Brazil's Mixed Public and Private Hospital System[1]

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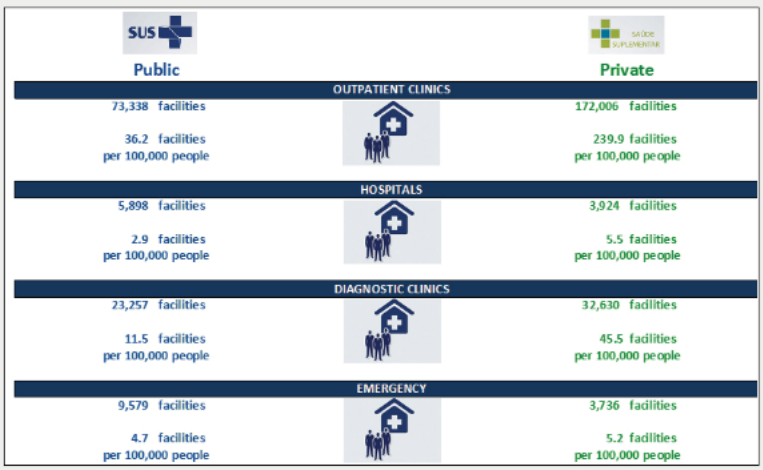
ABSTRACT: Brazil's hospital sector is vibrant and growing. Under the 1988 Brazilian constitution all citizens have the right to health care, anticipating the global commitment to Universal Health Care. Brazil's public sector prides itself on having one of the world's largest single payer health care systems, but complementing that is a significant and larger private sector that is seeing big increases in investment, utilization and prices. This article outlines the structure of the hospital system and analyzes the nature and direction of private health sector expansion. Twenty-six percent of Brazilians have private health insurance and although coverage is concentrated in the urban areas of the Southeastern part of the country, it is growing across the nation. The disease burden shift to chronic diseases affects the nature of demand and directly affects overall health care costs, which are rising rapidly outstripping national inflation by a factor of 3. Increasingly costs will have to be brought under control to maintain the viability of the private sector. Adaptation of integrated care networks and strengthening of the public reimbursement system represent important areas for improvement.

Providers and Payers in the Healthcare System.

The hospital sector has approximately 6300 general and specialized hospitals, ranging from small, low quality public and private hospitals to world class private and public research hospitals. A large segment of the private market is made up of small, inefficient facilities that are costly to operate (La Forgia and Couttolenc 2008). Most private hospitals provide services to public and private patients, as it is shown in Figure 1.

There are approximately 450,000 hospital beds in

Figure 1: Summary of Public and Private Health Care Facilities in Brazil, 2014



Source: IESS 2015; SIA/SUS

1 Thanks to Alex Spevak for expert research assistance for this paper and the associated PowerPoint.

Brazil (38.3% in public and 61.7% in private hospitals), but 70.6% of them are public health facilities. The number of beds has declined over the past decade from 2.9 beds per 1,000 population In 2000 to 2.3 in 2009. (OECD, 2014)

Brazil devoted 9,7% of its GDP to health in 2013, with health expenditure per capita of US$ 1,454 (PPP adjusted) (WHO 2015). The Single Unified Health System (Sistema Unico da Saude - SUS) is a national program financed by federal, state and municipal governments (though much of the funding comes from federal transfers to states and municipalities) that covers hospital and outpatient care. The federal government jointly with states conducts a highly successful home-base outpatient program targeted at low income households, the Family Health Program (Programa da Saúde da Familia, PSF).

As decentralization has taken hold the federal role has been diminished as the over 5,500 municipalities receive funds earmarked for health care and the 27 states have taken responsibility for some aspects of health care. Recent laws determine the shares of federal (49%), state (28%) and local (23%) government health care spending. However, public spending represents only 47 percent of all health care expenditure.

Private health insurance covers roughly 40 percent of private health expenditure and out of pocket the rest. The distribution suggests that SUS is not the biggest payer given the multiple other sources of funds for health care (IBGE 2014).

Hospitals represent the center of the health care universe in Brazil representing 67% of all spending., and 70% of public spending. SUS provides the lion's share of hospital services: 68 % of all admissions, 73% of emergency care, and 67% of hospital-based ambulatory care (SIA/SUS).

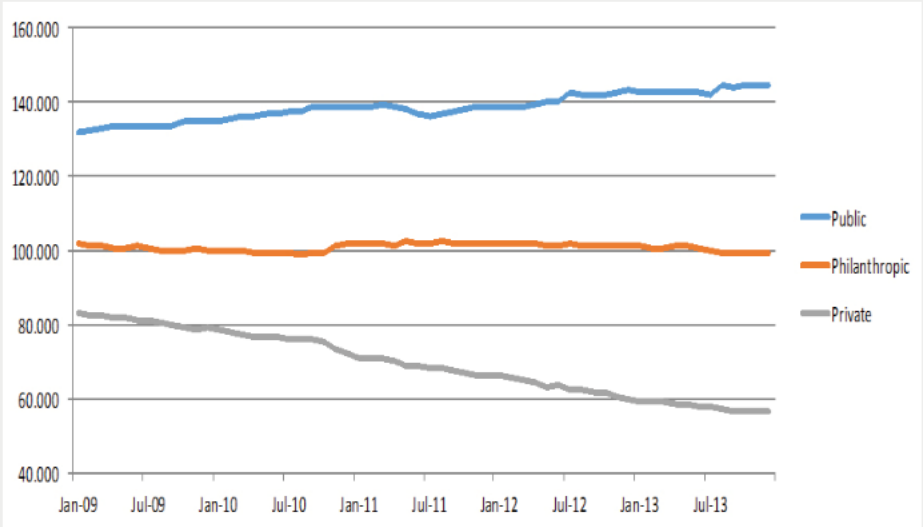
Public funds finance facilities operated by government (46%) via the federal prospective reimbursement system, AIH (Autorização Internação Hospitalar – Authorization for Hospital Admission). These specific, procedure-based payments are supplemented by direct salary payments to public sector workers. In some instances global budgets and fee for service payments are relied upon. The mix is determined by the type of government payer, eg federal, state or municipal payment. Public servants operate and staff the vast majority of public hospitals and, as in most public systems, government provides some in-kind inputs.

In 54% of hospitals AIH reimburses non-profit facilities for patient care at reimbursement rates identical to those at public hospitals though without commensurately paying for staff as in public run and operated hospitals. Six private high-complexity Centers of Excellence provide highly specialized care free of charge for the government. As compensation the hospitals receive tax breaks. These high end referral hospitals serve the whole country.

An innovative hospital financing arrangement known as "Social Health Organizations" (OSS) is a public-private partnership with public monies, public facilities and private, non-profit management of clinical and non-clinical services in roughly 30 hospitals and 100 ambulatory facilities in São Paulo state. Although representing less than one percent of hospitals they have outperformed the publicly owned and managed hospitals on quality, volume, efficiency and patient satisfaction (La Forgia and Couttolenc 2008). Despite its modest size the model has persisted for close to 20 years in the state. It is seen as a possible approach for other state hospitals and 23 states are moving toward or have initiated some form of OSS financed hospitals. While encouraging few states have adopted the discipline and autonomy that have made São Paulo so successful. But that kind of innovation is important to all federal, state and municipal health providers.

About half of SUS spending goes to public facilities. The trend in SUS financing is toward stable financing of non-profit hospitals, increasing expenditures in publicly owned hospitals and a sharp decline in spending on for-profit hospital, as shown in Figure 2. Such divergence moves the health care system to an increasingly separated arrangement, which runs the risk of reducing engagement, support and advocacy for improved performance from the middle and upper classes who increasingly rely on private insurers and providers.

Figure 2: Trends in SUS Payments for Hospitals by Ownership

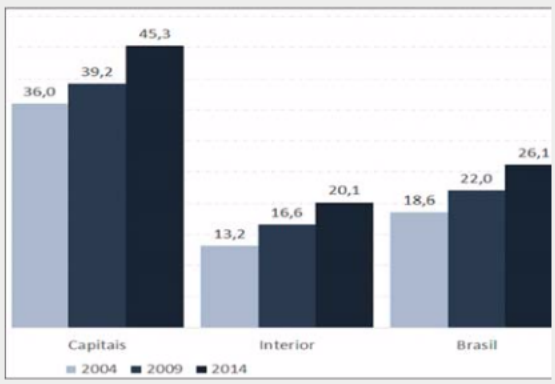


Source: SIA/SUS

Some of the decline in spending on for-profit hospitals has been made up by the growth in private health insurance. Effectively citizens pay for access to SUS through taxation and they or their employer pay again directly to insurance companies. Health insurance coverage has grown steadily over the past decade with gains of around 50 percent in both state capitals, where coverage is higher than elsewhere and particularly so in the wealthier southern capitals like São Paulo and Rio de Janeiro. Much of health insurance coverage is an employer-sponsored benefit and therefore tied to fluctuations in economic growth. Today over a quarter of all Brazilians purchase some form of health insurance, translating into roughly 50 million enrollees.

Figure 3 shows the breakdown of the levels and trends in coverage. The growth in the "interior" is impressive as it suggests a rising middle class in historically poor areas, and a willing to prioritize health insurance over other forms of consumption. These trends fuel demand for private care as private insurance rarely finances public care in Brazil.

Figure 3: Trends in Private Health Insurance Coverage 2004-2014 for Brazil, State Capitals and the Interior



Source: IESS 2015

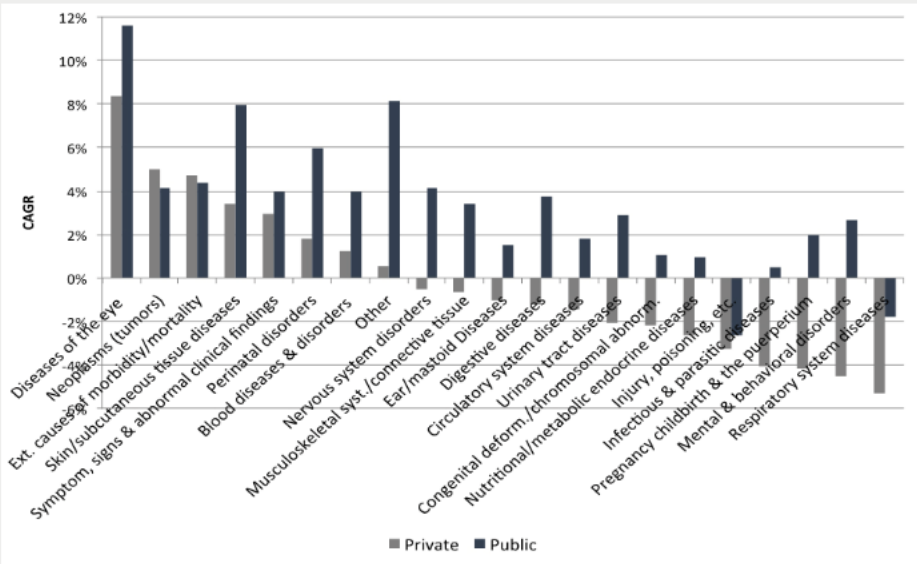
The payer-provider arrangements create awkward incentives that undermine the effectiveness of the overall health system. On the one hand SUS under-reimburses for care under its prospective payment system, AIH, for non-public providers, which has led to a decline in the number of philanthropic facilities that have been forced to close in many cases. On the other hand, citizens with private insurance do not compensate public hospitals for their care reverting instead to public insurance coverage. Public reimbursements that cover costs, and a requirement that public hospitals charge private insurers would make the system more balance and compensate providers fairly.

Trends in Health Services and Costs in Private Hospitals

The rise in chronic conditions and other non-communicable diseases across Brazil has contributed to a shift in hospital demand toward more complex treatments that on average are more costly than traditional complaints. The shifts can be seen in Figure 4 showing growth and declines in mortality rates for selected diseases in both the public and private sectors. Infectious parasitic diseases, respiratory illnesses and complications of pregnancy are falling in the private sector and declining in relative importance in the public sector, reflecting improved living conditions, rising levels of education, and improved preventive measures. Neoplasms, perinatal disorders and diseases of the eye, skin and blood have replaced the simpler complaints that claimed lives in the past. As a result, the trend is toward more specialty treatments many of which are long term chronic conditions like cancer, cardiovascular disease and diabetes, three of the most important sources of morbidity and mortality in Brazil today (SIA/SUS). And as experience in the OECD suggests, these conditions also drive up costs.

While individual costs for treatment cannot be obtained for either the public or private sector, aggregate figures for the private sector suggest the sharp increase in the average costs of diagnosis and treatment. Indeed, in 2013 the private health care inflation rate of 16 percent far outstripped the 5.9 percent national rate of inflation (IESS 2015). This is a trend observed since 2007 and while the level of difference has fluctuated divergence appears to be accelerating. Some costs can be passed on to the insured but there is a limit. Spiraling costs risk losing enrollees and

Figure 4: Growth in Mortality Rates by ICD-10 Code 2009-2013



Compound annual growth rate calculated as: $CAGR(t_0,t_n) = (V(t_n) / V(t_0))^{\frac{1}{t_n - t_0}} - 1$

Source: SIH/SUS

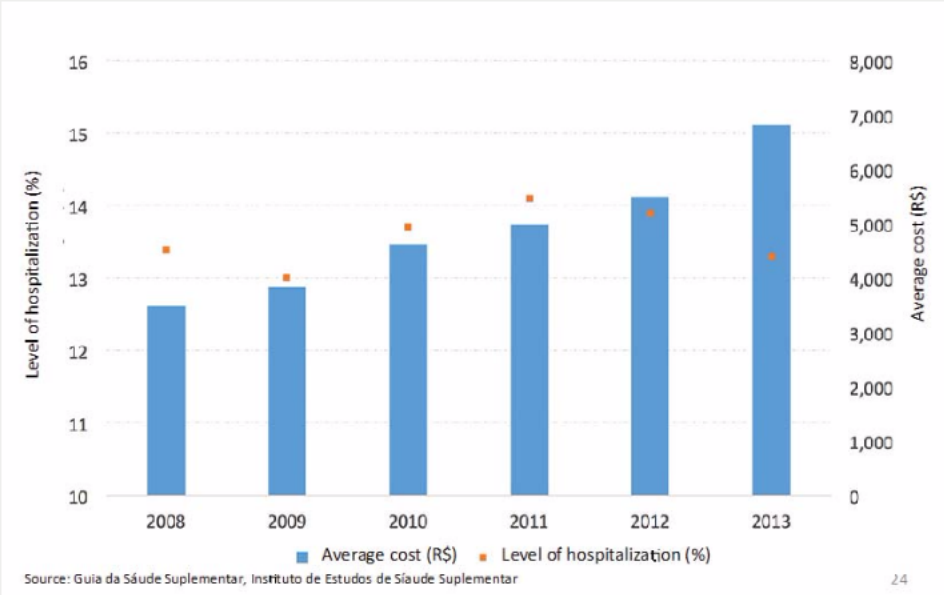
compromising future enrollee growth.

Only part of the cost spiral can be attributed to shifts in the disease burden. Heavy investment in high technology also contributes. Brazil has 6.7 MRIs per 1,000 population, more than the UK, Australia and Chile, and over three times as many as Mexico. It has more CT scanners per 1,000 population than Chile, Canada, France and the UK, and again more than three times that of of Mexico (OECD 2014; IESS 2014). Given the high correlation between supply of high technology and cost escalation these circumstances effectively build in higher costs.

The age distribution of private insurance enrollees balances 22.6 percent of children under age 18 with 23.1 percent over the age of 59, which is also likely to lead to higher costs. Given the high proportion of older enrollees and longer life expectancies health insurers face cost pressures in utilization (IESS 2015). Finally, hospitals face virtually no incentives to contain costs or improve efficiency, both necessary to control expenditures and volume of services.

Figure 5 compares the growth in average costs and the level (or percent) of hospitalizations. Cost increases are outpacing the rate of hospitalizations, and the latter have begun to decline in the last few years, which is consistent with the cost.

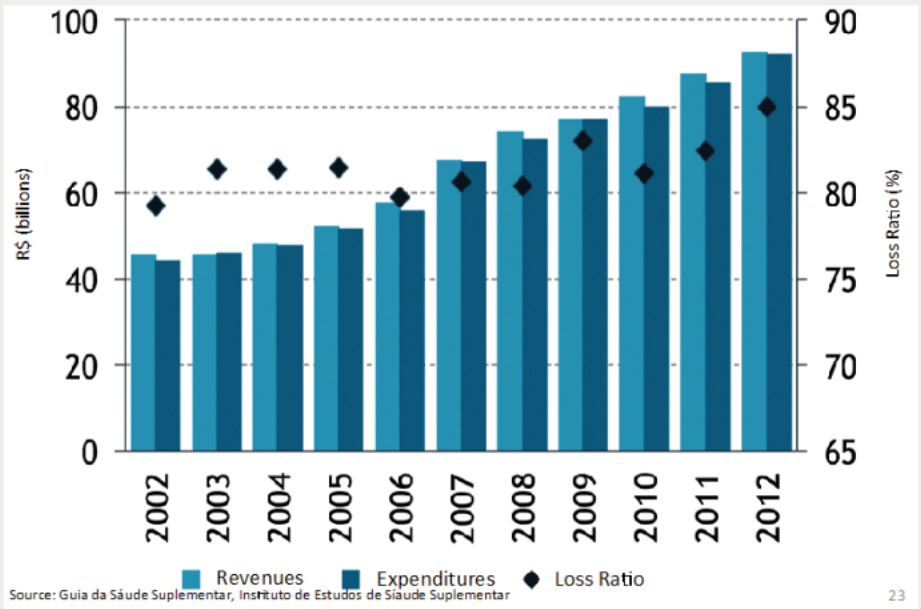
Figure 5: Use and Average Cost of Hospitalizations Covered by Insurance, 2008-2013



Source: IESS 2015

Increases described above. However, such rapid cost escalation risks profit levels if revenues do not keep pace. Indeed, the real risk is losses. This is indeed the trend in profits and loss. The private sector's loss ratios are starting to rise in response to reduced hospitalizations and rising costs, as shown in Figure 6. Revenues and expenditures moved in tandem over a decade between 2002 and 2012 but loss ratios have risen steadily since 2007, a worrisome trend that will need to be addressed by the industry to ensure long term solvency. The rising costs pose a challenge to both private insurers and providers as costs cannot increase indefinitely, but serious efforts will be needed to reign in spending and raise efficiency among insurers and providers alike.

Figure 6: Revenues, Expenditures, and Loss Ratios for Private Health Insurers, 2002-2012



Source: IESS 2015

Conclusions

Despite efforts to establish a single health care system, the current structure can best be described as mixed and fragmented. Government finances via SUS less than half of all health care with the balance covered by private health insurance or out of pocket payments. Hospitals represent 70% of SUS spending.

It's prospective payment system, AIH, offers one of the few incentives for hospital efficiency. Despite up-coding and other irregularity it remains the preferred method of hospital payment, which suggests the need for improving and expanding its application. For example, ensuring that costs and reimbursements are aligned will be key to its effectiveness and acceptability among private providers. AIH could also be adopted as a tool to encourage improvements in quality much like the US Medicare system that is currently driving up quality through specific incentives tied to reimbursements. In the same vein ensuring that hospital are paid for the services they provide is fundamental but private insurers often don't pay for public hospital care and public insurance shortchanges private hospital providers. This deserves attention.

The trend toward integrated networks of care in response to the rise of chronic conditions, and the commensurate need for continuity of care has not yet been embraced in most of Brazil. Hospitals continue to focus on episodes of illness with few linkages to outpatient services. This applies to both the public and the private sectors, but will become increasingly important to both in order to raise quality and control costs in both networks.

Costs will need to be controlled if the private health sector is to remain viable and to expand. Double digit inflation when overall prices increases hover around 5 percent will become an issue for insurers and the insured, the question is when. The implications could inflict damage to the image and economic health of private hospitals. Closing low volume, high cost small hospitals should be part of the solution but improved management, a focus on efficiency and value, and more consistent adherence to protocols could all contribute to greater productivity and quality. Bolstered accreditation and oversight could be helpful to both identify waste and promote improved performance, which in turn could lower costs.

Finally, consumers and patients deserve a bigger role and stronger voice to become part of the solution and to contribute to improved hospital and hospital network performance. This is a future agenda item but shouldn't be forgotten.

BIOGRAPHIES

Maureen Lewis is co-founder and CEO of Aceso Global, a non-profit organization that strengthens health systems in emerging markets. She is a Nonresident Fellow at the Center for Global Development and a Visiting Professor at Georgetown University's School of Foreign Service. She spent 22 years at the World Bank, and received her Ph.D. from Johns Hopkins University.

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