THE SUS ITS RELATIONSHIP WITH PRIVATE HEALTH CARE SYSTEM IN BRAZIL

Rodolfo Ludwig
State University of Rio Grande do Sul (UERGS)
Porto Alegre, Brazil
rodolfoludwig@hotmail.com
Degree in Systems and Health Services at the State University of Rio Grande do Sul, currently a researcher at the National Council for Scientific and Technological Development.

Lucas Casagrande
State University of Rio Grande do Sul (UERGS)
Porto Alegre, Brazil
lcasagrande@gmail.com
MsC in Management and Organizations at the Federal University of Rio Grande do Sul (UFRGS), currently professor at State University of Rio Grande do Sul (UERGS)

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Abstract

This study aims to verify the possible conflicts that may exist between the different systems, public and private, and whether these conflicts hamper the consolidation of SUS (Unified Health System) in Brazil. Some international models of public health systems have served as inspiration to the Brazilian. However, in none of these models there is a private health care system as large and with as much volume as in Brazil. Thus, the central question of this work is how is the relationship between the public and private health care in the country? It appears that this relationship brings direct losses for the funding of the public, since many resources go into the private system and leave to go to the public. The methodology is basically quantitative character, which analyzes the budget and the financial resources that make up both systems and the relationship that these same systems have with one another around the world. Secondary data are obtained from consolidated data from government and other area studies. In research about the topic, some work with similar themes were found, but were about case studies of a specific level. Thus, the originality of this work is based on the macro scale analysis.

Article Classification: Research Paper

Keywords: Public; Private; Healthcare; System; SUS; Brazil; Financing
**Introduction**

This study will examine the feasibility of having a public health system, which has as some of its principles: universality, comprehensiveness and equity, the guiding principles of SUS according to Brazilian Law 8080/90, acting simultaneously with the private health, which is growing increasingly in Brazil thanks to the current economic situation of the country. (ANS. 2011)

The Brazilian public health system, from the colonial era to the present day, has undergone a series of profound transformations, culminating in the establishment of universal national health care in 1988 (SUS), which was regulated two years later in 1990. Until the '20s, nothing concrete had been done in public health, with the exception of vaccination campaigns led by sanitaryian Oswaldo Cruz in the early twentieth century and had an almost military approach, even culminating in riots. However with the arrival of European immigrants, who formed the first mass workers of Brazil, the discussion begins by creating a model of health care to this population. Thus, in 1923, it was created the Eloy Chaves Law establishing the Retirement and Pension funds. These funds were a kind of welfare for workers and its administration was done by the companies themselves and had the following objectives: medical care to the employee and family, granting of special prices for drugs, retirement and pension to the heirs. Note that these funds were only available for urban employees.

In 1930, with the arrival of Vargas to power, it was created the Ministry of Education and Health and the funds were replaced by the Institutes of Retirement and Pensions (IAPs) that were administered by the unions and not by the companies anymore. The newly created ministry was responsible, in health, for measures such as the creation of agencies to combat endemic diseases and sanitary regulations.

In the late 1930s and early 1940s, the IAPs already had a large amount of resources as a result of continued growth in revenue, due to the increase in the number of registered workers. At the same time, expenditures were few since the demand for retirement was still small.

The Vargas government used much of the resources of IAPs to stimulate the industrialization process, lending to entrepreneurs or investing directly, as was the case of the development of the steel industry. In 1960 with the Organic Law of Social Security, which unified the IAPs in a single scheme for all workers under the Consolidated Labor Laws (CLT) the government begins for the first time to put its own resources in health care. In 1966, the various IAPs are unified at the National Institute of Social Security (INPS), centralizing the administration of resources but keeping the benefits for only to those who contributed, mainly the urban workers. (MS/CEAP, 2004)

That way, comes a much greater demand than supply, and the military government decides to pay private providers for services, and provide loans at subsidized interest rates. The private health system has a tremendous growth in the years 1969 to 1984. This system was only focused in a curative medicine, since the investment in prevention activities was very small. With the growth and its complexity, the INPS becomes the INAMPS, National Institute for Medical Assistance and Social Security, which worked in the intermediation of lending to the private sector.
At the end of the military dictatorship in 1985, the society has a small stake in public health. But with the creation of the administrative bodies of the National Council of State Health Secretaries (Conass) and the National Council of Municipal Health Secretaries (Conasems), now the society begins being listened more and participating process were created. In this context, the private health care system that had been privileged by previous policies, is forced to find new outlets. It was during this period that was created and strengthened the subsystem of medical attention. In other words, begins the era of health insurance. Arise five different modes supplementary medical care: group medical, medical cooperatives, self-management, health insurance and administration plan. As public services were still incipient, that population that was able to pay for new health plans, migrated to the system and secured substantial resources, which allowed its maintenance and expansion, even without the state contribution. Parallel to this, begins the mobilization for the construction of the SUS.

The advancement of the VIII National Health Conference in 1986, which is consolidated in the Brazilian Constitution of 1988, is the affirmation of Health as a right of everyone and a duty of the State. Therefore, the State must ensure that the necessary resources and manage the system in order to release the right to healthcare for the entire population. (MS/CEAP, 2004) However, when the public health system emerged, Brazil already had a private system, that was older and better structured. The private system began to fight for space, power and resources with the new. The 1988 federal constitution in its art.199 says: "health care is open to private enterprise," but this freedom can be harmful to the SUS, since unlike the private, must act according to a set of principles and rules that put the public system at a disadvantage compared to the private.

As the amount of resources devoted to public health is still insufficient, and consequently, the SUS becomes quite different from the theory, this study seeks to identify the losses that competition for health resources between the public and private sectors generates. Such competition for resources will be demonstrated as one of the causes of the problems of the public health system. It is important to note that laws that ensure minimum funding are not enough to ensure the maintenance, expansion and service quality, while there is another system, the private sector, to absorb some of which could be allocated to the public. Thus, the funding problem will persist.

Therefore it is of paramount importance to avoid losses and maximize gains, aiming for excellence in quality and delivery of what is right and duty of the state. Such measures are especially strategic to a country like Brazil, since there is few resources given the amount of obligations to fulfill, and the difficulty in better allocation of the same.

**Problem Definition**

The private health care system in Brazil already existed before the creation of the NHS, and catered to a specific portion of the population, who owned afford health plans for services used. However with the emergence of a public, private plans saw an opportunity to maximize your earnings without this they had to increase the amount of services available. We'll look at an example of how private operators took advantage of the public system.

The private health care system through health plans, creates a scheme in which some treatments for high complexity agents richest end up having better access to public health goods that the less well off without it if reverting to an cost savings for the public sector, including the
worsening situation of agents with less propensity to pay for private health goods. Individuals with higher incomes and therefore with higher propensities to consume private treatment, buy health insurance from the private sector. When there is the possibility of a disease or evil, such individuals are served by the private health care services. However, this network has lack of productive capacity specifically medical care of high complexity. In support of this hypothesis is given by the existence of large institutions of excellence in this type of treatment, such as INCOR (Heart Institute), Hospitals and University Hospitals, which are either public or are financed by the public sector. Moreover, by tradition, in Brazil, only the public sector finances research in significant amounts, can generate knowledge about border issues in medicine, particularly in the form of human capital. SUS, in turn, has a production capacity of greater goods of high complexity, albeit insufficient to meet all the demand exists. Thus, an individual who has health insurance and who is being treated by the private sector waiting time equal to zero, if you need some treatment of high complexity is immediately transferred to the care of the public sector. This results in two consequences: the first is that this individual does not have to wait in queue to be treated by the public system, as already conducted a number of tests required for treatment in the private system, faces $T = 0$ (time zero), passing in front of other individuals who do not have private health insurance, which usually do not have all the exams needed to start treatment due to high demand for this type of testing in the public sector and second, private companies generally do not perform the transfer of the payment by the insured to the NHS treatment. (Nishijima, 2004) As noted, the private health sector, characterized here in the form of health plans, and refer their patients to the public system, without having to face these queues, performs at least not in its entirety, payment for services rendered by the public entity to its policyholders. Another aspect that directly impacts the Brazilian public health, are deductions from income tax for taxpayers who use private health services, and the public entity would be paying indirectly to private health services and care provided by failing to raise a significant amount of taxes that contribute to the funding of the public. So the question is this research:

It is possible for a public health system, which has as some of its principles, universality, comprehensiveness and equity, to survive, fighting for space and resources with the private system?

**Methodology**

This study will examine the feasibility of having a public health system with a series of principles, in conviviality with the private system. The research will be eminently quantitative, exploratory, bibliographic and documentary. Will be used secondary data, obtained in websites, bibliography about public health and the Brazilian health legislation.

**The Creation of SUS**

The Brazilian public health care system, SUS, is formed by the set of health services provided by public agencies and governmental institutions of the federal, state and municipal spheres. The private sector is allowed to participate in this system in a complementary way.
The historical elaboration of the national health care system is a process that went through decades in Brazilian public administration, but its milestone was the completion of the 8th National Health Conference in 1986, which at first featured public participation. According to Rodriguez Neto (1988), the 8th National Health Conference was the result of negotiations between the Ministry of Social Security and the Ministry of Health.

According to Carvalho (1995), the 8th Conference was an unprecedented event. Unprecedented in the history of health policies because never before the executive branch has called Brazilian civil society to debate policies or government programs. All seven previous health conferences was guided by an eminently technical and social representativeness marked by very low participation by virtually restricted to managers and government technicians (Carvalho, 1995:53).

The conference was also responsible for the creation of the Unified and Decentralized Health System (SUDS) a kind of agreement between the National Institute of Medical and Social Security (INAMPS) and state governments. More important, however, was the foundation for what later came to be part of section on health in the Brazilian Constitution (1988).

The wishes of majority who were part of the 8th Conference materialized in 1988 with the creation of the public health system. The system, however, was implemented gradually: first came the SUDS, then the incorporation of National Institute of Medical and Social Security (INAMPS) to the Ministry of Health (Decree No. 99,060, de7 March 1990), and finally the Organic Health Law (Law No. 8,080 of September 19, 1990) that provided its regulamentation. Now the system officially established universal public health, representing the materialization of a new conception of health in Brazil. Before health was understood as: "the state of not disease," which meant that the logic revolved around the cure of diseases. This logic gave rise to a new concept focused on prevention of diseases and promotion of health. Therefore, health starts to be related to the quality of life of the population, which consists of the set of goods that include food, labor, income level, education, environment, sanitation, surveillance health and pharmaceutical, housing, leisure, etc. (Brazil, 2006)

The milestones of the SUS is given mainly in: 1 - Regulation: the organization, functioning services, community participation, intergovernmental transfer of resources and decentralization of the system. 2 - Implementation: information systems inpatient and outpatient programs, community agents, drug delivery and health care services specific. 3 - Creation: the national transplant, regulatory agencies, national health policies, many care services, new administrative structures and social programs. 4 - Approval: pacts, and release: campaigns, policies and programs for specific populations.

Thus, the public health system, in addition to management of diseases, has been concerned with preventing diseases, seeking to provide the population a better quality of life and thereby avoiding excessive demand for care services, which therefore generates less maintenance expenses.

The Brazilian Private System History

The Brazilian health insurance (health insurance providers and for-profit hospitals), began its structure after the Brazilian industrial revolution in the early twentieth century, when emerged Institutes of Retirement and Pensions (IAPs), which belonged to different professional categories and representing urban workers, to bought the services of the health workers.
Meanwhile, in the 40’s, also appeared the Assistance Boxes, as the employees of the Bank of Brazil, which benefited employees of some companies through loans or reimbursement for the use of health services.

In the 50’s, statal and private companies begin to provide health care services and directly. In 1966, the IAPs are unified, forming the National Institute of Social Security (INPS). This unification forced the expansion of accreditation of providers of private health services, hospitals and favoring multinational drug companies. With that, the 60 was a milestone in the history of health insurance simply because most employees already have health insurance, and also to be observed several possibilities of medical care: the INPS network, with their own units and accredited, accredited services to serve rural workers; services accredited medical companies, and self-management of companies with their own plans.

Was created the National System of Social Security (SINPAS) in the 70s, and it was part of the National Institute for Health Care and Social Security (INAMPS), which is responsible for the purchase of services and transfer of funds to the private sector, causing a huge capitalization of this sector. With the political, social and economic crisis of ’80s, and with the growing Brazilian health movement, the 8th National Conference of Health in 1986 culminates with the creation of the SUS; however, the private sector maintain continued expansion (Roncalli, 2003.).

The government itself stimulates the supplementary sector through tax expenditures in the deduction of income tax (R $ 1.7 billion in 1977 and estimated at $ 48 billion in 2011), with the certification of operators such as charities and buying health plans for public employees. Literature data used by Almeida and Bahia & Viana, show that: the health insurance market has very specific characteristics, such as the fact that the consumer does not have the autonomy to decide when to consume the service purchased / insured, the consumer information be incomplete and asymmetric with respect to the service provider, it is highly variable in time knowledge about the best way to control the health, as well as the speed of technological development sector; moral hazard, which refers to change in behavior of the insured due to not having to bear the full cost of care; adverse selection, which is the tendency of the system to have to incorporate higher-risk individuals, and the selection of risk, which are the barriers to entry imposed by insurers to policyholders in the system, removing the high risk.

In general, one can say that the regulation of private health insurance serves three main purposes (Chollett and Lewis, 1997): a) maintaining the stability of the insurance market, which includes setting standards for entry, operation and exit of companies, b) regulate the relationship patient-insurer / provider-provider, considering the problems of information asymmetry above and c) maximizing consumer welfare, ensuring greater fairness and equity in access to health care services and hospital.

Obviously the market regulation of private health care does not fully correct the shortcomings identified. However, in a deregulated market and competitive, administrative costs will be higher and the absence of some form of state intervention will lead to increased inefficiency and inequity.

In Brazil, 47 million Brazilians have health plans. The vast majority of beneficiaries - about 30 million - part of business agreements, offered by employers to their employees. The other customers are individual plans, family or group adhesion (formed by professionals who work in the same branch, organized in unions or associations). (ANS, 2012)
Public healthcare budget in Brazil and around the world

The budget of the Brazilian public health since the creation and regulation of SUS has undergone several changes and nuances. It is undisputed that the Brazilian public health funding is still insufficient, considering the large number of people who are part of the system, theoretically all those residing in the country, more than 190 million people (IBGE, 2010), because even those who have health insurance can be a day served in the public system, either because they suffered some complications and was taken to a public hospital or because your insurance does not give you coverage for certain health need.

Health expenditure in Brazil is about 8.4% of Gross Domestic Product (GDP), the sum of the wealth produced by the country in one year. In this perspective, the investment is in line with the global average of 8.5% annually, according to the report of the World Health Organization.

About the need for greater health financing in Brazil, often is on discussion the need for more public resources for health, and this requires a more detailed analysis. Based on estimates of health spending WHO, we can see that the global health spending reached $ 6.1 trillion in 2008, of which 60% would be spending (direct from government or indirect through public institutions of social insurance ) and 40% would be private (through direct expenditures of households, private insurance or philanthropy). The data analysis also allows the WHO show that the higher the income level of a country, the greater tends to be the share of public spending on total health spending, as seen in figure 1 below:

Figure 1: Public healthcare expenditure/total healthcare expenditure according to average income of countries.

![Bar chart showing public healthcare expenditure/total healthcare expenditure according to average income of countries.](image)


The countries classified as upper middle income group, as Brazil, are spending on average 57% of their health expenditure across the public sector. However, Brazil spends only 44%, and is therefore a range of intermediate share of public spending between low income country and lower middle income.
Brazil invests the amount of 8.1% - 10% of GPD in health care, remembering that included the expenditures of the private health system. The difference in Brazil is who pulls the expenses. In the country, 56% are private (and benefit about 47 million subscribers) and 44% public - all favor the 190 million Brazilians. (WHO, 2012)

Figure 2: Total expenditure with healthcare/GDP


In Brazil the participation of the private system corresponds to 45.1% - 70% of total health spending in the country. Among all countries that have public health system, Brazil is the only one where the private sector invests more than the public.

Figure 3: Private expenditure of healthcare/Total expenditure of healthcare

The average spending of countries with public health systems like the Brazilian health care system, such as Canada, France, and UK, is 77% of health expenditures, as seen at figure 4. (OECD, 2010)

Figure 4: Evolution of the public expenditures in healthcare

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Source: OECD, 2010.

We note that in Brazil the healthcare gets a percentage between 5% - 8% of the GDP only, compared with the UK which also has a universal health care spending on health is 15.1% - 20%. This data can illustrate a situation of underfunding of the Brazilian system, whereas the UK system has a financial contribution twice.

Figure 5: 2012 total expenditure/GDP

The research from the Institute of Applied Health Rights (IDISA) points to a per capita expenditure of R $ 1,488 for a population of 47 million people served by private health. In the case of public health which accounts for 150 million people are served by the public health system spending per capita is $ 846, almost half of which is spent by the private network.

In Brazil, total health expenditure per capita in dollars are between $ 301 - $ 1000. Canada, which also has public health system, the spending per capita is more than $ 5000. (Figure 6)

Figure 6: Total expenditure per capita (US$)

Brazil has a universal health care system, which is said to be universal, comprehensive and equal, but with a total expenditure of health less than the private system and that caters to only a quarter of the population (ANS, 2012). It is evident the need for a massive increase in financial resources to ensure the consolidation of these principles.

**Deduction and Reimbursement, resources that could contribute to the SUS**

Deductions authorized by tax laws seek to adjust the taxable income of the taxpayer in order to better estimate the citizen's ability to pay, and provide a fairer distribution of the tax burden. Certain items of deduction are reported by the taxpayer and represent actual expenditure and are subject, in some cases, to legal limits. In the case of the deduction for dependents, the value is constant and set by the tax laws. (DIRF 1999)

However, with deduction for health care costs, there are no limits. This means that, in practice, a taxpayer who has high income can pay no tax if have spent enough with the private health system.
In 2011 the deductions with medical expenses cost the public purse R$ 48.6 billion\(^1\), equivalent to 62% of the federal health budget of R$ 77 billion. That's significant since if there was no deduction on health tax income, this feature could increase the health budget, making stay very close to achieving the optimal level of public spending on health. (WHO, 2012)

The amount of deductions for health of income tax makes public spending on health in the country, both in the public as in the private system remain similar with a financial amount. But paradoxically, in this case the state is giving more resources for those with higher income, since the insured can have all their health care expenditures deducted from your income tax, no matter how sophisticated the service he bought.

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It can be observed that the possibility of not deduct health expenses of income tax may become a solution to the public health budget, as this measure would be favoring the income distribution in the country.

Added to this, there is a growing private sector debt with the public health sector. Whenever a citizen with private healthcare plan is covered by the public network, his plan must reimburse the SUS. Otherwise the private insurance is committing the offense of unlawful enrichment. (ANS, 2012)

This debt comes from the Brazilian regulatory system. In this system, the National Health Agency (ANS), which regulates the private health sector, makes a data crossing between the insured from the private to the public appointments system. Thus, it is first created an administrative process where operators of private health plans receive a Letter of Notification of Identified Beneficiary Notice (ABI). It established a period of thirty days for operators to submit information in order for the cancellation of its service. Companies may claim, for example, that the beneficiary was in grace period on the date of service or procedure is not covered. The ANS will evaluate all documentation submitted and its decision may be appealed within ten days, to the Board of the Agency. (ANS, 2012)

For beneficiaries of the health plan there are any cost in the process of reimbursement to SUS, since neither the ANS nor the carriers may charge the recipient any amount as compensation to the SUS. However, in cases where the beneficiary has a contractual obligation to pay for part of costs of health care as co-participation, the share that would be under their responsibility is deducted from the amount to be reimbursed to the SUS and nobody is charged. (ANS, 2012)

Operators have the payment term of 15 days from the receipt of the charge. The amounts owed not fully settled by the due date suffer additions to a daily fine of 0.33% to a maximum of 20% (twenty percent), plus interest at the benchmark rate of the Special System for Settlement and Custody (SELIC\(^2\)), accumulated monthly. Calculations are made from that date until the month

\(^1\) In May, 1, 2013, 1 R$ = US$ 0.498 = £ 0.32

\(^2\) SELIC is the Brazilian equivalente to the LIBOR.
prior to the payment, and one percent for the month in which the payment is being made. In addition, the following measures are adopted:

a) inclusion of the name of the debtor in Informative Credit Unpaid Federal Public Sector - CADIN in accordance with law;

b) Registration of the debt in the Active Debt of ANS;

c) filing of a tax lien. (ANS, 2012)

However, the problem is that the carriers are challenging in court the charges made by ANS. This makes the proper enforcement of compensation only happen long after the time when the debt was contracted. Moreover, as the courts often take more than five years to judge the cause, much of the debt prescribes, and therefore will not be paid. According to Article 4 of Law No. 12.469, of August 26, 2011, amounts collected as reimbursement to the SUS are credited to the National Health Fund (NSF), which funds the public health system.

As much as over the years the NSA has been able to charge more and more of the health insurance companies, the total outstanding debt with private plans SUS is over R$ 370 million. (ANS, 2012)

**Final Thoughts**

According to the data presented here, it appears that the public health systems in the world, similar to the Brazilian hold a budget mostly public. In some cases there is a co-payment (as in Japan), which the state bears the largest percentage of health spending and the other part is left to the user, who can hire a private health plan to make this co-payment instead or himself makes. Another feature of these public health systems is that the role of private entities is well defined and tightly regulated by the state, since the state in most of the times is the primary payer of the private. These control measures are designed to contain rising health care costs. Figure 7 shows that in countries where the state is only one of payers and not the main one, like U.S.A., the costs of health care rise disproportionately. Krugman (2012) argues that this is because the public system loses ability to bargain prices, in addition to losing scale.

Figure 7: Evolution of total health expenditure per capita.
When the state is the largest single payer or the biggest payer of health care services it becomes a monopsony (single buyer), or oligopsony, and soon has the power to bargain prices, always seeking the lowest cost, so that the public health system can work more efficiently. Such optimization of resources is necessary and for that the state should assume a central role in the system. (Krugman, 2012)

In Brazil, the SUS serves the vast majority of people who use the health services in the country, but ¼ of the population has private health plans. This does not mean that the SUS does not cover their needs, as seen in the previous chapter, when observing the debt that private operators have with health care provided by the SUS to their clients. It is observed that the number of people that even having a private health plan, and are also served by SUS is significant. Even serving 25% of the population, the private healthcare system has a larger budget than the public, R$ 157.1 billion in private sector versus R $ 123.5 billion in public system. This is a unique case among all countries that have universal public health systems (WHO, 2012). However if we include the deductions of health care spending in the income tax, totaled R$ 48.6 billion in 2011 and the outstanding debt of health care plans with the SUS totaling R$370 million, the public health budget would exceed the private placing the public system as the largest investor in health carein Brazil. However, even yet the budget per capita in the private health care sector would remain nearly three times bigger than the public, since the public serves 150 million people (without private health insurance), and private only 47 million people.

It can be inferred that such a difference per capita occur due to differences in the models of the two health care systems. As noted in the Brazilian Institute of Geography and Statistics (IBGE) in 2012, the private system has 4,036 establishments with hospitalization, while the public system has 2,839\(^3\). However, when it comes to health establishments without hospitalization, the

\(^3\) Note that the public system purchase services from the private where their performance is not enough. Such care are computed in this work as being offered by the public sector, since this is what pays for the service.
public system has 47,414 against 20,487 in private establishments. Still, public establishments without hospitalization are primarily responsible for general care practitioner, while the private system operates in more specialized care. This characterizes the public system as a system that operates on prevention and health promotion, in order that the patient does not have the need for a hospital, because hospital costs are considerably higher than prevention, due to the complexity of the cases, the technologies and professionals involved.

Other data that support this hypothesis: the public sphere is the most professional in the field of nursing, while in the private sector are predominantly practitioners of medicine. The diagnostic imaging equipment belong mostly to the private system and are used mostly for it. This type of equipment is characterized by high cost and the diagnosis of more serious health problems and focus on hospitals and specialized clinics. Thus the private health care model focuses mainly on the doctor in hospitals and specialty centers and diagnostic imaging equipment, these characteristics of a model focused on curing diseases, which therefore requires a greater complexity in care due to the existence of pathology.

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If these facts were taken into account, the figures presented by the world health organization with respect to public health expenditure, private expenditure on health and health investments per capita, would be completely changed, placing the country in a favorable position as public investment in health.

In fact, Krugman (2012) suggests that competition in healthcare is expensive: it generates a system of multipayer (which has high administrative costs that could be downsized in a single machine using a high gain scale), a bloated legal system, in addition to economic incentives for non perform the services to which they were hired. This is especially true in health care because the client (patient) usually are not willing to incur the transaction costs required for a thorough market research when he needs the services (given his fragile health and psychological impacts of the same) and can not do careful market research by insurance and health plans as informational asymmetry between what is expected to be provided and what it is.

Furthermore, the author adds an important point to understand the dynamics of high costs of private health sector: the private sector has no economic incentives for investment in prevention - while the public has high incentives. Thus, for the private sector is more interesting incurring possible cost than small everyday low costs (even representing lower costs in the long run). This is because there is no assurance that the customer will continue to be so in the future.

Another highlight in the research of the IBGE, is the dependence relationship set up between the public and the private health care system, especially in the categories: hospital beds and medical imaging equipment. In both cases the majority belong to the private, however, with respect to the beds, the greater user is the SUS, which means that the public health care system uses the private structure to ensure a greater number of hospitalizations. Therefore the possibility of
using the private system makes the public system does not notice the lack of public beds to ensure services without the need to use the private for that.

From the data presented and the difficulties in research, it appears that the existence of a private health care system of the magnitude of the Brazilian impairs the consolidation of a public health system that has as principles, universality, comprehensiveness and equity. This is because part of the population fails to contribute with funds from income tax, and so the state is obligated to pay more than usual with health because he is paying for a service provided by a private entity with larger costs.

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