the existing contradictions between the State and the private health plan market: (i) tax expenditure was and is key for replication of the private sector; (ii) this subsidy does not influence the calibration, by ANS, of price rises in individual private health plans (ANVISA, for instance, monitors the reduction of drug prices due to fiscal disencumbrance for the pharmaceutical industry sponsored by the government); (iii) the amount of the relief associated with tax returns of individuals and companies is not controlled by the Brazilian Ministry of Health or the Brazilian Ministry of Economy: it is connected to income and depends solely on the health expenditures by individual tax payers.

Notwithstanding, the Brazilian Ministry of Health cannot yield its role of regulating tax expenditures in health, whose design will depend on the government’s institutional project for the area, as well as its power of bargaining to overcome distribution conflicts in the area and to resist its being captured by the market. There is a body of evidence that points to the following perspective: the tax relief mechanism, supported by ANS’s regulatory *laissez-faire*, may lead to the growth of private health plan market, rather than strengthening the SUS. This scenario replicates iniquities, as it favors the upper-income strata and the lucrative activities of the area – more and more concentrated, centralized and internationalized. This situation is worsened, as Emanuel & Fuchs ⁵ point out, due to the possibility of tax evasion by the employer, and the sharing of health care costs with the employees – or paying low salaries or asking for higher prices.

For the Brazilian health system to overcome these challenges, stronger political mobilization

is necessary to restructure the public funding and redefine the rules of the public and the private sectors ⁶.

Final considerations

The bloc that advocates that public health should fight to expand funding, improve management and strengthen social participation is the SUS; at the same time, however, along with its criticism of privatization, it should propose the establishment of institutional frameworks and regulatory mechanisms that will draw segments of the private health services clientele to SUS, in addition to reducing expenditures of workers, families and older people with health plans, medical and hospital services, and drugs (the aging of the population is a key element for the rising health expenditures, typically associated with chronic-degenerative diseases, which points to the need of significant institutional changes within SUS, and the regulation of the private health plan market).

In face of the economic stagnation and the chronic budgetary limitations, an effective measure to strengthen SUS and reorient its care model is to convince the government and society about the positive aspects of eliminating, reducing or targeting subsidies: on one hand, by restraining tax loopholes and/or evasion by employers and high-income taxpayers who receive fringe benefits; on the other hand, by spending the taxes paid by private health plan companies – which

was about BRL 9 billion in 2012 – in primary care (Family Health Program, health promotion and prevention actions, etc.), and in semi-complex facilities (urgent care units, medical practice with specialized practitioners and technological diagnostic and therapeutic resources etc.).

In other words, turning indirect into direct public expenditures would make better medical and epidemiological sense if it denied and went over the current care delivery model, i.e., if it chastised the duplicate and parallel system that encourages over-production and unrestrained use, and that approaches chronic conditions with the same logic of care as acute conditions, and that, after a longer period of time, may lead to disastrous public health and economic outcomes.

In the context of financial globalization in the health area ⁷, considering the conservative profile of the government coalition and the poor ability of civil society to exert pressure, the expansion of the market and the subsidies, in line with the conception of the Obama Care and the proposal of international bodies for universal coverage seems to be the more feasible scenario. After all, considering the dismantling of the British National Health System, the recent detrimental changes to SUS funding and the development of institutional bases for the internationalization of the market tend to worsen the underfinancing of the public sector, and the inequalities of the system and of the Brazilian society itself.

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