

## 2 Health care needs and the health care system in Brazil

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The current principles and structure of Brazil's health care system (*Sistema Único de Saúde*, SUS) were conceived in 1988 after the approval of the new Brazilian Constitution that established health as a universal right for the whole population and a state responsibility. Many measures of health system performance in Brazil have improved since SUS inception, but gains have not been equal across population groups. While virtually the entire population is formally covered by the public health sector, with equal benefits and equal financial protection, private sources of spending predominate either via voluntary private health insurance or direct payments by households which affect disproportionately Brazil's poor and disadvantaged populations. Low public health spending, along with demographic and epidemiologic transitions, are also challenging the financial sustainability of the Brazilian health care system.

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## 2.1. Introduction

The current principles and structure of Brazil's health care system were conceived in 1988 after the approval of the new Brazilian Constitution that established health as a universal right for the whole population and a state responsibility, which cemented the way towards the implementation in 1990 of the Unified Health System (Sistema Único de Saúde, SUS). Three principles underpin SUS (Massuda et al., 2020<sup>[1]</sup>):

- The universal right to comprehensive health care at all levels of complexity (primary, secondary, and tertiary).
- Decentralisation with responsibilities given to the three levels of government: federal, state, and municipal.
- Social participation in formulating and monitoring the implementation of health policies through federal, state, and municipal health councils.

Since SUS inception, Brazil has had significant developments by improving in most of the general population health indicators, increasing access to health care and reducing health inequalities. SUS prioritisation on primary care permitted an easier contact with health services at the community level and citizen's participation on health issues was institutionalised at the municipal, state and federal levels.

Brazil has continuously progressed towards universal health coverage (UHC), since all the population has health care coverage through SUS. Total expenditure in health increased to USD PPP 1 514 per capita in 2019 (as compared to an average of USD PPP 4 087 per capita among OECD countries), with private sources of spending predominating as over 50% corresponds to voluntary payments schemes and out-of-pocket spending. Public health care providers dominate the system, but a significant presence of private providers exist, mainly for people able to purchase private insurance. While the share of out-of-pocket payments has come down in the last two decades reaching 25% of total health expenditure in 2019-below many countries in the LAC region but above the 20% in the OECD, Brazil has increased its spending share of voluntary health insurance reaching 30% in 2019, the highest in LAC and way over the 5% in the OECD.<sup>1</sup> Demographic and epidemiologic transitions, along with low public health care spending and several sources of wasteful health spending are challenging the financial sustainability of the Brazilian health care system.

This chapter describes the Brazilian health care system by analysing the demographic, socio-economic and epidemiologic context in which the system operates, as well as describing the major actors in the Brazilian health care sector. The chapter examines Brazil's current situation in terms of achieving UHC, including a particular analysis of the inputs of health care services in the country in order to provide information for planning and management.

## 2.2. Health and health care needs in Brazil

### 2.2.1. Demographic transition is generating new challenges for Brazil's health system

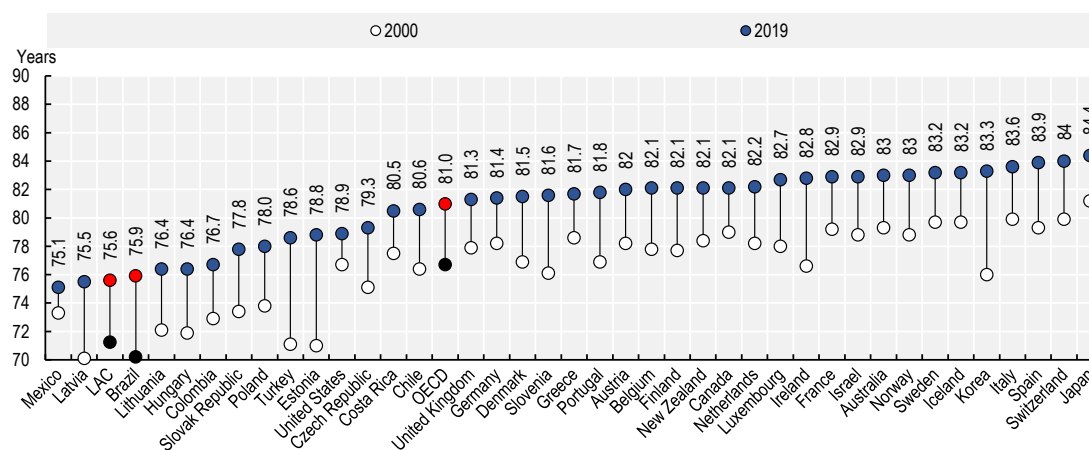
Brazil is located in South America, sharing borders with ten countries, almost all the countries in the sub-region with the exception of Chile and Ecuador. This Portuguese-speaking country has a total land of 8 358 140 km<sup>2</sup> and its territory is administratively divided into 26 states, one federal district, and 5 570 municipalities. The states and the federal district are also grouped into five regions: Northern, Northeast, Central-West, Southeast and Southern, which are used mainly for statistical purposes and to define the distribution of federal funds. In 2020, the population in Brazil was estimated to be more than 212 million inhabitants, with an annual population growth of 0.8% (OECD, 2020<sup>[2]</sup>). In 2015, 45.2% of the population considered themselves as white, 45.1% mulatto (mixed white and black) and 8.9% black (IBGE, 2016<sup>[3]</sup>). In 2015, 0.3% of Brazilian population was regarded as immigrant, with 46% of them being women (IOM,

2020<sup>[4]</sup>). Population density reached 25.1 inhabitants per km<sup>2</sup> in 2018, compared to 17.8 inhabitants per km<sup>2</sup> in 1990, which is linked to the increasing urban population that rose from 73.8% in 1990 to 86.8% in 2019. However, the annual growth rate of urban population has decreased from 2.9% in 1990 to 1.05% in 2019 (World Bank, 2020<sup>[5]</sup>).

Life expectancy at birth in Brazil increased from 70.2 years in 2000 to 75.9 years in 2019 still five years below the OECD average of 81 years but above the LAC average of 75.6 years (see Figure 2.1). Infant mortality rates have decreased from 30.3 deaths per 1 000 live births in 2000 to 12.4 deaths per 1 000 live births in 2019. Despite this decrease, the infant mortality rate in Brazil is also above the OECD average of 4.2 deaths per 1 000 live births. The same is true for maternal mortality rates in Brazil, which have decreased to 60 women per 100 000 live births in 2017 (13 percentage points reduction since 2000), although still higher than the OECD average of 8 per 100 000 live births but lower than the LAC average of 83 (OECD/The World Bank, 2020<sup>[6]</sup>).

**Figure 2.1. Life expectancy at birth in Brazil has increased but remains five years below the OECD average**

Life expectancy at birth, among OECD and LAC countries, 2000 and 2019 (or nearest years)

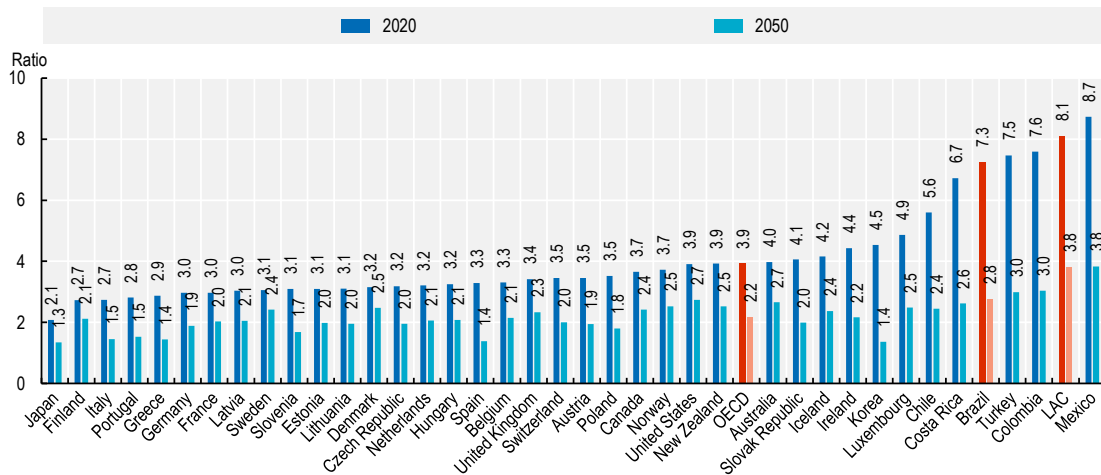


Source: OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>, the World Bank World Development Indicators Online 2021.

These improvements in general population health have been accompanied by decreasing fertility rates, moving from 2.9 births per woman in 1990 to 1.7 births per woman (World Bank, 2020<sup>[5]</sup>), as in many OECD countries. Falling fertility rates, along with increasing life expectancy means that Brazil is experiencing a demographic transition similar to that of OECD economies; a narrowing younger base and an expanding number of older adults in the population pyramid. In 2020, the ratio of people aged 15-64 to people aged over 65 years was 7.3 in Brazil, nearly twice the OECD average but below the LAC average, meaning that a larger proportion of working age population exist in Brazil than in the OECD. Yet, this ratio is projected to substantially decrease to 2.8 by 2050, almost matching the ratio of 2.2 projected for the OECD (Figure 2.2). This rapid demographic transition is having an important impact on the health of the population in Brazil, putting pressure on both the health care system and the economy.

**Figure 2.2. Brazil is projected to experience a rapid population ageing process with a decrease on the proportion of working age population by 2050**

Ratio of people aged 15-64 to people aged over 65 years, 2020 and 2050



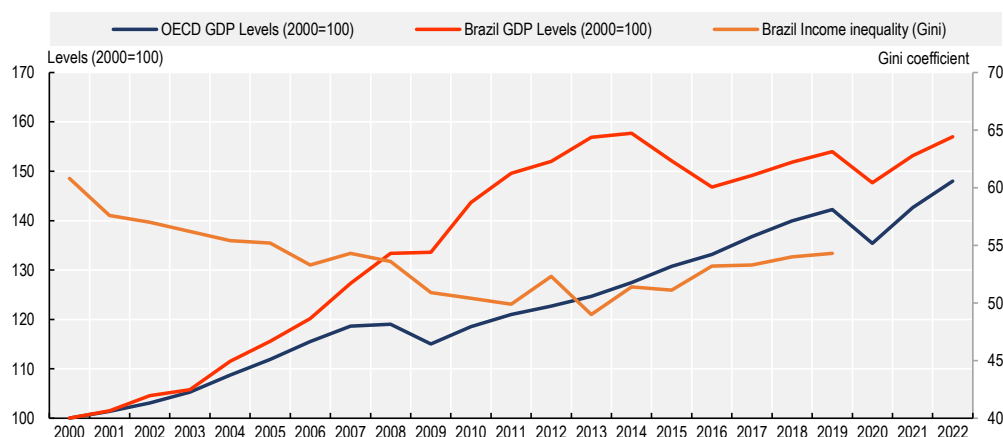
Source: UN World Population Prospects 2019.

### 2.2.2. A strong recession and governance challenges have limited Brazil's progress towards development and better health

Over the past two decades, Brazil has had strong economic growth combined with remarkable social progress, making it one of the world's leading economies. However, socio-economic inequality remains as a key issue and economic recovery after the recession in 2015 and 2016 has been slow. The situation of its fiscal accounts is challenging with high and rising public debt, while the labour market is characterised by high and persistent labour informality (OECD, 2018<sup>[8]</sup>). Figure 2.3 shows how Brazil's GDP growth was strong in the 2000s, but lagged behind OECD economies in the 2010s, while the projections for 2021 and 2022 also put Brazil below the OECD estimated averages (OECD, 2021<sup>[9]</sup>). From 2000 to 2013, the Gini coefficient for income inequality in Brazil dropped continuously from 60.8 to 49. However, after the economic crisis it increased to 51.4 in 2014 to 54.3 in 2019.

Overall, Brazil has progressed over the last decade in terms of improving the quality of life of its citizens. However, according to the OECD Better Life Index 2020 (OECD, 2020<sup>[10]</sup>), Brazil performs well in only a few well-being measures relative to most OECD countries. Brazil ranks above the average in civic engagement (involvement in democracy) and community (quality of social support networks), but very low in safety (murder and feeling safe), income (household income and financial wealth) and education (people's education and outcomes). Brazil is also below average in terms of jobs and earnings, housing, environmental quality, life satisfaction, work-life balance and health status. These rankings are based on available selected data (Figure 2.4). All these areas of life are closely related to the population's health status as they reflect the social and economic determinants of health.

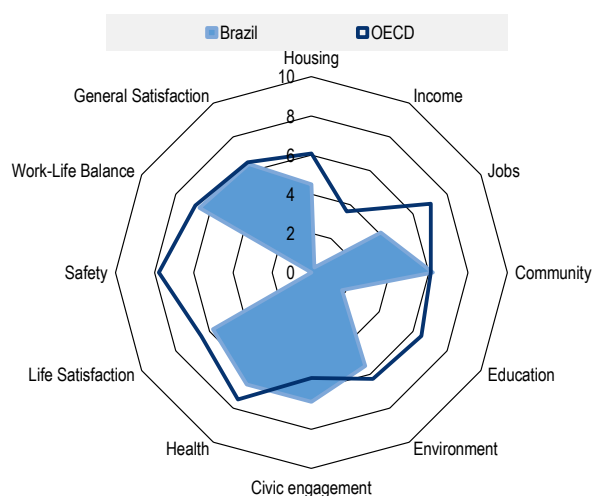
**Figure 2.3. GDP levels and income inequality in Brazil over the past 20 years**



Note: Estimations for 2021 to 2022.

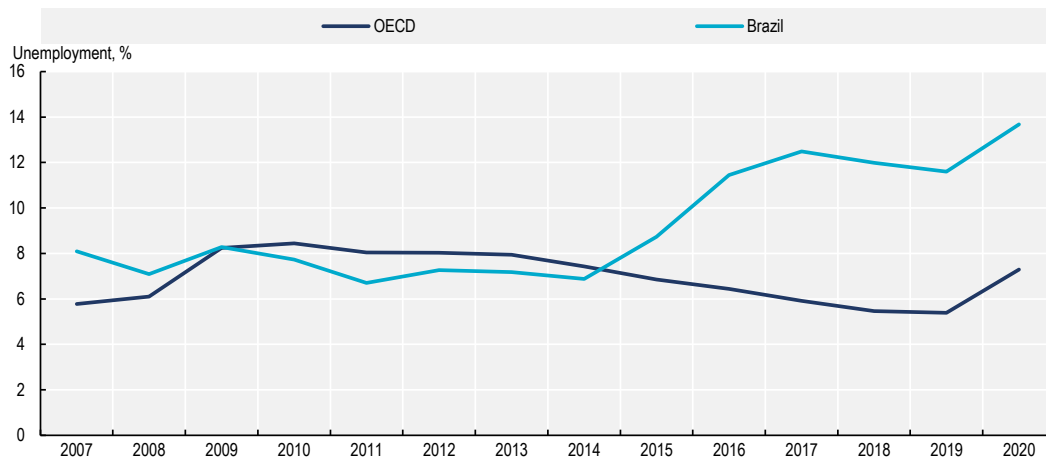
Source: OECD Economic Outlook (2021<sup>[9]</sup>) <https://doi.org/10.1787/edfbca02-en>, and World Income Inequality Database (UNU-WIDER, 2020<sup>[11]</sup>), <https://www.wider.unu.edu/project/wiid-%E2%80%93-world-income-inequality-database>.

**Figure 2.4. Brazil's well-being indicators highlights the challenges in comparison to OECD averages**



Source: OECD Better Life Index (2020<sup>[10]</sup>), <http://www.oecdbetterlifeindex.org/countries/brazil/>.

Unemployment has been another issue affecting Brazil's economy and, therefore, population's health. Before the economic crisis of 2014, unemployment was below 8% and even below 7% in 2014, similar to OECD averages in those years. However, it went up to 11.5% in 2016 and has remained at that level until 2019, while in the OECD unemployment continue to decrease reaching 5.4% in average in 2019 (Figure 2.5) (OECD/ILO, 2019<sup>[12]</sup>). In 2020, the unemployment rate reached 13.6%. In addition, labour informality is a significant issue in Brazil, reaching 41.5% in 2018 (as a share of total non-agricultural employment), lower than Colombia (57.3% in 2019) and Mexico (57.3% in 2016), but higher than Chile (27.8% in 2019) and Costa Rica (36.9% in 2019) (World Bank, 2021<sup>[13]</sup>; OECD, 2020<sup>[14]</sup>).

**Figure 2.5. Unemployment in Brazil and OECD countries, 2007-20**

Source: OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

Additionally, recent political turmoil and corruption allegations at the highest levels of government and businesses have exposed significant challenges in economic and political governance. Corrupt practices, kick-backs and collusion among bidders for public funds generate a waste of public resources and exacerbate income inequalities by allowing relatively prosperous public officials and businessmen to divert taxpayer resources. The reduction of corruption through structural reforms (e.g. by improving procurement laws and whistle-blower procedures) would have an estimated impact of 3% on real GDP in Brazil (OECD, 2018<sup>[8]</sup>), which could also increase the availability of public resources for the health sector, amongst the total public budget. Corruption has also a correlation with some practices in the health sector itself, as discussed on Chapter 3.

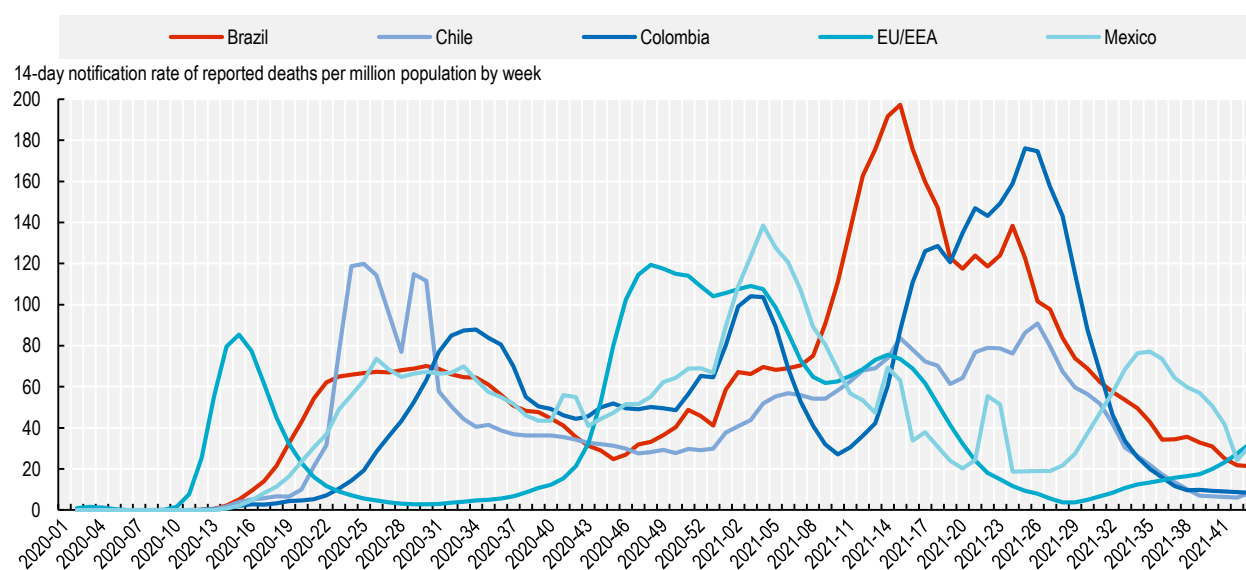
### **2.2.3. The impact of COVID-19 on health and the economy in Brazil has been large, revealing governance weaknesses**

The first case of Coronavirus Disease 2019 (COVID-19) in Brazil was reported on the 25 February 2020. Since then, the impact on population health and the economy has been large. The total number of registered deaths is above 611 000 as of 17 November 2021 with 41 000 average monthly registered deaths in 2021. This situates COVID-19 as the first cause of death during the pandemic when compared to the average monthly figures for 2015-19 of deaths attributed to other conditions, the highest ones being 30 000 for circulatory diseases, 18 500 for cancers, and 13 000 for diseases of the respiratory system.<sup>2</sup> However, there is evidence of underreporting of around 22% of deaths, due to limitations in the ability to perform SARS-CoV-2 RT-PCR test screening (Carvalho, Boschiero and Marson, 2021<sup>[15]</sup>).

Brazil's economy was also hit hard. During 2020, GDP in Brazil dropped by 4.1%, a larger contraction than the 3.5% and 3.1% in the World and G20 countries, respectively. OECD projections released also show signs of a weaker recovery in Brazil, with a projected GDP growth of 3.7% in 2021 and 2.5% in 2022, lower than the 6.3% and 4.7% forecasted for G20 countries (OECD, 2021<sup>[16]</sup>).

The mortality epidemic curve in Brazil experienced an increase by early April 2020, reaching the first peak during July, later than what Europe experienced in the early months of the pandemic. Then, cases started to reduce but remained at relatively high levels, similar to other Latin American countries such as Chile, Colombia and Mexico. By mid-November, cases in Brazil began to rise once again. By the beginning of April 2021, mortality rate in Brazil reached its highest levels since the start of the pandemic and then started to decline (Figure 2.6).

**Figure 2.6. COVID-19 mortality rate evolution in Brazil and selected OECD countries between March 2020 and October 2021**



Source: ECDC (2021<sup>[17]</sup>), European Center for Disease Prevention and Control, <https://www.ecdc.europa.eu/en>.

One of the most important problems in handling the COVID-19 pandemic in Brazil was weaknesses in governance of the health sector. At the federal level, in the first year of the pandemic, four different ministers of health were in office, limiting continuity in the management of the response. Risk communication from federal authorities has also been conflicting and confusing for the population. Brazil is not unique, in that other OECD countries have pursued similar approaches.

The co-ordination between the federal, state and municipal levels has been complex as well. In many OECD countries, national governments have steered stay-at-home and mask-wearing policies. In Brazil, states and municipalities were left with the responsibility to decide and enforce. Shortages in medical supplies and technologies have also been reported. Some states have stepped in to cover their gaps. For example, the state of Maranhão purchased more than a hundred mechanical ventilators on the international market, at a moment of fierce international competition for equipment (Alvarenga et al., 2020<sup>[18]</sup>). Amongst other initiatives, the Interstate Consortium of Sustainable Development of the Northeast Region, created the Scientific Committee to Combat Coronavirus (C4NE) composed of national experts for advising the Consortium and monitoring the pandemic, something that did not exist at the federal level (Pessoa, Teixeira and Clementino, 2020<sup>[19]</sup>).

More recently, the Federal Government has developed a National COVID-19 Vaccine Operationalisation Plan. The plan provides national guidelines regarding the epidemiological situation and definition of the target population for vaccination; the COVID-19 vaccines and its pharmacovigilance; the available information systems; the operationalisation of vaccination; the monitoring, supervision and evaluation; the budget for vaccination operationalisation; post-marketing studies; communication campaign; and the closing of the vaccination campaign (Ministério da Saúde, 2021<sup>[20]</sup>). This plan is very important to align efforts around vaccination, especially as vaccine hesitancy is also widespread in Brazil, linked to scepticism towards the industry and decision makers, the lack of trust in research, and inaccurate information circulating on social media (Caracilo Carvalho Bivar et al., 2021<sup>[21]</sup>). Brazil also takes part in the United Nations COVAX Facility, which is an important mechanism to improve the country's supply of vaccines and for a more equitable distribution of vaccines globally.

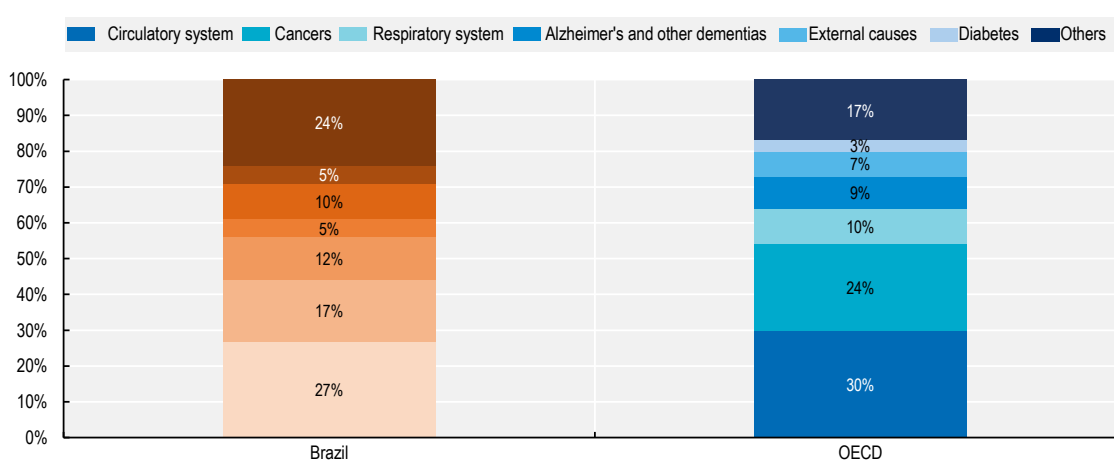


### 2.2.4. Overall, chronic non-communicable diseases represent the greatest burden of disease in Brazil and this is expected to continue

Brazil, similar to many Latin American countries, has had a rapid epidemiological transition moving towards the predominance of chronic non-communicable diseases (NCDs). In 1990, the five main causes of death were varied including two NCDs (cardiovascular diseases, 27.8%, and neoplasms, 11.4%), maternal and neonatal conditions (7.9%), one communicable disease (respiratory infections and tuberculosis, 7.8%) and one injury (self-harm and violence, 5.1%) (IHME, 2021<sup>[22]</sup>). In 2019, four NCDs dominated the causes of mortality in Brazil: circulatory system diseases (27%), neoplasms (17%), chronic respiratory diseases (12%), external causes (10%) and diabetes (5%) (Figure 2.7).

**Figure 2.7. Chronic non-communicable diseases causes most death in Brazil and OECD**

Causes of mortality in Brazil and OECD, 2019



Source: OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

Population death rates in Brazil have been reduced. Between 2000 and 2019, all-cause mortality rates decreased by 14.9% in Brazil, lower than the average decrease of 19.8% in LAC countries and 26% in the OECD. The mortality rate reduction on Brazil's cardiovascular diseases was for example 25.1% between 2000 and 2019. However, there are areas of concern. For instance, deaths attributable to high blood glucose in adults aged 20-69 years old increased by 42% between 2010 and 2019, much higher than the 7.6% increase in LAC and opposite to the reduction of 14% observed in OECD countries.

**Table 2.1. Disability-adjusted life years (DALYs) in Brazil, 2019**

Rank and disorder	DALYs rate per 100 000 people	% change since 1990
1. Cardiovascular diseases	4 089.91	-13.2%
2. Neoplasms	3 154.45	31.01%
3. Mental disorders	2 269.21	20.32%
4. Musculoskeletal disorders	2 218.88	37.17%
5. Other non-communicable*	2 089.45	-40.1%

Note: \*congenital birth defects, urinary diseases and male infertility, gynecological diseases, hemoglobinopathies, and oral disorders.

Source: IHME (2021<sup>[22]</sup>), <https://vizhub.healthdata.org/gbd-compare/>.



In terms of Brazil's national burden of diseases as measured by Disability-adjusted life years (DALYs), the epidemiological transition has also been substantial. In 1990, three among the first five causes of DALYs were communicable and maternal and child health diseases, with maternal and neonatal disorders in the lead explaining 12.94% of all DALYs. By 2019, all first five were chronic non-communicable diseases, while maternal and neonatal disorders moved to 8<sup>th</sup> place (5.15%) (IHME, 2021<sup>[22]</sup>). Table 2.1 shows the current stance and change since 1990 of the top five conditions explaining DALYs in Brazil in 2019.

### **2.3. Brazil's progress towards universal health coverage**

In the past 30 years, Brazil has progressed in well-being for its citizens, including also major health reforms that introduced a universal system that has allowed Brazil to virtually reach universal health coverage although with significant challenges around inequities, quality and sustainability. This section describes the main legal framework and continued reforms of the Brazilian health care system.

#### **2.3.1. A new federal constitution in 1988 gave birth to the current Unified Health System (Sistema Único de Saúde)**

The origins of the Brazilian health system can be traced back to the times of Portuguese colonialism (16<sup>th</sup> to early 19<sup>th</sup> century) with the first hospitals in the main cities, and the imperial phase (second half of 19<sup>th</sup> century) with some organised sanitary police and the first public health tasks being assigned to municipalities. From the end of the 20<sup>th</sup> century, after its first attempts to become a republic and frequently shifting between an unstable democracy and authoritarian regimes, multiple relevant institutional developments occurred, such as the foundation of the Ministry of Health in 1953 and the creation of social security institutions later on (Paim et al., 2011<sup>[23]</sup>).

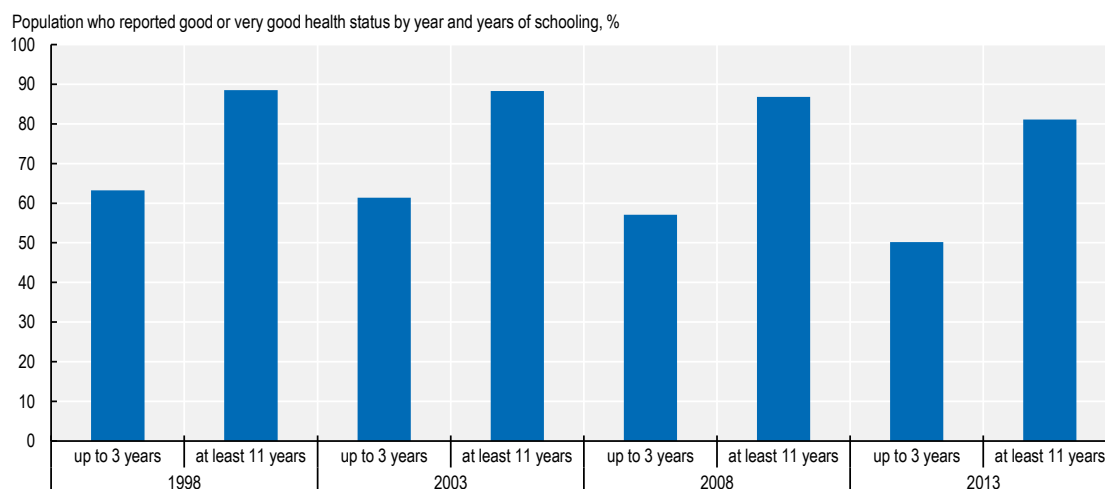
However, the major step towards UHC followed the Federal Constitution of 1988, which paved the way for the creation of the Unified Health System (Sistema Único de Saúde, SUS). The SUS was put in practice after the enactment of Laws 8080 and 8142 in 1990, which enshrined the principles of universality, integrality, decentralisation, and community participation within the health system. They also moved power and responsibility to local governments by transferring duties and health care provision funds from the federal to state and municipal governments (Castro et al., 2019<sup>[24]</sup>). This milestone in the history of Brazil meant that health coverage for the whole population was assured by SUS. However, the extent to which services are covered and the level of financial protection have varied in time and remains a key challenge for Brazil's health system.

#### **2.3.2. The path towards UHC has been quite unequal across socio-economic groups and geographic regions**

As in other OECD countries, Brazil's progress in population health has substantial inequalities. According to the findings of a study analysing national surveys of 1998, 2003, 2008 and 2013 (Viacava et al., 2019<sup>[25]</sup>), people with at least 11 years of schooling who reported good or very good health status has been consistently over 80%, while among people with up to three years of schooling it was over 60% in the first two surveys but closer to 50% in the last two. The gap between these two groups has increased in time: in 1998 the difference was of 25 percentage points, but in 2013 reached almost 31 points (see Figure 2.8).

## Figure 2.8. Socioeconomic inequalities in health are substantial in Brazil

Percentage of population who reported good or very good health status, by years of schooling, by year

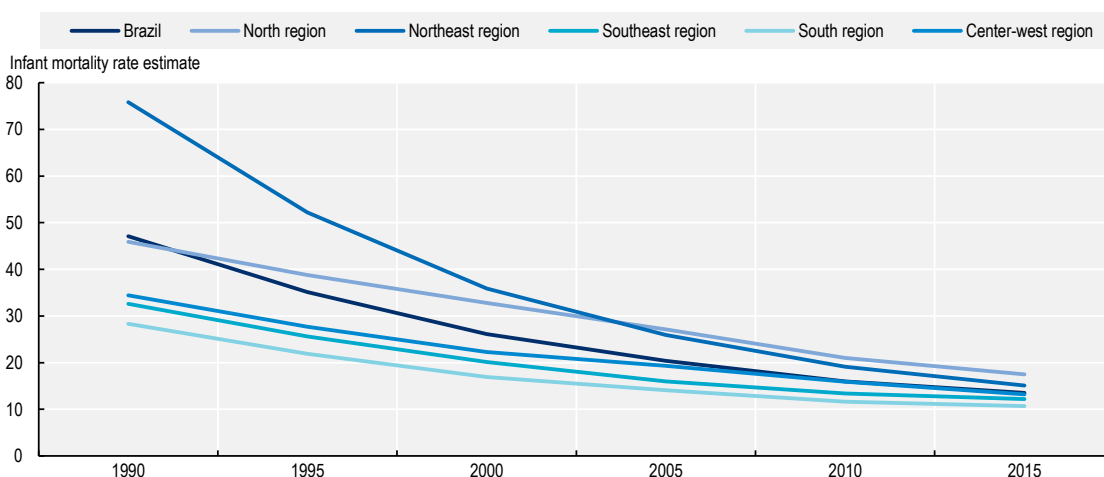


Note: Surveys were PNAD 1998, PNAD 2003, PNAD 2008, and PNS 2013.

Source: Data from Viacava et al. (2019)<sup>[25]</sup>, "Desigualdades regionais e sociais em saúde segundo inquéritos domiciliares (Brasil, 1998-2013)" <https://doi.org/10.1590/1413-81232018247.15812017>.

Another expression of health inequalities can be seen in terms of infant mortality rate (IMR) in Brazil. IMR decreased from 47.1 to 13.4 per 1 000 live births between 1990 and 2015, a reduction of 71%. However, the magnitude of this reduction was not the same across all Brazil's regions. The Northeast region showed the most significant decline of 80% in the period, while the lowest degree of reduction occurred in the Centre-West and North regions (62%). The latter region had the highest IMR in 2015 with 17.5, followed by the Northeast region with 15.1 (Figure 2.9).

## Figure 2.9. Geographic health inequities in infant mortality rate in Brazil, 1990 to 2015



Source: Data from Szwarcwald et al. (2020)<sup>[26]</sup>, "Inequalities in infant mortality in Brazil at subnational levels in Brazil, 1990 to 2015", <https://doi.org/10.1186/s12963-020-00208-1>.

Brazil has pushed forward different policies to reduce health inequalities, particularly among disadvantaged groups of the population. For instance, adding information on colour and race to SUS National Health Cards; providing SUS coverage to gender reassignment surgery; giving attention to sickle cell anaemia, which disproportionately affects black people; exempting homeless from having to show proof of residence to qualify for SUS care; and recognising the role of healers and midwives in health care. In the Ministry of Health, the Special Secretariat for Indigenous Health was created to co-ordinate and manage policies and programs related to the health of indigenous people. As expected, the expansion of primary care has led to large improvements in access and in health outcomes as well (Massuda et al., 2020<sup>[1]</sup>).

### **2.3.3. Health utilisation is higher among wealthier population who can pay for supplemental private health insurance**

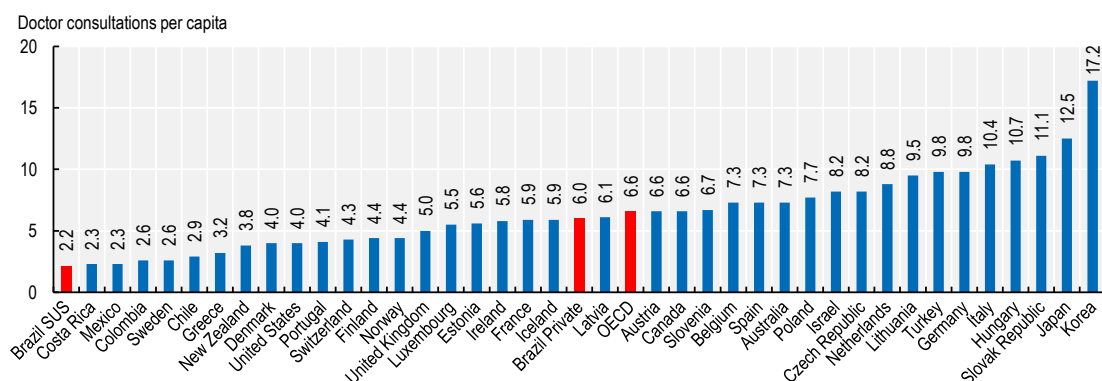
As mentioned before, 25% of the Brazilian population has private health insurance, which is linked to having a better socio-economic situation in order to purchase this type of product. In general, people with private health insurance have higher access to health care services and better health status. Here we summarise a selection of research findings to highlight these differences.

In the area of health status, a study using the Brazilian National Health Survey (BNHS) of 2013 found higher prevalence of current smoking, leisure-time physical inactivity, sedentary lifestyle, whole milk consumption and low ingestion of greens, vegetables, and fruits among those without private health insurance. The authors created a score of unhealthy behaviour, which was significantly worse among those without private health insurance (PR = 1.78) (De Azevedo Barros et al., 2016<sup>[27]</sup>). Another study using the same survey found that populations with lack of private health insurance in Brazil present a similar prevalence of various NCDs (only higher stroke prevalence, but lower musculoskeletal disorders and cancer). However, this group reported much greater degrees of limitation due to these diseases, in particular, from hypertension, asthma, spinal problems, depression, cancer and chronic kidney failure (Malta et al., 2016<sup>[28]</sup>).

About health care services utilisation, a study also using the BNHS 2013 found that people without private health insurance compared to those with private health insurance were more than two times likely to underutilise the health system (AdjOR = 2.11, 95% CI = 1.83-2.44). This meant that people with no private insurance had a higher rate of reporting never visited a physician, or never visited a dentist, or never checked the blood glucose, or never checked the blood pressure (Boccolini and De Souza Junior, 2016<sup>[29]</sup>). This is also confirmed by a study focusing on breast cancer outcomes in Brazil, which observed that patients with no private health insurance presented with more advanced disease at diagnosis ( $P < 0.001$ ) and had worse disease-free survival and overall survival for stage III – IV patients ( $P = 0.002$  and  $P = 0.008$ , respectively). They also found worst post-relapse survival among the group with no private health insurance ( $P < 0.001$ ) (Liedke et al., 2014<sup>[30]</sup>). Moreover, a recent study using data from the National Household Survey 2008 applied an econometric methodology to estimate the effect of private health insurance and the government subsidy by means of an income tax rebate. The study results indicate that private coverage increases the odds for women examinations for pap smear and mammogram, and the number of visits to a doctor in the last two weeks and in the last year. On the other hand, private health insurance had no effects on the use of non-preventive care, such as inpatient and outpatient care utilisation, surgery, in home emergency service and the use of prescribed and non-prescribed drugs (Menezes-Filho and Politi, 2020<sup>[31]</sup>).

Amongst OECD countries, a commonly used measure of health care access relates to medical consultations. Figure 2.10 shows that Brazil has the lowest doctor consultations per capita among OECD countries. In 2019, Brazil had 2.2 doctor consultations per capita in SUS, lower than the OECD average of 6.6. On the other hand, Brazil had six doctor consultations per capita considering the population with private insurance.

**Figure 2.10. Consultations with a doctor in the past year in population with and without private health insurance in Brazil and OECD countries, 2019 (or latest year)**

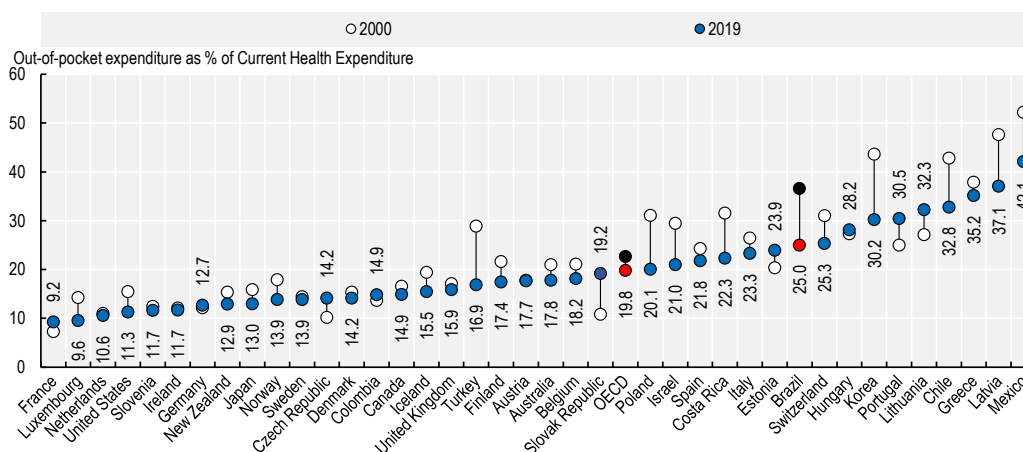


Source: Ministry of Health of Brazil, ANS Brazil, OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

### 2.3.4. Out-of-pocket expenditure has been substantially reduced in recent decades, but remains higher than the OECD average

As coverage expanded, households' out-of-pocket expenditure in health have fell in the past two decades (Figure 2.11). Today, out-of-pocket expenditures in Brazil reach 25% of total national health expenditure (equivalent to around 1% of GDP), positioning the country above the 20% OECD average but below many countries in the LAC region. The sustained reduction of out-of-pocket expenditure in health is a significant achievement of SUS expansion and consolidation (see Chapter 3 for further details).

**Figure 2.11. Evolution of Brazil's out-of-pocket expenditure as percentage of current health expenditure, 2000-19**



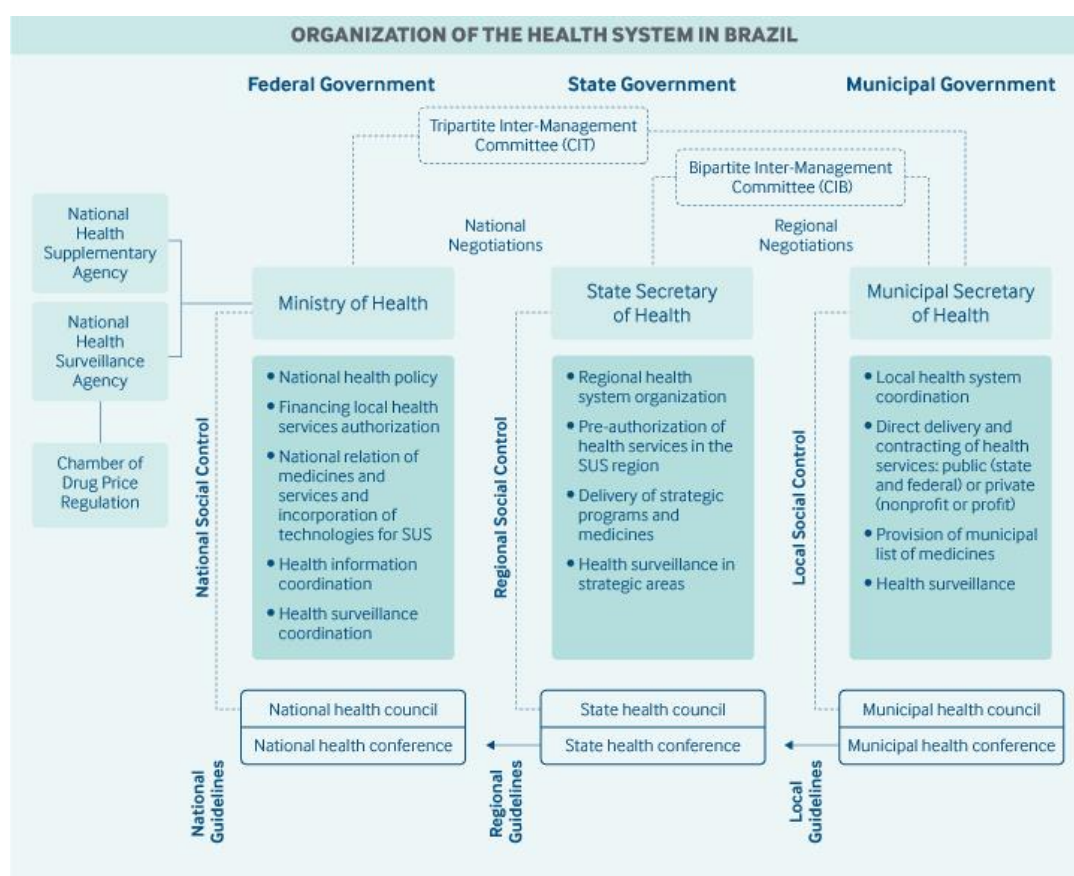
Note: In 2019, around 3% of all health spending in Brazil cannot be allocated to any financing scheme so the actual share of OOP expenditure may eventually be higher.

Source: OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

## 2.4. The major actors in the Brazilian health care sector

The Brazilian health care system is predominantly public in terms of governance, funding and provision through SUS. The Federal Constitution also allowed the open participation, in a complementary way, of private initiative in the provision of health care. The central management of the system is the responsibility of the Ministry of Health, while the execution of actions occur mainly in a decentralised manner, with the municipal component being the main health care provider. All citizens are entitled to the services provided by SUS, which is the major source of health care for low-income groups and those without access to private health plans. Figure 2.12 presents a scheme with the general organisation of the Brazilian health system and its main actors.

Figure 2.12. General organisation of the Brazilian health system



Note: Acronyms in the figure are in Portuguese.

Source: Adapted from Massuda et al. (2020<sup>[1]</sup>), "Brazil – International Health Care System Profiles", <https://www.commonwealthfund.org/international-health-policy-center/countries/brazil>.

This section presents the major stakeholders within the Brazilian health care sector, as well as their responsibilities. It also describes important challenges for the actors within the public system, as well as the evolving role of private health care providers.

### **2.4.1. Federal government and national agencies are responsible for steering the health sector**

Considering the legal bases of SUS, the Ministry of Health has the mandate to formulate, define, audit, control and evaluate the set of health policies and services linked to SUS, along with the co-ordination of its national actions. The execution of activities is preferably carried out in a decentralised manner, with the municipal component being the main provider of health care services.

The areas considered under the Ministry of Health mandate include food and nutrition policies; health surveillance systems; the network of public health laboratories; the health care network, especially of high complexity; as well as the national strategic planning within the scope of SUS, in technical co-operation with the States, Municipalities and the Federal District. Regarding the latter area, Box 2.1 describes Brazil's Multi-Annual Plan 2020-23 and the National Health Plan 2020-23. In addition, universal access to highly complex procedures, such as organ, tissue, cell and human body transplants has been a high priority in Brazil. With more than 400 000 transplants since 2001 (of which 90% is financed by SUS), the National Transplantation Policy in Brazil is one of the largest programme worldwide.

#### **Box 2.1. Planning for health in Brazil at the national level**

##### **Multi-Annual Plan 2020-23 (Plano Pluriannual, PPA 2020-23)**

The current Multi-Annual Plan (PPA) was approved by the National Congress and instituted in Law No. 13971 of 27 December 2019. The PPA is a government planning instrument developed by the Secretariat of Evaluation, Planning, Energy and Lottery (Secap), which defines the guidelines, objectives and goals of the federal public administration for a four-year horizon. It considers a wide range of key areas for the country, for instance, around tourism, sustainable agriculture and livestock, integral early childhood care, civil aviation, among others.

The PPA 2020-23 law mentions, in its Article 3, its 20 directives. Item XI is related with health: expansion of the coverage and resolution of primary health care, with a priority in prevention and the strengthening of integration between health services, containing seven programmes:

- Programme 5017: Pharmaceutical services in SUS.
- Programme 5018: Specialised Health Care.
- Programme 5019: Primary Health Care.
- Programme 5020: Scientific, Technological and Productive Development in Health.
- Programme 5021: SUS Management and Organization.
- Programme 5022: Protection, Promotion and Recovery of Indigenous Health.
- Programme 5023: Health Surveillance.

### National Health Plan 2020-23 (Plano Nacional de Saúde 2020-23)

Law No. 8 080/90 defines the legal obligation to elaborate a National Health Plan, in alignment with the health policy needs and the availability of resources in health plans of Municipalities, the States, the Federal District and the Union.

The current National Health Plan 2020-23 has the same seven programmes listed in the PPA 2020-23, bringing details of the commitments of the Federal Administration for the health sector.

Sources: Information taken from Presidência da República (2019<sub>[32]</sub>) “Lei Nº 13.971. Institui o Plano Plurianual da União para o período de 2020 a 2023”, [http://www.planalto.gov.br/ccivil\\_03/\\_ato2019-2022/2019/lei/L13971.htm](http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2019/lei/L13971.htm) and Ministério da Saúde (2020<sub>[33]</sub>), “Plano Nacional De Saúde 2020-23”, [https://bvsms.saude.gov.br/bvs/publicacoes/plano\\_nacional\\_saude\\_2020\\_2023.pdf](https://bvsms.saude.gov.br/bvs/publicacoes/plano_nacional_saude_2020_2023.pdf).

The main quasi-autonomous national level health agencies are the National Supplementary Health Agency (*Agência Nacional de Saúde Suplementar*, ANS) and the National Health Surveillance Agency (*Agência Nacional de Vigilância Sanitária*, ANVISA). Both agencies are linked to the Ministry of Health having an arms-length relationship, being governed by collegiate boards consisting of five directors with 3-year terms, which can be renewed.

As the Federal Constitution allows the open participation, in a complementary way, of private provision of health care, the ANS was created in the year 2000 with the mission of “promoting the defence of the public interest in supplementary [private] health care, regulating sector operators, including regarding their relations with providers and consumers, contributing to the development of health actions in the country” (Law 9961, of 28 January 2000).

The agents regulated by the ANS are the operators of health care plans (private insurance companies), because what circumscribes the object of the regulation are not the medical-hospital or dental services themselves, but the guarantee of health care coverage, which is characterised by the intermediation of these health care services. The ANS is in charge of proposing general policies and guidelines for the authorisation, regulation, monitoring and control of the supplementary health market. In particular, the ANS can define the list of health care procedures and events that constitute the basic reference for health care coverage and evaluate the technical and operational capacity of private insurers, aiming to guarantee the compatibility of the coverage offered, including regarding the dimension of the health care network. The ANS also monitors the evolution of the prices of plans and service providers, and authorises readjustments and reviews of the financial characteristics of health plans, after consulting the Ministry of Economy, while also sanctioning processes of spin-off, merger, incorporation or transfer of the operators’ corporate control. In this way, the ANS monitor and evaluate the economic and financial situation of the operators, with a view to preserving the systemic balance of the sector. Importantly, the ANS articulates with consumer protection agencies and establish norms for the reimbursement to SUS. ANS takes care, in particular, of certain aspects of the functioning of the market, seeking, if not to correct, at least, to mitigate its flaws, especially the asymmetry of information between beneficiaries, operators and health care providers, in the search for systemic balance between these actors and, with this, the sustainability of the sector.

ANVISA was created by Law No. 9782 of 26 January 1999 as an independent public entity under a special regime, which has its headquarters and jurisdiction in the Federal District, and is present throughout the country through the co-ordination of ports, airports, borders and customs areas. ANVISA’s mission is to protect and promote the health of the population by intervening in the risks arising from the production and use of products and services subject to health surveillance, in co-ordinated and integrated action within SUS.

ANVISA is responsible for the health surveillance and regulation of medicines; medical devices (health products); food; sanitizing; cosmetics; smoking products, whether or not derived from tobacco; health services and services of interest to health; in addition to blood, tissues, cells and organs. This body is



responsible for registering, operating authorisation, standardisation, certification of good practices, post-market surveillance and health surveillance.

#### ***2.4.2. Brazil's health system governance is shared across different entities and its management decentralised***

The SUS has a shared governance structure, foreseen in the Federal Constitution from the perspective of common competence of the three levels of the federation: federal, states and municipalities. State government duties include regional governance, co-ordination of strategic programs (such as provision of high-cost medicines), and delivery of specialised services that have not been decentralised to municipalities. Health departments in the 5 570 municipalities largely handle the management of SUS at the local level, including co-financing, co-ordination of health programs, and delivery of health care services.

In order to respect the autonomy of each federative entity, the so-called Interfederative Pact of Executive Management allow SUS to have a dynamic functioning through agreements between its parts (Ministério da Saúde, 2015<sup>[34]</sup>). To this end, there are several spheres of governance, namely Councils and Commissions. The main ones are described in Box 2.2.

## Box 2.2. Main governance bodies in the Interfederative Executive Management of SUS

### Conselho Nacional de Saúde (CNS)

The National Health Council (CNS) is a collegiate, deliberative and permanent body of SUS with the mission to oversee, monitor and supervise public health policies, taking the demands of the population to public power. The CNS is composed of 48 members and their respective first and second alternates, representing users, workers, SUS managers and health service providers. Entities of health professionals, scientific community, service providers and private sector are part of the CNS. The CNS has elections every three years to choose its members. Among its main tasks, the CNS approves the health budget and monitoring its implementation, evaluating the National Health Plan every four years.

### Conselho Nacional de Secretários de Saúde (CONASS)

It brings together the health secretaries of the states and the Federal District and their legal substitutes, with the purpose of operating the exchange of experiences and information among its members. It aims to ensure the implementation of the constitutional principles, legislation and guidelines into health actions and services. It makes efforts for the health secretariats of the states and the Federal District to participate in decision making concerning the development of SUS, together with the Ministry of Health. Its board is elected in annual assemblies.

### Conselho Nacional das Secretarias Municipais de Saúde (CONASEMS)

It is a non-governmental, non-profit entity created to represent the municipal health departments. Its importance in the Brazilian political scenario is because it is primarily up to the municipalities to provide health services, with the technical and financial co-operation of states and the Union. CONASEMS holds an annual congress to discuss issues of interest to the municipal managers and define guidelines for their representatives. Every two years, CONASEMS elects its board of directors.

### Conselho Estadual de Secretarias Municipais de Saúde (COSEMS)

The municipal health secretaries get together at COSEMS to discuss the strategic issues before presenting their positions at the CIB. The COSEMS are also instances of political articulation between municipal health managers.

### Comissão Intergestores Tripartites (CIT)

Body for the articulation and consensus in the federal sphere of SUS governance, including the development of SUS strategies, guidelines, programmes and resource allocation. It is made up of SUS managers from the three spheres of government: five are appointed by the Ministry of Health, five by the CONASS, and five by the CONASEMS. Decisions are taken by consensus.

### Comissão Intergestores Bipartites (CIB)

State spaces for articulation and political agreement aimed at guiding, regulating and evaluating the operational aspects of SUS decentralised health actions. Members are representatives appointed by the Secretary of State for Health and by the COSEMS.

Source: Information taken from the Ministry of Health of Brazil (2009<sup>[35]</sup>) "O SUS de A a Z: garantindo saúde nos municípios", <http://www.saude.gov.br/bvs>.

The Federal Constitution guarantees community participation in the public health system at all levels of government. The so-called 'social control' takes form through health councils (Box 2.2) and health conferences, which are composed of 50% community members, 25% providers, and 25% health system

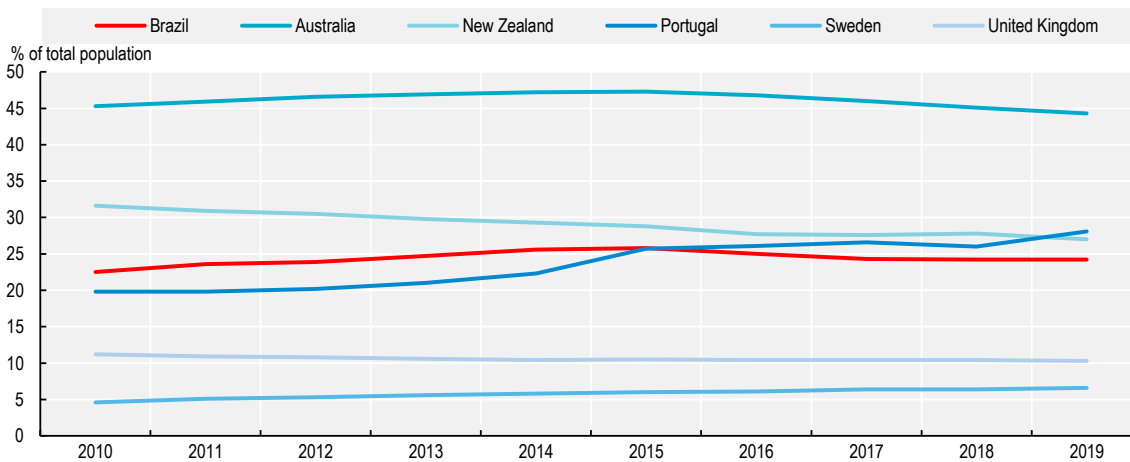
managers. The health councils are deliberative and permanent collective bodies of SUS, proposing strategies and monitoring the implementation of health policies, including its economic and financial aspects. The creation of the councils must be the subject of a law or decree at municipal level or state. Conferences are institutional spaces designed to analyse the progress and setbacks of SUS and propose guidelines for health policy formulation at corresponding levels. The decisions on public health policies, elaborated in the councils, are discussed during the conferences. Conferences should take place every four years (Ministério da Saúde, 2009<sup>[35]</sup>).

### 2.4.3. Private actors are sizable players in the Brazilian health system

Private sector is present at the financing and provision levels of health care. Restricted access and discontent with health care services have progressively motivated middle-income and high-income households to seek private care.

Private health insurance (PHI) is voluntary and can be classified as duplicate coverage as it covers medically necessary curative services that are also covered under SUS. In 2019, 24.2% of Brazilians had PHI while in 2008 this proportion was around 22% (OECD, 2021<sup>[7]</sup>). When compared with other OECD countries having a national health service or a national health insurance scheme and reporting to have duplicate PHI, Brazil stands close to Portugal (28.1%) and New Zealand (27%), lower than the 44% in Australia and higher than the 6% and 10% in Sweden and the United Kingdom, respectively (Figure 2.13).

**Figure 2.13. Duplicate private health insurance in Brazil and selected OECD countries, 2010-19**



Note: Selected OECD countries have either a national health service or a national health insurance scheme and report having duplicate PHI.  
Source: OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

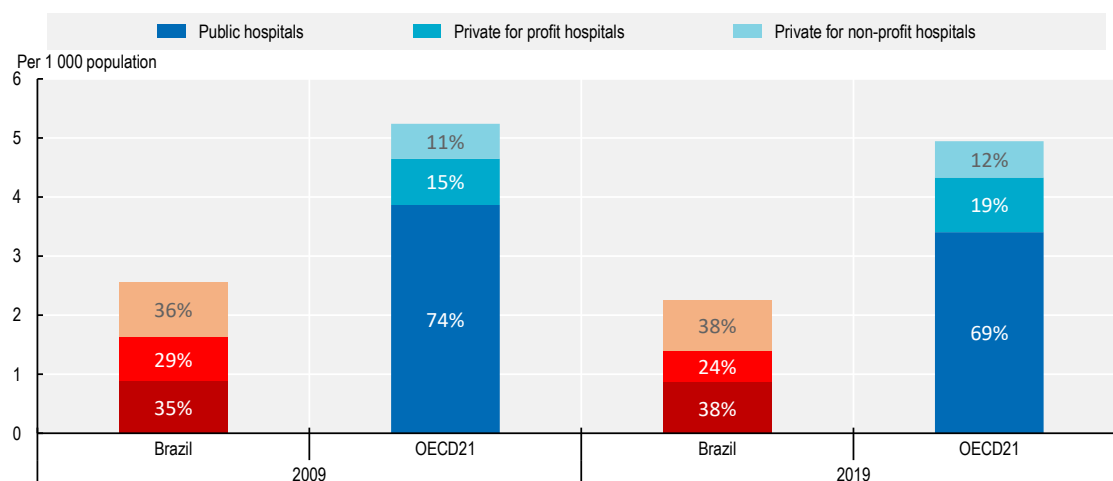
Nearly 70% of Brazilian beneficiaries receive their private health insurance as an employment benefit. Private health plans offer health care services through their own facilities or through accredited health care organisations. Alternatively, private insurance can reimburse enrollees for purchased health care services. Brazil spends 0.5% of GDP on tax exemptions for private health care, primarily to subsidise those who pay for private health insurance (see Chapter 3). Individuals and legal entities may deduct health insurance costs as well as the purchase of health services, medicines, and medical supplies from their taxable expenses (Massuda et al., 2020<sup>[11]</sup>).

On the provision side, in Brazil 38.2% of hospital beds were public, 38.1% private non-profit, and 23.6% private for-profit in 2019, while in the OECD the largest portion of beds is public with 69% and only 19% is

private for-profit (Figure 2.14). Between 2009 and 2019 in Brazil, public hospital beds increased by 10%, while private for-profit beds decreased by 18% and private non-profit beds increased by 5%. In total, Brazil saw a reduction of 11.5% in the number of beds, higher than the reduction of 5.7% in OECD countries. When estimated in per population basis in 2019, Brazil had a total of 2.2 beds per 1 000 population, much lower than the average of almost five beds per 1 000 people in OECD countries.

**Figure 2.14. The share of public hospital beds in Brazil is much lower than in OECD countries**

Hospital beds by ownership type in Brazil and OECD, 2009 and 2019



Note: OECD21 averages represent years 2009 and 2019.

Source: Ministry of Health of Brazil and OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

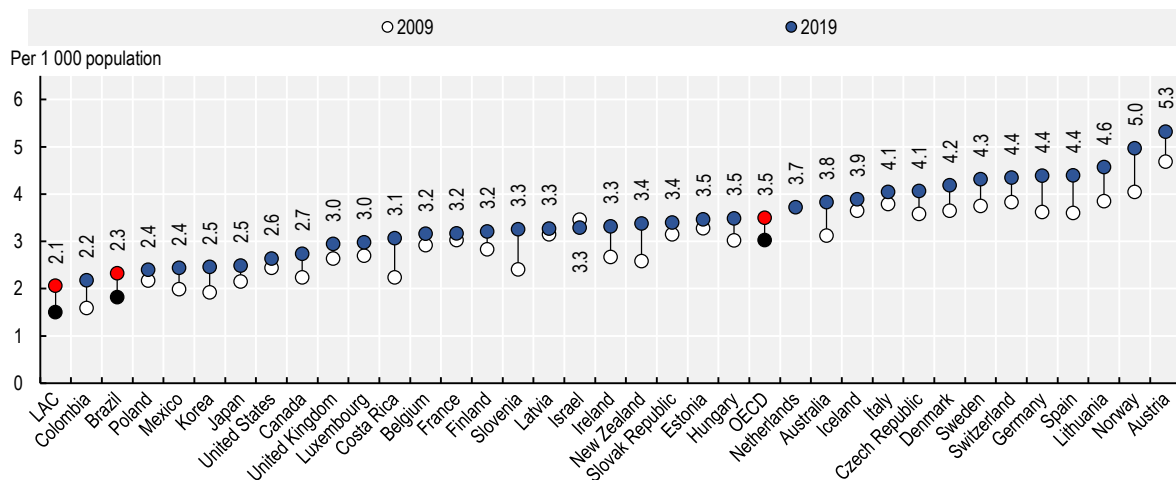
#### 2.4.4. Brazil has fewer doctors and nurses when compared to OECD averages

Compared to OECD health systems, Brazil has very few doctors and nurses. Physician density in Brazil in 2019 was 2.3 per 1 000 inhabitants, lower than all OECD countries (except Colombia) and well below the average of 3.5. Although, it is above the LAC average of 2.1. Between 2009 and 2019, Brazil increased this rate by 28%, while LAC countries in average increased by 37% and the OECD by 16% (Figure 2.15).

The number of medical schools is growing exponentially, driven mainly by the opening of private institutions. In 2020, there were 345 medical schools, offering more than 35 000 training positions. Of these schools, 41% were public and 59% private. Public medical schools are free, while tuition at private medical schools varies from USD 700 to USD 2 500 (BRL 3 600 to BRL 13 000) per month (Escolas Médicas do Brasil, 2021<sup>[36]</sup>).

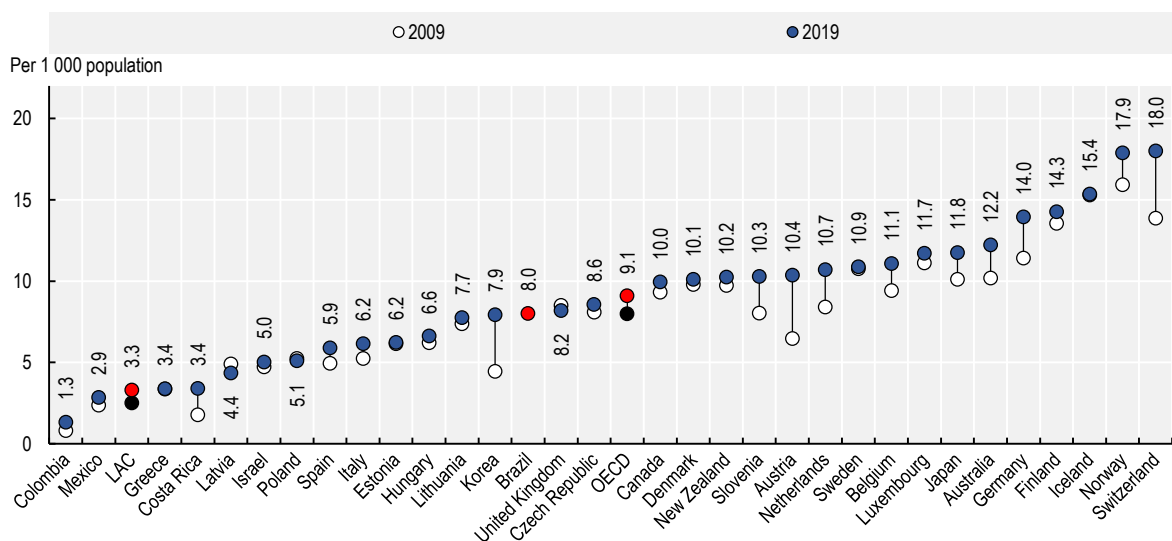
Brazil's nursing workforce has increased over the past decade to reach 8 nurses per thousand population in 2019, moving closer to the OECD average of 9.1 (Figure 2.16).

**Figure 2.15. Practising physicians per 1 000 population in Brazil and OECD countries, 2009-19 (or latest year available)**



Source: Ministry of Health of Brazil, WHO for LAC average and OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

**Figure 2.16. Nurses per 1 000 population in Brazil and OECD countries, 2009-19**



Source: Ministry of Health of Brazil, WHO and OECD Health Statistics (2021<sup>[7]</sup>), <https://doi.org/10.1787/health-data-en>.

In general terms, two of the main health workforce problems that persist in the Brazilian health system are the shortage of doctors and the misdistribution of professionals between levels of health care and between geographical areas (Oliveira et al., 2017<sup>[37]</sup>). Addressing Brazil's health workforce issues requires attention to some fundamental issues, in particular related to governance and political matters that have been underpinning the development and stability of national policies. For instance, the More Doctors Programmes (*Programa Mais Médicos*) was implemented by the Federal Government (Law No. 12 871 of 2013) with the purpose of reducing the shortage of doctors in prioritised regions and improving medical training in the country. By November 2020, the programme was responsible for the presence of more than 16 000 doctors in 3 837 Brazilian municipalities. This programme has proven to have positive results, for instance, in terms of doctors availability and health outcomes (Hone et al., 2020<sup>[38]</sup>; Netto et al., 2018<sup>[39]</sup>;

OECD, 2021<sup>[40]</sup>). In this scenario, a new programme called *Médicos pelo Brasil* (law No. 13.958 of 18 December 2019) was initiated by the new Federal Government administration. Its purpose was to increase the provision of medical services in places of difficult delivery or of high vulnerability, along with promoting the training of doctors specializing in family and community medicine. The *Médicos pelo Brasil* programme is expected to gradually replace the Programa *Mais Médicos*, in particular by hiring Brazilian trained doctors who have already shown to be scarce or not wanting to go to isolated or underserved areas. This type of changes represent a governance challenge for the Brazilian health system, which should develop a strategic vision to preserve and amend policies and programmes that have shown to improve outcomes.

## 2.5. Conclusion

Many measures of health system performance in Brazil have improved since SUS was created in 1988. Virtually all of the population is covered for equal benefits and equal financial protection within the public health sector, while one-quarter of the population that can purchase private health insurance obtains mostly duplicate health care services. Out-of-pocket payments represent around 25% of total national health expenditure, higher than the OECD average.

The new epidemiologic profile and persistent health inequalities, along with a post-COVID-19 recovery period, suggest that continued adjustments and reforms are needed in Brazil's health system. In broad terms, SUS and the range of health care providers are not as developed as they need to be to both keep Brazilians healthy and to deliver a high-quality, people-centred and sustainable health care system – issues that will be considered in further detail in the following chapters.

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## Notes

<sup>1</sup> Around 3% of all health spending in Brazil can currently not be allocated to a financing scheme so the actual shares of the individual financing schemes may in fact be slightly higher.

<sup>2</sup> Data for COVID-19 deaths retrieved from OWID, and data for all-causes of mortality in Brazil during 2015-19 retrieved from DATASUS.



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