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Panel 'Redesigning health systems in a changing world'

Wednesday, 29th April, 2009, from 11:00 to 12:30

Presentation:

**REDEFINING HEALTH SYSTEMS IN A CHANGING (OR
CHALLENGING?) WORLD**

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Ladies and Gentlemen,

“Health for development” – that is, the idea that health is a key dimension in achieving higher levels of development – has increasingly permeated

political discourse nationally and internationally, to the point where today health issues are one of the main concerns of many countries' foreign policy – and that includes Brazil.

The recognition that health is a key determinant of economic growth, labor productivity and poverty reduction has propelled the issue of health to the forefront of the international development agenda. Correspondingly, since the start of the twenty-first century we have seen the health landscape transformed by a six-fold increase in foreign aid and private spending.

On the other hand, reducing health disparities by way of their social determinants is inextricably linked with social protection policy, economic management and development strategy.

Unfortunately, the increased number of national players, resources and political support for global health has yet to deliver in providing tangible change in health outcomes for all populations. In many parts of the world, even those we have credited as

economic success stories, health remains a striking challenge.

By far the major part of new global health money has been committed to some disease (HIV/AIDS, now a billion-plus effort, or tuberculosis and malaria), diverting attention and funds away from the more fundamental political, social and economic determinants of poverty and the spread of infectious diseases. While the share of health aid devoted to HIV/AIDS more than doubled between 2000 and 2004, the share devoted to primary care almost halved over the same period.

The world is desperately short of health professionals, and that gap promises to widen; there is an external and an internal brain drain; and the difficulties of treating HIV and other diseases and of scaling up prevention measures are further exacerbated by the current state of the health systems and capacities in precisely the countries hardest hit by health problems. In other words, health systems have an important role to play in this dynamics.

To a large degree, this situation has been explicitly induced over recent decades by restrictive economic and social policies. The severe economic crisis of the 1970s and 80s marked far-reaching, simultaneous, world changes which substantially altered the nature of economic and power relations among nation-States.

The crisis also called into question values and principles that, until then, had been consolidated and widely accepted:

- the State's power of intervention in the market;
- the universal nature of social policies, including health policies;
- and the primacy of the collective over the individual.
- Economic reform policies in all central and peripheral countries were determined by the macroeconomics of adjustment and restructuring processes, which extended the same dynamics of restrictive reforms to social and health matters.

In the 80s, arguing fiscal crisis and the high cost of medical care, opposition to any policy designed to expand or even maintain existing

patterns of health system growth and performance gained extraordinary momentum. The control over public deficit and health spending was bundled with macroeconomic demands, incorporating the same principles of “less State” and more privatization, flexibility and deregulation – and this for all countries, even though the origins of the public deficit and the levels of national health spending were so very different in countries of the North and South.

New models for reforming and reorganizing health systems and services were proclaimed and implemented worldwide, while the State was pronounced inherently inefficient as a public service manager, and the private sector was heralded as a far superior means of achieving better results both in public health service access and in care provision, with greater equity and efficiency. This happened even in countries and regions with a history of high private health spending, such as Latin America and Africa.

The confluence of all these dimensions heightened the individualist – in opposition to the

collective – attitude to resolving social problems and demanded far-reaching institutional changes, besides having serious implications for economic, political and social development worldwide.

As a result, by and large, these reforms of health services systems did not help overcome existing inequalities, in either the North or the South; rather, in many cases, particularly in the South, they further impaired health systems' already precarious problem-solving capacity, thus worsening the inequities.

Access to health ceased to be regarded as a public good, and privatization worsened people's access to health services, demanding greater private spending, even among the neediest populations. There is disregard for epidemiological concerns and for the execution of public health programs, and prevention and control of endemic, epidemic and transmissible diseases.

The situation is different where, historically, health has been considered a fundamental social and human right and, as a result, attempts to

dismantle systems were unsuccessful, as for instance in the countries of Western Europe.

In the same way, despite the onslaught against the universality of public health protection, even in the South it was possible to carry through reform processes – like Costa Rica’s – that abide by the universal principles on which health systems are structured, and also to implement health system reform – like Brazil’s – based on the principle of the “right to health as a citizens’ right”, which was totally at odds with the restrictive ideas dominant at the time.

In any country, investment in strong public health systems and in universal access to health services is key to improving healthcare worker morale and retention. It curtails the spread of infectious disease and improving the overall health of individuals and populations. The construction of such health systems requires years of long-term investment.

However, the challenge is enormous, as illustrated so well by Health reform in Brazil. In my

country, we went clearly against the international trend, when establishing our universal health system.

The Brazilian Health System

The Brazilian national health system is based on the Federal Constitution of 1988, following in the context of the re-democratization process after the military dictatorship, which sets out the principles and guidelines for the delivery of public health and health care in Brazil through the country's Unified Health System (SUS).

The Constitution establishes (article 196) that 'health is a right of all and a duty of the State and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other hazards and by the universal and equal access to actions and services for its promotion, protection and recovery'.

This system is guided by the principles of universality, equity, integrality, decentralization and

community participation. It is integrated in a regionalized, multilevel network under the responsibility of the three levels of government (federal, state, and municipal). The private sector plays a complementary role.

The SUS operational guidelines call for decentralized management, integrated care, and community participation, approved by the governing bodies of the system: the Tripartite Interagency Commission (CIT) and the National Health Council (CNS).

To ensure coordination of the SUS' activities in the three spheres of government administration, there are two negotiating and consensus-building bodies, which meet regularly:

- at the state level, the Bipartite Interagency Commission, with equal representation of the State Secretariat of Health and the Council of Municipal Secretaries of Health (CONASEMS);
- and at the national level, the Tripartite Interagency Commission, with equal representation of the Ministry of Health and of the National Councils of State and of

Municipal Secretaries of Health (CONASS and CONASEMS).

The agreements reached by these Commissions are formalized at the corresponding level of government.

Social participation in the SUS occurs primarily through two formal bodies: health councils and health conferences, organized on the federal, state, and municipal level.

The Ministry of Health is responsible for leading the process of regionalization of health care networks and ensuring that the public health system has adequate response capacity. To that end, it proposes and approves general guidelines and standards for regionalization, in accordance with the norms and agreements of the Tripartite Interagency Commission currently in effect. The Ministry, through the states and municipalities, is also responsible for providing technical and financial cooperation to the health regions, giving priority to the most vulnerable regions and promoting equity among regions and states.

The private sector is regulated by the Ministry of Health through the National Supplementary Health Coverage Agency - *Agência Nacional de Saúde Suplementar* (ANS) that monitors trends in the prices of private plans, as well as the activities of private providers and the use of resources; it also authorizes corporate subdivisions, mergers and acquisitions, incorporations, and modifications, and it oversees coordination with consumer protection entities.

Production and marketing of health related goods and services, processes, inputs, and technologies are regulated by the federal, state, and municipal agencies that comprise the National Health Surveillance System. The Ministry of Health coordinates the system through the National Health Surveillance Agency/*Agência Nacional de Vigilância Sanitária* (ANVISA), which is also responsible for health regulation at ports, airports, and borders.

Universality through the primary health care

Primary care in Brazil has undergone a progressive process of strengthening with the implementation of Family Health Strategy (FHS) in every municipality in order to become effectively the gatekeeper of the health system and coordinator of the process of integration of the health services.

The FHS aims to provide health care guided by the principles of universality, accessibility, coordination of care within the network of services, and continuity, comprehensiveness, accountability, equity.

FHS is developed by multi-professional teams composed by at least a general practitioner or family doctor, nurse, nursing technician and a group of community health workers. Each Family Health Team (FHT) takes responsibility for a territory of around 1,000 families or 4,000 inhabitants. They must perform comprehensive care and coordinate actions in promotion of health, health surveillance, prevention and treatment of diseases, and rehabilitation within the scope of primary care.

The coordination of the referral process by the FHT avoids the fragmentation and deregulation of the health system. An integrated health system accounts to outcomes such as cost control or expenditure regulation, increase in health provision efficiency, implementation of new patterns of health services, shifts in continuum of health care, i.e. improving patients satisfaction as well as quality of services and health gains.

Therefore, the network must be understood as a set of interrelated establishments. The primary care unity is the service that naturally stands closest to the users. A number of FHT is always supported by services such as diagnostic or laboratory centers. Furthermore, there must be services which provide specialized care and/or inpatient treatment whenever the team detects the need.

Currently (2008), the PSF was being carried out in 5.233 Brazilian municipalities, with 29.149 family health teams providing care for approximately 93.178.011 million people (49,5% of the population). The program also applies differentiated strategies in

the poorest areas and the areas with lowest coverage; in particular, rural areas of the Amazon region and municipalities with fewer than 30,000 inhabitants and a Human Development Index of 0.7 or less. Since 2004, through the “Smiling Brazil” program, resources have been allocated to expand oral health teams and establish oral health care centers. In 2008, 674 centers were operating in 5.564 municipalities of 27 states.

Current health strategies and programs

The Health Industry Complex

The Ministry of Health of Brazil nowadays has a new perspective on the Health Industrial Complex, which represents 8% of the GDP. Since December 2007, when the “Mais Saúde” (“More Health”) program was launched, Health has been seen not only as a condition of citizenship, but also as a space for the production of income and wealth, for economic development and qualified jobs.

Among the criteria for attracting investments, one could mention: research and development activities (“R&D”) in Brazil; partnerships with local private and public producers; contribution to the trade balance; and benefits for Public Health in terms of access to and quality products (cooperation with the regulatory system – sanitary, intellectual property, public sector intermediation, etc.).

Following this point of view, measures were taken to strengthen the health industry complex, including the articulation of nine PPPs (Public Private Partnerships) (seven public laboratories e 10 private companies) for the production of 24 pharmaceutical in Brazil, destined to be used by SUS patients. Besides this, the Brazilian public sector has started to produce the generic version of the ARV (antiretroviral) Efavirenz.

Efavirenz is part of the anti-AIDs cocktail, and is produced in Brazil through a compulsory licensing scheme, due to the fact that its manufacturer insisted in imposing on Brazil a pricing scheme of its own,

based on a segmentation of the international markets that placed an unacceptable burden on Brazil.

The Ministry of Health of Brazil has also published a list of the areas of interest for investments and actions designed to use the purchasing power of the Federal Government to increase national research and production.

Closing remarks

International technical cooperation in health and international donors also have an important role to play, contributing not only the necessary funding, but more importantly supporting the endeavor to strengthen the national institutions that structure health systems. It is on that basis that the Ministry of Health of Brazil, through Fiocruz, is pursuing its work of South-South cooperation with African and Latin American countries.

The present financial crisis and global economic recession demand we think about their

potentially devastating impact on health and the prospects for health sector reform.

But, while the crisis certainly holds many dangers, a severe economic crisis — precisely because of the social pain it inflicts — can also be an opportunity, and the painful lessons learned over recent decades can also galvanise political will and leadership towards sustained social change.

A number of recent international initiatives point to the existence, in the social field, of a new outlook on addressing the present critical situation – the MDGs, the work of the CSDH (Comission on Social Determinants of Health), the Declaration of Paris, Health Diplomacy, the resurgence of PHC and so on.

Meanwhile, the election of left-wing governments in Latin America and Barack Obama in the USA usher in a new political and economic environment, and we could also see a forceful reassertion of the role of the State by national governments, not only strengthening their regulatory authority over markets, as in past decades, but also playing a greater role in social protection, which

entails revitalizing the principle of universal coverage, i.e., a broader social construct of health.

For that to happen, however, Governments must and can decide to work in favor of their populations.

Thank you.