Mobilizing Financing for Universal Health Coverage in Brazil

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Resilient Health Systems

Resilience is a fundamental attribute of well-developed and well-functioning health systems through which health providers, institutions, and populations prepare for and respond effectively to crisis, maintain core functions when a crisis arises, and reorganize based on lessons learned if conditions warrant.

Strategy for Building Resilient Health Systems and Post-COVID-19 Pandemic Recovery to Sustain and Protect Public Health Gains

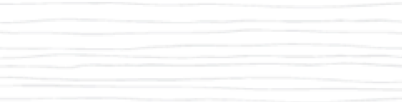
Resolution CD55.R8, PAHO, 2016 [CD55-R8-e.pdf (paho.org)](CD55-R8-e.pdf)

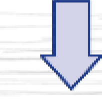
Increase public funding for health and social protection

- Increased and sustained public funding for health to support health systems transformation.
- Investment in essential public health functions and the implementation of the International Health Regulations (IHR).
- Prioritize investment in the first level of care.
- Improve efficiency in spending.
- Intersectoral action to improve social protection – linkages between health and the economy.

Health system performance assessment: a framework for health policy analysis

Context (socioeconomic, political and cultural), shocks





HSPA Framework for Universal Health Coverage

Functions | Intermediate objectives | Final goals

Resource generation

Governance

Service delivery

Financing

Efficiency of service delivery

Equity of service delivery

Effectiveness

Safety

User experience

Access

Quality

Efficiency of health system

Equity of health system

People-centredness

Health improvement

Financial protection

Societal Goals

Economic development

Social cohesion

Well-being

Socioeconomic determinants of health

Structural / functional links

Performance links within health system

Intersectoral performance links

Overview of the Context and Challenges for the Development of Resilient Health Systems in Brazil and the Americas

Universal Health in numbers

Challenges for the Americas

1,7 million

Estimated number of preventable deaths if there were accessibility to high-quality services (1.3 million in ALC).

37,1

Total gap between subregions in the HAQ index, from 54.2 (out of 100) in the Caribbean to 91.3 in North America (70 in South America).

29,3%

Estimated percentage of the population that did not seek care due to different access barriers (279 million people).

7,8%

Total gap between the poorest 20% and the richest 20% of the population that did not seek care (31.5% vs. 23.7%).

40,6%

Estimated percentage of individuals who did not seek appropriate care due to institutional barriers (economic, organizational, availability, and geographic).

57,9%

Estimated percentage of people who did not seek appropriate care for personal and cultural reasons (beliefs, language, preferences, self-perception of their health, health knowledge).

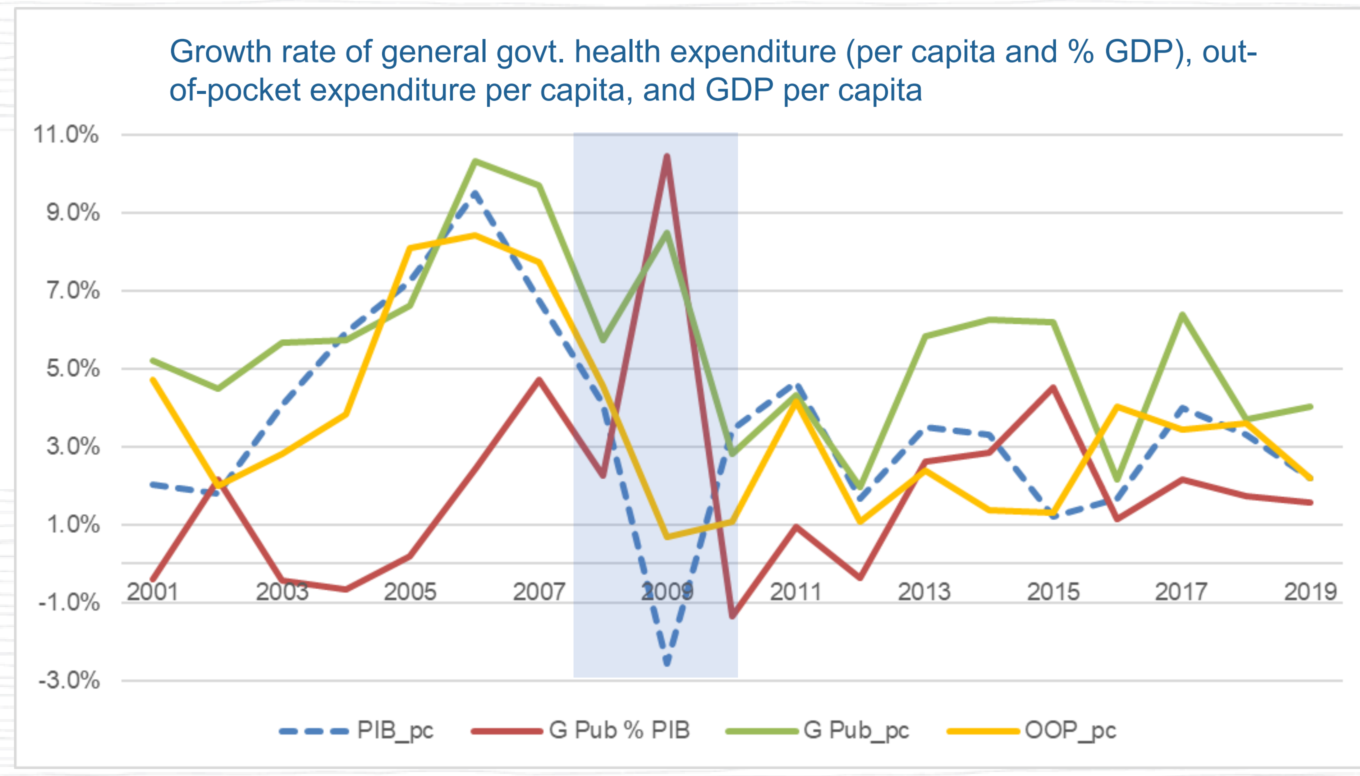
11,3%

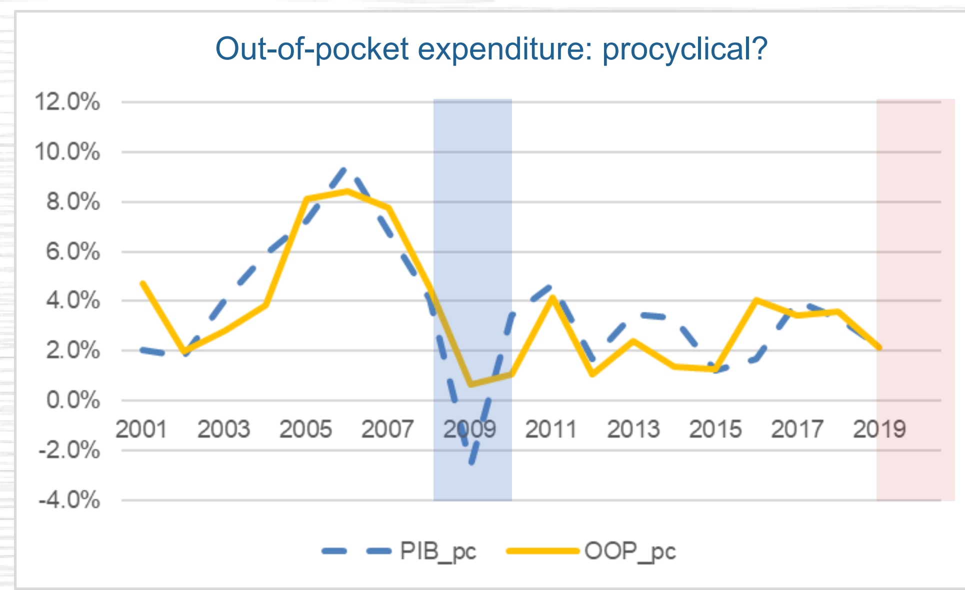
Estimated percentage of people with catastrophic health expenditure relative to 10% of their income or expenditure (109.8 million people); [1.8% (18 million), 25% threshold] in 2015.

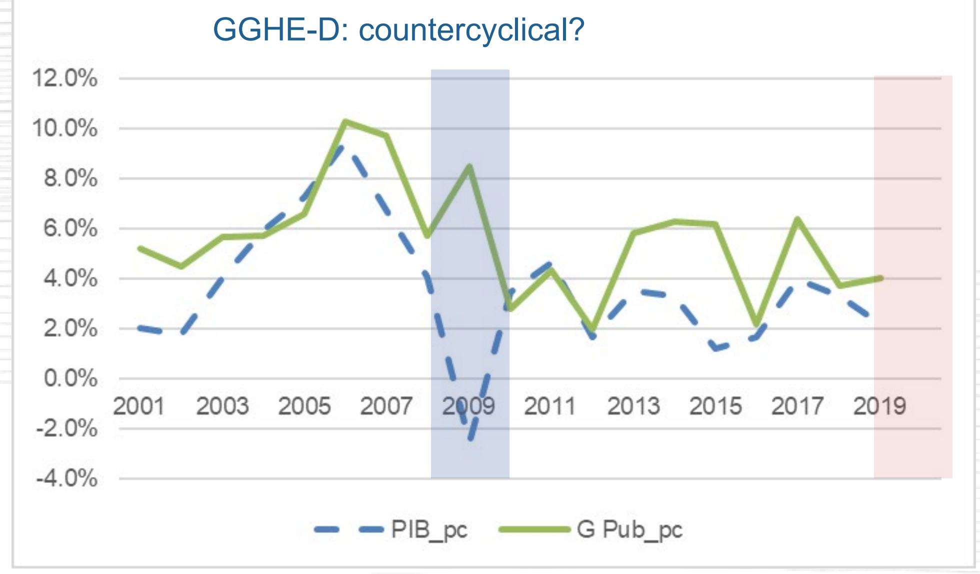
2,2%

Estimated percentage of people impoverished by GBS relative to the poverty line of 60% of per capita consumption (14.6 million people); [0.4% (4.2 million) poverty line $ 3.20] in 2015.

Expenditure trends in LAC: 2000-2019

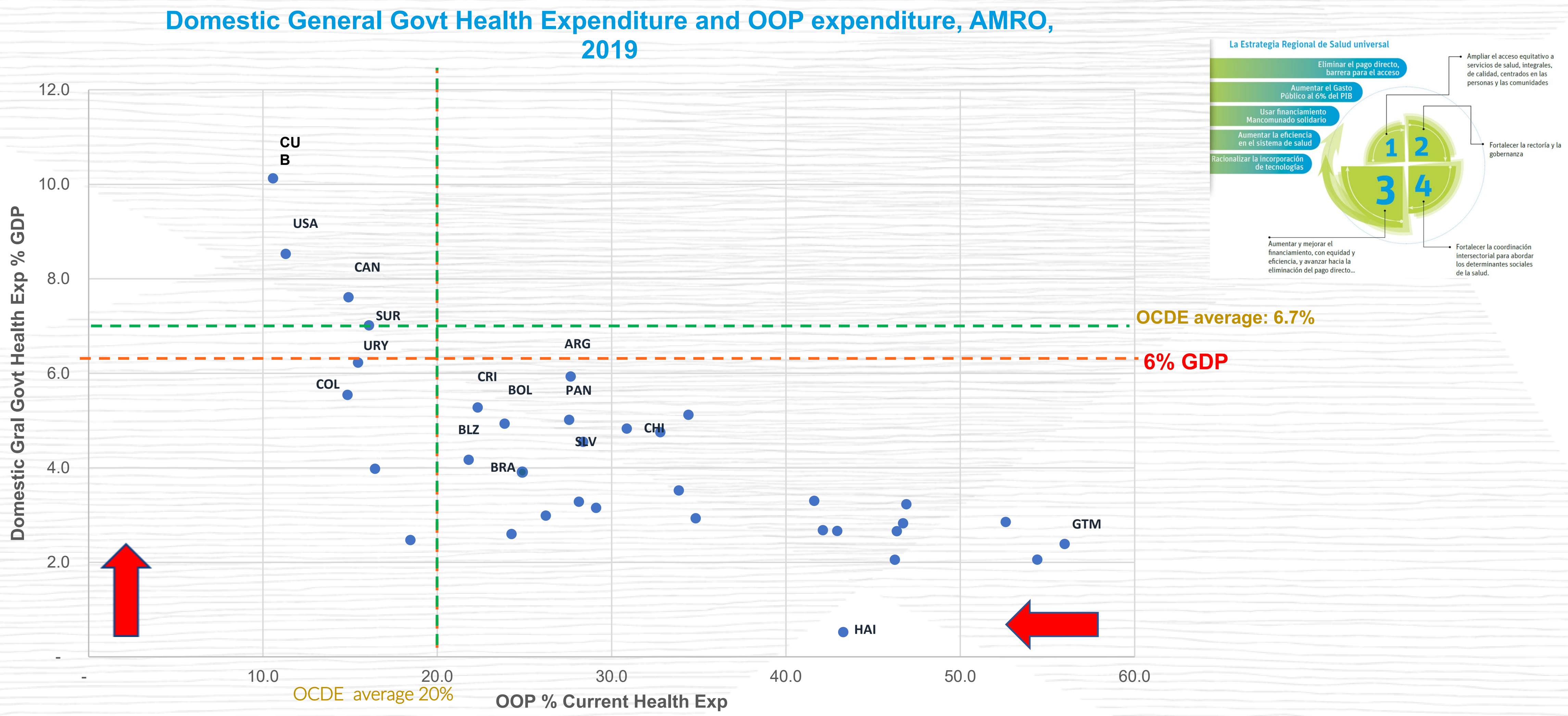






- OOP spending has been "procyclical" and public spending, "countercyclical" in times of crisis (e.g. 2008).
- What will be the effect of the COVID-19 pandemic?
- Economic growth is the main source of fiscal space

Insuficiently finananced health systems…



Source: PAHO HSS/HS calculations based on WHO Global Health Expenditure Database (GHED); and OECD Health at a Glance, consulted on March 15, 2022

… and health systems with a high segmentation.

Source: PAHO HSS/HS, based on WHO Global Health Expenditure Database (GHED), consulted on 3 Jan 2022
**Graph excludes Canada and the USA

Financing sources (Global, Public vs OPP)

Domestic general government health expenditure (GGHE-D) as percentage of current health expenditure (CHE) (%)

100
90
80
70
60
50
40
30
20
10
0

BRA

0 10 20 30 40 50 60 70 80 90

Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)

Source: WHO. Global Health Expenditure Database, Access, June 2022.

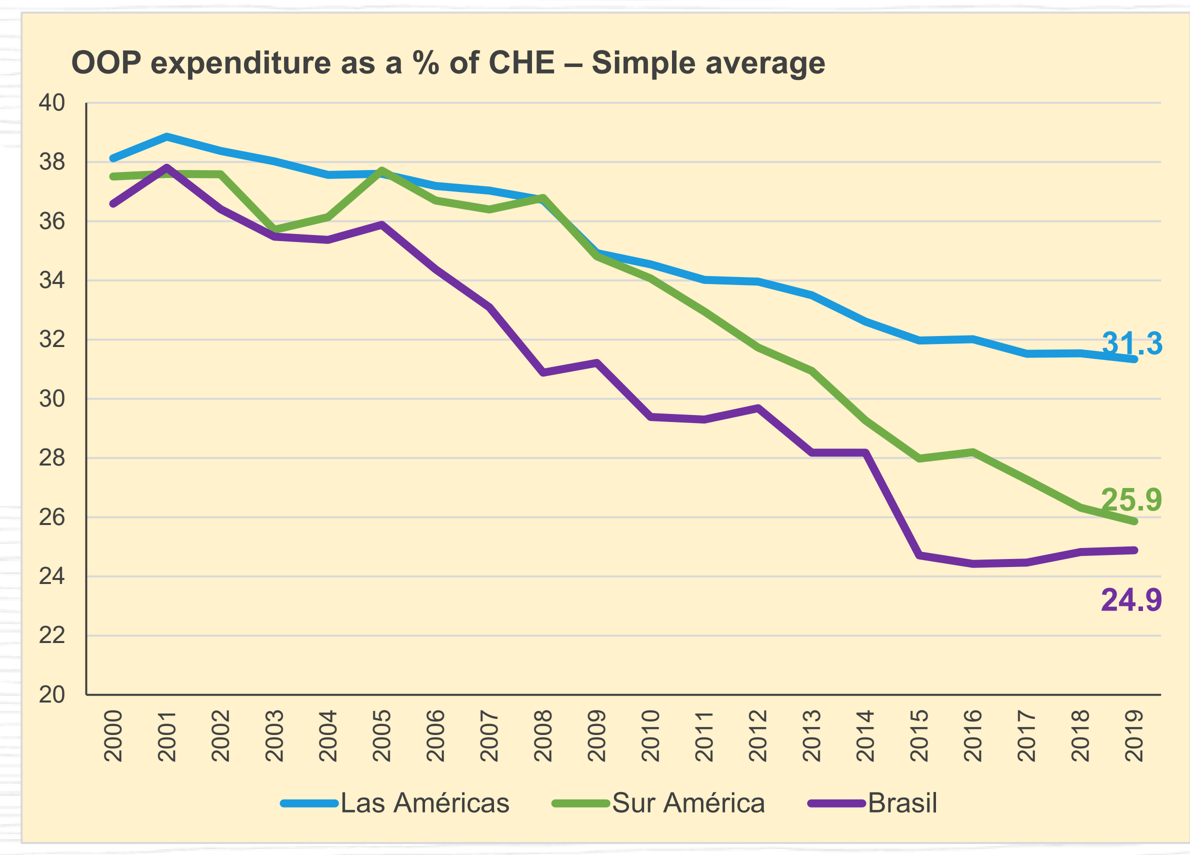
Financing sources (Brazil)

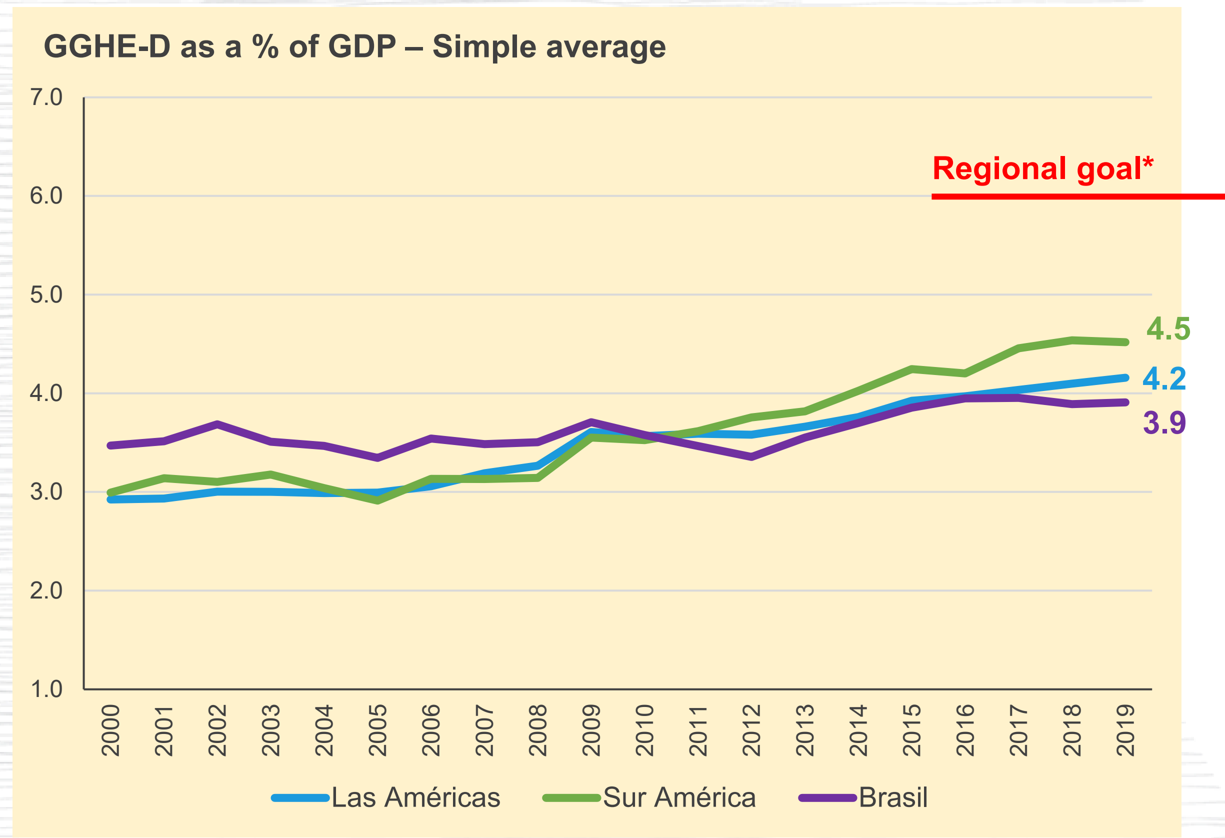
Percentage of Current Health Expenditure (CHE)

Year	Gasto público	Seguro voluntario privado	Gasto de bolsillo	Externo
2000	42	21	37	0
2001	41	21	38	0
2002	42	21	36	0
2003	43	21	35	0
2004	43	21	35	1
2005	42	22	36	0
2006	43	23	34	0
2007	42	24	33	0
2008	44	25	31	0
2009	44	24	31	0
2010	45	25	29	0
2011	44	26	29	0
2012	43	27	30	0
2013	45	27	28	0
2014	44	28	28	0
2015	43	32	25	0
2016	43	32	24	0
2017	42	34	24	0
2018	41	34	25	0
2019	41	34	25	0

Source: WHO. Global Health Expenditure Database, Access, June 2022.

Two relevant indicators – health financing





Source: WHO. Global Health Expenditure Database, Access, June 2022.

Public spending at the first level of care 2020

B. 13 countries of the Americas: public expenditure on the first level of care as a percentage of total public health expenditure, 2020

Country	%
El Salvador	44.2
Cuba	42.6
Bolivia (Plur. State of)	38.1
Barbados	33.0
Mexico	28.3
Canada	24.7
Median	24.0
Argentina	24.0
Uruguay	22.0
Chile	21.0
Brazil	21.0
Jamaica	20.0
Costa Rica	20.0
United States of America	15.2

0 5 10 15 20 25 30 35 40 45 50

Source: ECLAC-PAHO Report. Health and the Economy: A Convergence Needed to Address COVID-19 and Retake the Path of Sustainable Development in Latin America and the Caribbean. PAHO/ECLAC 2020.

Inequalities and Barriers to Access to Healthcare Services 2020

Acceptability
Accommodation
Effective coverage
Contact
Availability
Financial
Geographic

0 5 10 15 20 25 30 35 40 45 50 55

Quintile I (lowest income)
Average
Quintile V (highest income)

ECLAC-PAHO Report. Health and the Economy: A Convergence Needed to Address COVID-19 and Retake the Path of Sustainable Development in Latin America and the Caribbean. PAHO/ECLAC 2020.

Access and coverage conditions (Brazil)

Health coverage

- **71,5%** of the population depends only on SUS.
- **28,5%** of the population has a supplemental healthcare plan.
- **86,8%** of the population with higher income (over 5 minimal wages) has a supplemental healthcare plan.
- **2,2%** of the population who receives les than ¼ minimal wage has a supplemental healthcare plan.

Health services utilization

- **76,2%** of the popuation consulted a medical doctor at least once in the 12 months prior to the survey
- **89,6%** of the population with higher incomes consulted the doctor at least once in the 12 months prior to the survey
- **67,6%** of the population with no income or with income less than ¼ consulted the doctor at least once in the 12 months prior to the survey.

Access to health services

- **76,5%** sought care when needed in the last year.
- **46,8%** did so in the SUS; 22.9% in a private practice or private clinic
- **18,6%** sought health care when needed in the last 2 weeks.
- **73,6%** of those who attended managed to get care on the first attempt (down from 95.3% in 2013).
- **85,0%** of those who obtained care were able to obtain the prescribed medications.
- **79%** of the low-income population obtained the medicines after receiving the prescription
- **30%** of those attended by the public service obtained prescription drugs

Source: IBGE. Pesquisa Nacional de Saúde 2019.

Strategic recommendations for strengthening governance and stewardship

Stewarship

Leadership

Aproach of the renewed EPHF

Governance

Institutional arrangements

"The **capacities** of the health authorities, at all their institutional levels, together with civil society...

... to strengthen the health system and ensure the full exercise of public health by acting on the factors and social determinants that affect the health of the population".

Capacities to manage, coordinate or promote individual and collective health interventions.

Capacities to prioritize the allocation of resources for comprehensive health interventions that address factors and determinants of health.

ACCESS

Access to comprehensive, quality services

Health promotion and healthy behaviors

Addressing the social determinants of health

ASSESSMENT

Monitoring and evaluation

Surveillance, control, and risk management

Research and knowledge management

Rectoría de las Autoridades de Salud

RESOURCE ALLOCATION

Development of human resources for health

Medicines and other health technologies

Health financing

POLICY DEVELOPMENT

Policies, legislation, and regulatory frameworks

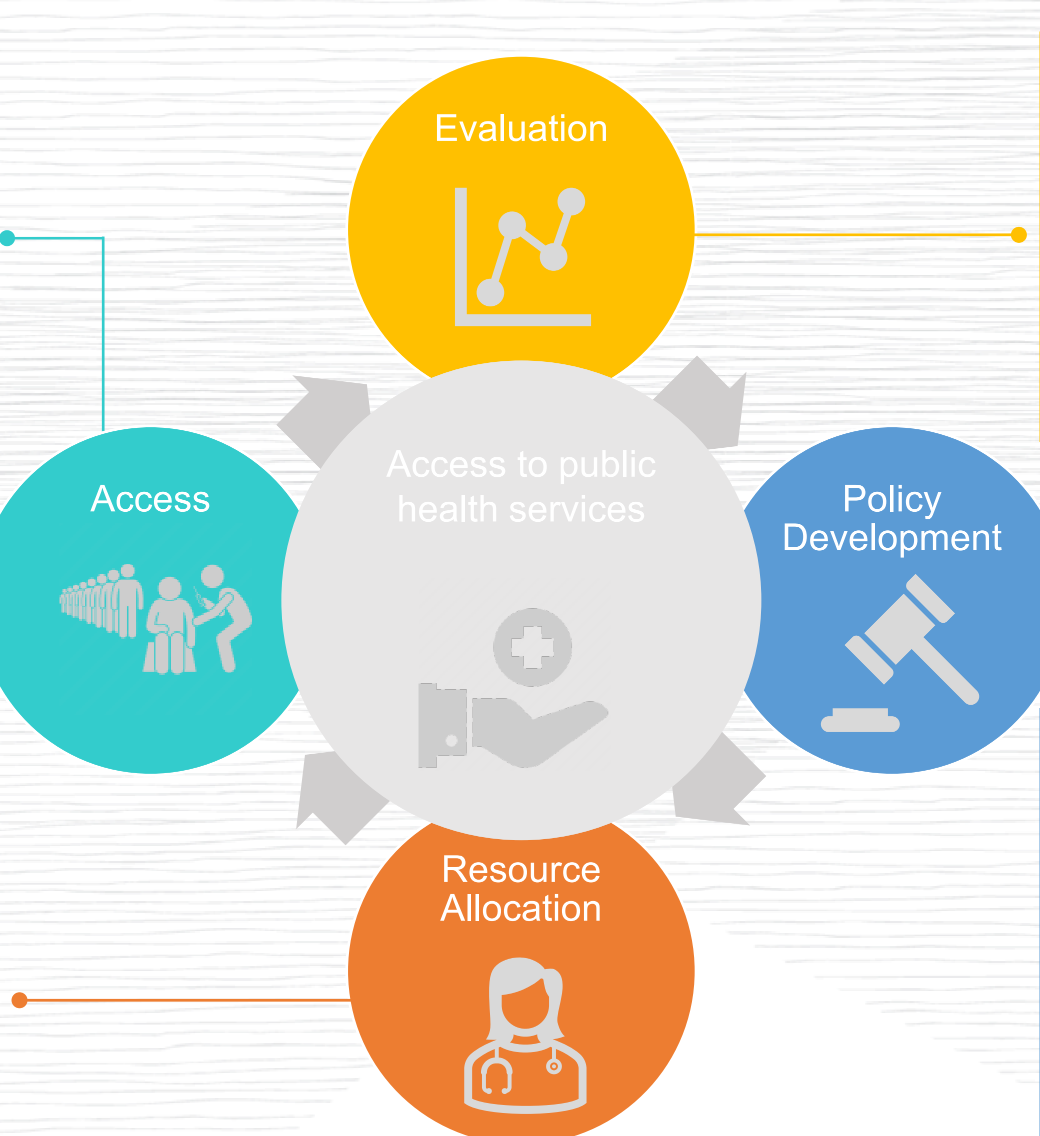
Social participation and social mobilization

Capacities to interpret the problems and determinants of population health

Capacities to influence regulatory frameworks and involve key actors with accountability mechanisms.

Gaps in EPHF capacities affecting access conditions in the Region of the Americas:

1. To update policies on accessibility and incentives for quality of care and equality.
2. Strengthen the PHC approach in the country's priority programs.
3. To build an integrated strategy for health development.
4. Strengthen the advocacy for healthy environments (water quality and sanitation) and actions to address risk factors: physical activity, SRH, mental health and violence prevention.
5. Strengthen the approach to STP and DSS through intersectoral articulation.



1. Identify and establish standard minimum criteria for the different M&E subsystems.
2. Improve the compatibility and interconnectivity of the various sources of information.
3. Use the information produced for program and policy evaluation.
4. Strengthen mechanisms to ensure effective participation and empowerment of the community in M&E.
5. Improve the production, analysis and use of information on DSS, access, barriers and utilization of services, including satisfaction and acceptability.

1. Design National Strategy for RHS Development: planning of needs, development and retention of RHS in order to improve availability and distribution.
2. Improve work strategy together with the Ministry of Finance and other stakeholders: collection, segmentation and allocation criteria, reduction of GBS.
3. Strengthen STD and medicines and capacities for centralized purchasing of medicines and strategic inputs.
4. Promotion of generic drugs

1. Strengthen the ANS leadership in the formulation and updating of health laws, its M&E, including its relationship with the Legislative Branch.
2. Update national health objectives and priorities to the new health context.
3. Strengthen/expand structures, resources, training and periodicity/effectiveness of social participation and accountability.
4. Address the observations of human rights organizations in relation to health: migration, voluntary interruption of pregnancy and LGBT population.
5. Review formal mechanisms to guarantee the exercise of health rights.

Capacity gaps identified during Phase 2 of FESP in countries that have applied the approach

Influence of capacity gaps on PHC outcomes: experience of access barriers.

EPHF in the integrated public health approach

- Evaluation
- Policy Development
- Allocation Of Resources
- Access

Access Barriers Identified During Phase 1 of EPHF

Availability of critical resources

- Unequal distribution of critical resources (centers) in the PNA
- Lack of qualified health personnel
- Lack of medicines, supplies and equipment.
- Limited supply of providers

Administrative

- Limited hours of operation
- Problems with quality of care

Contact/ promotions

- Lack of information and health knowledge in the population

Finances

- Improvements in affordability, but persist, mainly for the low-income population,
- Limited health insurance coverage limits the guarantee of access to medicines and vaccines + out-of-pocket expenses.

Acceptability

- experiences of discrimination, stigma and marginalization for certain populations
- Cultural factors and beliefs

Geographics

- Distance between home and place of health care (rural areas)

Implementation of EPHF in the countries

Caribbean: Suriname and Bahamas (situation analysis and Institutional Analysis with the participation of teams, technicians and authorities), (Bahamas, St. Kitts & Nevis, St Lucia with ongoing processes articulated with processes to strengthen health systems)

Central America: Costa Rica and the Dominican Republic (Situation Analysis, Stewardship and Governance, with broad participation of technical teams, authorities and other sectors and civil society. El Salvador (situation analysis and institutional analysis with technical teams and Health authorities)

South America: Bolivia (health situation and Institutional Analysis plus subregional dialogue) Peru (situation and Institutional Analysis with Health teams and authorities). Brazil: (tools adaptation analysis to the federal context).

Communication activities in other countries: Chile, Ecuador, Panamá, Uruguay, Colombia.

Thanks!