

Health Reform in Brazil

**Case Study for Module 3:
"Reproductive Health and Health Sector Reform"**

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Health Care Assistance Plan: Sao Paulo, Brazil

National Health Care Reform Efforts

In the 1970s, Brazil's economy was in crisis, and inflation was rampant. As a result of a severe recession in the early 1980s, public health care expenditure fell substantially, and services as well as infrastructure deteriorated. During this time, the responsibility for and provision of health care services were fragmented among various public and private entities, and the sector relied heavily on the services of contracted private providers. Furthermore, health services were largely focused on inpatient treatment, rather than preventive care. These inefficiencies exacerbated the negative effects of the general economic downturn experienced by the health care sector.

In response, a council consisting of representatives from federal ministries, employee unions and medical professions was formed to create a strategy to reduce health care costs in order to operate within more stringent budgets. The council's strategy, Reforma Sanitaria, constituted a health care reform effort that was implemented in three phases throughout the 1980s. The objectives of reform included creation of a unified health system, a greater emphasis on primary care provision, an increased reliance on underutilized public rather than private facilities, control of high-cost medical procedures, and control of contracted services costs.

Three Phases of Health Reform

The first phase of health care reform, Integrated Health Actions (Acoes Integradas de Saude – AIS) went into effect in 1984. During this phase, coordination in the health care sector was improved. In addition, service delivery was decentralized from the Ministry of Health and its primary financing mechanism, INAMPS (Instituto Nacional de Assistencia Medica da Previdencia Social), to the state and municipal levels, and, as a result of the reduction in beaurocracy, efficiency was enhanced.

The second phase of reform was the creation of Unified and Decentralized Health Systems (Sistemas Unificados e Decentralizados de Saude – SUDS) in 1987-1988. During this phase, decentralization became more complete as control of staff and facilities was assumed by state and municipal health secretariats. As a result, each state came to be viewed as a single system of health care, rather than part of a national system.

With a new Brazilian Constitution in 1988, changes which had been occurring in the health system were ratified and legislated. This paved the road for the passage of a 1990 law creating the Single Health System (Sistema Unico de Saude –SUS), which constituted the third phase of reform. The SUS embodies the constitutional mandate of the right to equal access to health services for all Brazilian citizens. While the SUS in many ways continues the efforts to decentralize the system as provided in the first two phases of health reform, several measures reflect a partial re-centralization of federal

authority. For example, states and municipalities must receive federal approval of uses proposed for federal funds.

The Sistema Unico de Saude (SUS)

The SUS provides a universal, free, all-inclusive benefits package and currently is the sole source of medical care for approximately 120 million Brazilians. The system encompasses a huge network of public facilities and accredited private services, and provides over 70% of inpatient and outpatient care. In 1996, new operational guidelines for SUS were approved, granting local managers further autonomy to define priorities and allocate resources.

The Brazilian government provides about 55 percent of the funding for the SUS through several revenue sources, including social security (paid by companies and employees), a tax on financial transactions, and general tax revenues. The government serves as the central regulating body for the public health care sector. Brazil's 27 district governments provide 22 percent of the funding for SUS, and are responsible for hospital care and disease prevention activities, and sometimes operate networks of outpatient clinics as well. The municipal governments, which provide 23 percent of funding, are increasingly assuming responsibility for ambulatory care, and some own and operate hospitals.

All Brazilians are guaranteed the right to health care through SUS, the public health system; however, the private health system handles approximately one-third of the demand for health care services. The private sector usually serves those individuals who are employed by companies that provide private health insurance, or who can afford to pay out-of-pocket for health care services.

Comprehensive Women's Health Program (PAISM)

At the time of early health reform, the Ministry of Health recognized the importance of basic reproductive health. Accordingly, the Comprehensive Women's Health Program (or PAISM, *Programa Assistencia Integral a Saude da Mulher*), was created in 1984 to be included in Brazil's basic public health network; however, the PAISM was implemented as a vertical (separately managed) program. PAISM is extremely comprehensive. The program integrates prenatal care, delivery, and post-partum care; breast and cervical cancer screening; STD care; adolescent and menopausal care; treatment of reproductive tract infections; infertility services; family planning education; and contraception assistance. PAISM covers women and adolescents of all ages.

Still, as late as 1995, public health services still lacked basic interventions such as prenatal care, maternity care, and cervical and breast cancer screening and treatment. Furthermore, as the PAISM agenda had not been incorporated into the SUS, it was implemented to varying degrees across municipalities.

With the continued decentralization of the health care system that occurred through SUS throughout the mid-1990s, the vertical approach represented by PAISM became untenable. Thus, PAISM had to be incorporated into municipal-level primary health services provided within the SUS system. As a result, basic interventions such as prenatal and maternity care have improved. As an example, prenatal consultations increased by 51 percent between 1995 and 1997. Access to contraception is expanding within primary health programs in many different settings, and twelve sites now offer legal abortion services. Adolescent care and prevention and treatment of STDs/HIV are better integrated with family planning and reproductive health services. Finally, as a result of the launch of national cancer screening programs, cervical and breast cancer screening increased 14 percent and 44 percent respectively between 1995 and 1997.

Continued Concern over Health Indicators

Despite health reform efforts and a particular focus on reproductive health, many of Brazil's health indicators continue to be cause for concern. Like many countries, there is wide disparity in Brazil's demographic and reproductive health indicators. Maternal and infant mortality rates are nearly three times higher in the northeast region (250 per 100,000 live births and 75 per 1,000 live births, respectively) than in the south and southeast; overall infant mortality in 1998 was 37 deaths per 1,000 live births. In northeast Brazil, 55 percent of births in the last five years were classified as 'high risk.' Especially concerning, Brazil exhibits one of the highest rates of Caesarean deliveries in the world at 36 percent in 1996.

Furthermore, although the population growth rate has dropped from 2.9 percent in the period 1950-1960 to 1.3 percent at present and the total fertility rate dropped from 3.5 in 1986 to 2.5 in 1996, fertility has remained high in several locales – up to 3.5 in rural areas. Studies reveal a large number of unwanted pregnancies, even in urban areas. In 1998, the birth rate was 21 births per 1,000 population. The unmet need for contraceptives among married women is estimated at 13 percent nationwide. It is estimated that about 1.4 million abortions are carried out every year, approximately one for every two live births. Fertility rates among the 15-19 year age group have been increasing, according to recent studies; approximately 28 percent of pregnant women who use the public health service are adolescents.

Continuing Reform: Health Assistance Program (PAS)

Between 1993 and 1996, the quality, access and cost of SUS services began to be questioned. Problems with the SUS system include a lack of management ability; an overemphasis on facility construction and equipment purchase; an inadequate number of physicians, in part due to low wages; high absenteeism among all health care workers, resulting in long wait times for care; excessive lengths of stay; and high costs of care overall.

As a result of the debate, new models of health care provision have been proposed. Many of these models take place at the level of the local municipalities. One new model, known as “Shared Administration,” is being adopted in several municipalities, and represents a joint venture between the municipal government and health care professionals. This new model has been adopted in Sao Paulo, where it is known as the Health Assistance Program, or Plano de Atendimento a Saude (PAS).

PAS was implemented in 1996 to create an environment where the citizens of Sao Paulo, particularly the poor, can benefit from the higher quality primary and secondary health care offered by the private health sector. To do so, the mission of PAS is to stimulate the participation of health professionals and private organizations in managing public resources for public health services. Universal and equal access to health care are also the goals of PAS.

PAS Structure and Services

PAS divides Sao Paulo, a city of 10 million inhabitants, into 14 health modules. PAS is headed by the Secretary of Health, who oversees a management council and each module’s board of directors. This group includes representatives from the municipal government, the cooperative, and consumers. The function of this group is strategy, control and budget development and approval. The municipality funds the modules’ hospitals, equipment and administrative buildings.

Health care professionals are organized into cooperatives, or Basic Health Units (UBS), and take responsibility for the care of the population. Cooperatives include physicians, nurses, dentists and other health professionals. Each cooperative is managed by a director chosen by the participating professionals. Overall, over 5,000 physicians and over 9,000 other health care professionals have chosen to join a cooperative. Citizens receive a beneficiary identification card, and are free to enroll in any UBS.

Each UBS is also responsible for financial management and operations, and includes an administrative and fiscal council and cooperative directors. Each UBS is a non-profit, limited liability company with the aim of providing administrative and support services in the public health arena; participants include public health professionals at the university, technical, and operational levels. Each UBS includes several public health centers and one or more hospitals. UBSs are health management units that are characterized by a great deal of autonomy: they determine the providers they use, the personnel they hire, and the cost-control mechanisms they adopt.

Because many UBSs lack in-house administrative expertise, most hire a management institution, a private company, to manage the module. The management institution is responsible for: economic/financial management activities, such as accounting, treasury, budgeting, cash flow, investment planning, production reports and cost management; contract management, such as service supply contracts, materials and medicine contracts,

and service planning; human resources functions, such as personnel quality, training and payroll; legal and fiscal support; and information systems.

Primary health care services are available in all modules. Services include first-aid stations, ambulatory attendance stations, health attendance stations, and day hospitals for mental health. Health attendance stations provide services in general health care, pediatrics, gynecology, obstetrics, and odontological care. Ambulatory attendance stations also provide care to ambulatory patients in the areas of cardiology, dermatology, orthopedics, pneumology, homeopathy, psychiatry, nose and throat care, neurology and ophthalmology. The first-aid stations provide care aimed at immediate care for adults and children directed to clinical care or surgery. Care for urgent and emergent cases is driven by the severity of the patient's state, including risk to life or functional loss.

Secondary health services offered by inpatient general hospitals are available in almost all modules. Tertiary care is available in selected modules, and is available on a referral basis to inhabitants throughout the city.

Provider Payment Mechanism

Under the SUS system, physicians and other health care workers receive a fixed salary from the municipal government, regardless of productivity; this lead to severe absenteeism and low productivity. In contrast, under PAS workers within each cooperative are paid an income which is tied number of hours worked and to UBS performance; financing comes from a monthly capitation per enrollee paid by the municipality. As mandated by the constitution, health services are free of charge to enrollees.

Results

The performance of PAS is evaluated both internally and externally. Internal evaluation is accomplished through information system tracking as well as supervision by the secretary. External evaluation is accomplished through an independent financial audit of the cooperative, and audit of service quality, and patient satisfaction surveys.

PAS has achieved significant results. All citizens who need care now have access to it. Evaluators note that with the existence of PAS, more citizens are willing to come forward for care. Although the program was originally targeted at poor residents, PAS is actually serving a broad spectrum of citizens, drawing some away from the private sector. In 1995, before PAS, the city served 6.9 million patients; that figure increased to 15.5 million by 1997.

Particular segments of health care services have exhibited this increase in service. For example, the average increase in the ambulatory population serviced was 98.8% -- from approximately 325,000 people per month before the implementation of PAS (in 1995) to almost 650,000 people per month after PAS was fully operational (1997). The average

increase in hospitalizations due to PAS was 140% -- from approximately 5000 hospitalizations per month in 1995 to approximately 12,000 hospitalizations per month in 1997. Similarly, surgeries increased by 137%, urgency/emergency attendance increased by 165%, birth (under a physician's care) increased by 173%, and ICU care increased by 200%. Overall, PAS resulted in an average increase in care of 152%.

Health professionals in PAS, because of their capitated reimbursement, have responded to this strong incentive for productivity; As such, wait times for care have been vastly reduced. As a result, the percentage of patients in Sao Paulo who are satisfied with public health services jumped from 10% in 1995 to almost 90% by 1997. Furthermore, as a result of capitation, the new system has reduced length of stay and overall health care costs significantly.

Future Improvements

A new model for PAS has been developed to drive further improvements in the system. The new model aims at quicker implementation through enhanced use of information systems. Systems to be adopted include a health management system, a financial administrative system, a managing information system, and a bank clearing house system. In addition, PAS administrators hope to interconnect these four systems, so that planning, operation, management and control are all linked. Further links will be developed through a process of "single identification of the user," which will make the history of the user available in every care unit.

In addition, competitiveness among medical cooperatives will be established in order to offer users a greater range of choice among the various modules of care so that they can select the highest quality of care possible. In this way, institutions will remain in the system according to the quality of services provided.

PAS can also be improved through the development of health prevention initiatives. In addition, interaction with existing preventive health programs can be enhanced. The office of the municipal secretary of health includes a coordination department responsible for the development and implementation of prevention programs. Some of the programs will be developed by the federal government to be implemented by the state and municipality sectors. Other programs will be based on proposals made by specific groups within the secretary of health; the programs below were considered by PAS to be priorities:

- Nutrition program
- Health education program
- Female health attention program
- Adult health program (hypertension, diabetes mellitus)
- Deficiencies prevention program
- Eye health program
- Mental health care program

- Mouth health care program
- Seniors' health care program (preventive activities)
- Workers' health care program
- Sexually transmitted diseases/AIDS prevention program

In addition, a home assistance program would be developed to offer far-reaching care to the citizens. Through this program, PAS would be able to implement and check preventive actions with medical and multi-professional care teams. Related to the home assistance program, a family doctor service would be created to establish a bond between the physician and the patient, enhancing health prevention and care.

Day hospitals for mental health were implemented in PAS modules; this idea could be extended to the implementation of units where patients could spend the day receiving treatment required by their cases, and return home at night.

Rescue services must be improved, in terms of both devices and personnel training.

Finally, the PAS system must maintain quality even as the capacity of the system grows. PAS administrators will work collaboratively with the State of Sao Paulo and the federal government's health system, with the goal of seeking the best care for the population despite political aims. Better use of resources and lower costs will hopefully be achieved in both the private and the public sectors.

<u>Indicators: State of Sao Paolo</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>
Low Birth Weight	8.7	8.7	8.6
Percentage of Teenage Mothers	19.8	n/a	n/a
Maternal Mortality (/100,000)	42	n/a	n/a
Child Mortality (/1000)	22.7	21.6	18.7
Newborn Mortality (/1000)	15.0	14.6	12.6
Infant Mortality (/1000)	7.7	7.0	6.1
Pre-natal Assistance (Estimated # of consultations)	684,092	1.4 million	2.1 million
Fertility Rate	2.3	n/a	n/a

Sources:

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