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Universal Health Coverage for Inclusive and Sustainable Development

Country Summary Report for Brazil

Magnus Lindelow and Edson C. Araujo

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Acronyms

ACS	Community Health Agents
ESF	Family Health Strategy (Estrategia de Saude da Familia)
FESF	Public Foundation of Family Health (Fundacao Estatal de Saude da Familia)
PACS	Community Health Agents Program (Programa de Agentes Comunitários de Saude)
GDP	Gross Domestic Product
GNI	Gross National Income
HRH	Human Resources for Health
MDG	Millennium Development Goals
MoH	Ministry of Health
NGO	Non-governmental organization
OECD	Organisation for Economic Co-operation and Development
OOP	Out of pocket health spending
SO	Social Organizations (Organizacoes Sociais)
PAB	Basic Health Package (Piso da Atenção Básica)
PHC	Primary Health Care
PPI	Integrated Program (Programação Pactuada Integrada)
PPP	Purchasing power parity
PROVAB	Enhancement Program for Professionals in Primary Health Care (Programa de Valorização dos Profissionais na Atenção Básica)
SUS	Unified Health System (Sistema Único de Saúde)
THE	Total Health Expenditure
UHC	Universal Health Coverage

Preface

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself. This led to the formation of a joint Japan–World Bank research team under The Japan–World Bank Partnership Program for Universal Health Coverage. The Program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The Program was funded through the generous support of the Government of Japan.

This Country Summary Report on Brazil is one of the 11 country studies on UHC that was commissioned under the Japan–World Bank Partnership Program. The other participating countries are Bangladesh, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication “Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies,” available at:

<http://www.worldbank.org/en/topic/health/brief/uhc-japan>.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services, to safeguard all people from public health risks, and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

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The Program was led by a team comprising Akiko Maeda, Lead Health Specialist and Task Team Leader for the World Bank, and co-Team Leaders, Professor Naoki Ikegami, Department of Health Policy and Management, Keio University School of Medicine and Professor Michael Reich, Taro Takemi Professor of International Health Policy, Harvard School of Public Health.

This report was prepared by a World Bank team comprising Magnus Lindelow, Sector Leader, and Edson C. Araujo, Health Economist.

The report was edited by Jonathan Aspin.

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Country Summary Report for Brazil

Overview

Over the last 20 years, Brazil has seen profound economic, political, and demographic changes. After a period of military dictatorship (from 1964 to 1985), political and economic stability was achieved in the mid-1990s. The country has urbanized, improved access to water and sanitation, achieved solid economic growth, and reduced income inequality.¹ It was one of the first Latin American countries to establish universal health coverage (UHC) as a fundamental right, based on the principles that health care is a duty of the state and should be free at the point of use. The reform in the late 1980s created the Unified Health System (Sistema Único de Saúde, or SUS) and was based on the principle that health care should be free at the point of use to all Brazilian citizens.

Table 1: Data overview

Population	196,655,014*
Gross domestic product (GDP)	2,477 billion (current US\$)*
Gross national income per capita in Purchasing Power Parity	11,420*
Total health expenditure (THE) as % of GDP	9%**
THE per capita (in current exchange rate dollars)	990.39 (current US\$)**
Public expenditure as share of THE	47.02%**
OOP spending as % of THE	31.3%
Life expectancy at birth	73.44*
Hospital beds per capita	23/10.000 pop*

Source: World Development Indicators, The World Bank, 2013.

Note: The data points are for *2011, **2010, and ***2009.

The previous system had several vertical, independent, and uncoordinated systems, each with its own source of funding, network of facilities, and beneficiary population. SUS integrated these schemes into a single publicly funded system for the whole population, financed through general taxes. The reform increased access and use of public services, especially through the expansion of primary health care (PHC). However, access to specialist care and diagnostic services remains an important bottleneck. The new arrangement allowed for the private health

¹ Between 1991 and 2008, the country's GDP doubled and its Gini coefficient, one of the highest in the world, fell from 0.637 to 0.547 (Paim et al., 2011).

insurance market to continue, although in a supplemental role², but private spending has in fact remained stable over the last 15 years, and the number of people with private health plans has gradually increased over the last 20 years: by 2012, more than 50 million Brazilians were covered by some form of private health plan (around 25 percent of the population).³

Part I. Universal Coverage⁴

A. Overview of current status

The SUS was formally established by the 1988 Constitution, with its framework outlined in Laws 8.080 and 8.142 of 1990. Previously, the health sector was funded through four main financing sources: Social Security (SS) through the National Institute of Health Care (INAMPS), which covered the working population in the formal sector and its dependents; the non-SS public systems, consisting of independently managed federal and state government facilities that provided basic services, mostly to the poor and other groups not covered by SS; the private health insurance system; and direct out-of-pocket payments for drugs and services (mainly provided by the private sector). The impetus for the SUS came in part from rising costs and a crisis in the social security system, but also from a broad-based political movement calling for re-democratization and improved social rights. In the health sector, the sanitary movement (Movimento Sanitário) championed far-reaching health system reforms.⁵

The founding principles of SUS as stated in the Constitution and its basic laws include three overarching principles: universal access to health services, with health defined as a citizen's right and an obligation of the state; equality of access to health care; and comprehensiveness and continuity of care. These were underpinned by other attributes, including decentralization of most responsibilities to municipalities with joint financing responsibilities; increased community participation; re-organization of the system to enhance integration and coordination, and to reduce duplication; patient autonomy and right to information; and enhanced effectiveness through use of epidemiology to define priorities and allocate resources. The Constitution and subsequent legislation (Laws 8.080 and 8.142) defined the national system under construction as public and publicly financed, with the private sector's role supplemental.

Twenty years after the SUS reform came in, the share of total health spending financed by the government remains far lower than in countries in the Organisation for Economic Co-operation and Development (OECD) and in many middle-income peers. The continued growth in private spending, and in the number of individuals covered by private health insurance, has resulted in a two-tier health system. Those with sufficient means or whose employers provide health coverage—around 25 percent of the population—have recourse to a private system of health

² According to the OECD taxonomy supplemental health insurance refers to private health insurance that provides coverage for additional health services that are not covered by the public scheme (OECD, 2004). However, in reality, private health insurance in Brazil covers most of the services provided by the SUS and those privately insured enjoy double coverage (SUS and private insurance).

³ The privately insured enjoy, in principle, double coverage (SUS and private insurance).

⁴ This section draws extensively on the publication "Twenty Years of Health System Reform in Brazil: An Assessment of the Sistema Único de Saúde" by Michele Gagnolati, Magnus Lindelow, and Bernard Couttolenc, published by the World Bank (2013).

⁵ The sanitary movement is an informal coalition of health professionals, academics, and others who demanded a public health system responsive to and controlled by the public and health as a fundamental human right to be guaranteed by the constitution.

care that provides better access to treatment and more sophisticated facilities.⁶ The rest of the population relies on a system of public facilities or facilities that have been contracted to provide services to SUS patients. Access remains a significant issue, in particular for medium- and high-complexity care, and there is significant variation in both the status of facilities and equipment, and the technical quality of care. . However, the privately insured often rely on SUS for vaccines, high-cost services, and complex procedures such as hemodialysis and transplants.

In terms of service delivery, the SUS reforms targeted perceived weaknesses of the pre-SUS system, including the limited availability of services in some parts of the country, the weak primary care system, and excessive centralization. Access to health care picked up sharply with the SUS, especially at PHC level: the number of people seeking PHC in clinics increased by about 450 percent between 1981 and 2008. Between 1990 and 2009, the number of medical consultations per capita also increased, by 70 percent, and the volume of basic care procedures per capita climbed from around 2.5 to over eight. The health facility network has expanded significantly, with the number of establishments growing from nearly 22,000 in 1981 to almost 75,000 in 2009 (Paim et al. 2011; Gragnolati et al. 2013). The SUS reforms also signaled an important shift in policy direction and resource allocation, with ambulatory facilities accounting for most of this growth in establishments. The expansion of the supply of services was accompanied by a reduction in regional disparities, such as the density of hospital beds (Gragnolati et al. 2013).

The growth in ambulatory facilities provides an indication of a growing emphasis on primary care over the last couple of decades. A key driver has been the rapid deployment of the Family Health Strategy (Estrategia de Saude da Familia - ESF⁷) and the Community Health Agents Program (Programa de Agentes Comunitários de Saude -PACS).⁸ The ESF has grown rapidly: between 1998 and 2010, ESF teams increased from 4,000 to over 31,600 and enrollment expanded from 10.6 million to over 100 million people, or just over 50 percent of the population (Figure 1). However, “enrollment” is determined by whether a person’s residence is within the ESF team’s catchment area, not based on individual choice. In heavily populated areas there may be more than one ESF team per health facility, but each team is assigned a specific territory and has a list of which families it serves. As with all other services delivered by the SUS, there are no user fees for services and most medications are delivered free of charge.

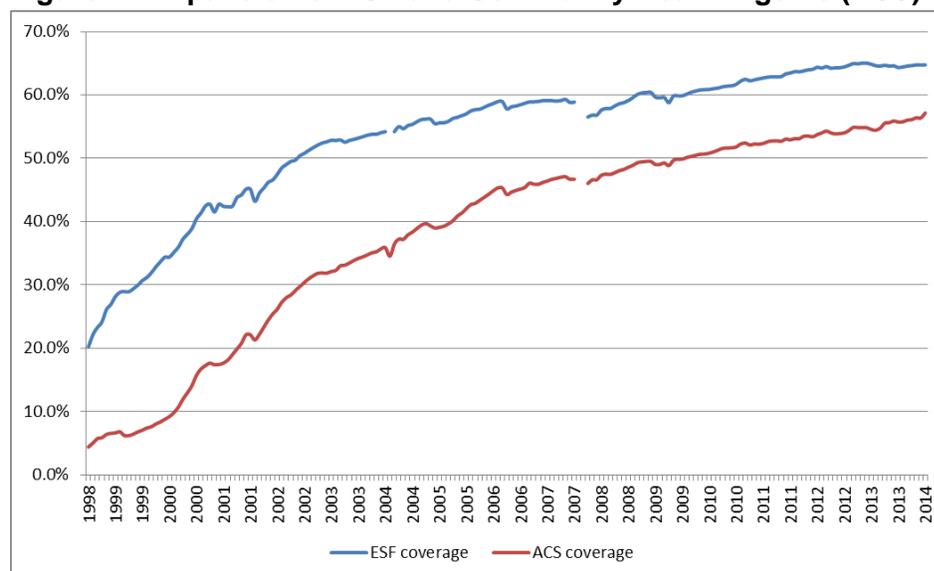
⁶ The private insurance sector has been able to enroll a younger, healthier population and offer plans with different levels of choice and type of health care provider. The higher level of spending in the private sub-sector is reflected not only in greater access, but also better facilities and, at least in some areas, higher quality. However, with the rapid expansion of the private health insurance market that is trying to cater for a broader segment of the population, the variability across plans in terms of cost, benefits, access and quality has increased over time.

⁷ The ESF are multi-professional health teams (composed of a physician, a nurse, a nurse assistant and four to six community health workers) organized by geographic region to provide primary care to some 1,000 families (or about 3,500 people).

⁸ PACS became important after the reorganization of health service delivery around ESF. The ACS (community health agents) are recruited from the neighborhoods where they are deployed, trained for up to three months, and employed by the municipal health authority. ACSs are responsible for a wide range of services in PHC (chronic disease management, triage, child development, etc.) and public health (screening, immunizations, etc.). Where the ESF is not fully implemented, the PACS act as a transition model. There are 234,767 ACSs around the country, in rural and urban peripheral areas (Johnson et al., 2013).

ESF expansion proceeded unevenly throughout the country, but it is now present in over 90 percent of the country's 5,565 municipalities.

Figure 1: Expansion of ESF and Community Health Agents (ACS) coverage, 1998–2014



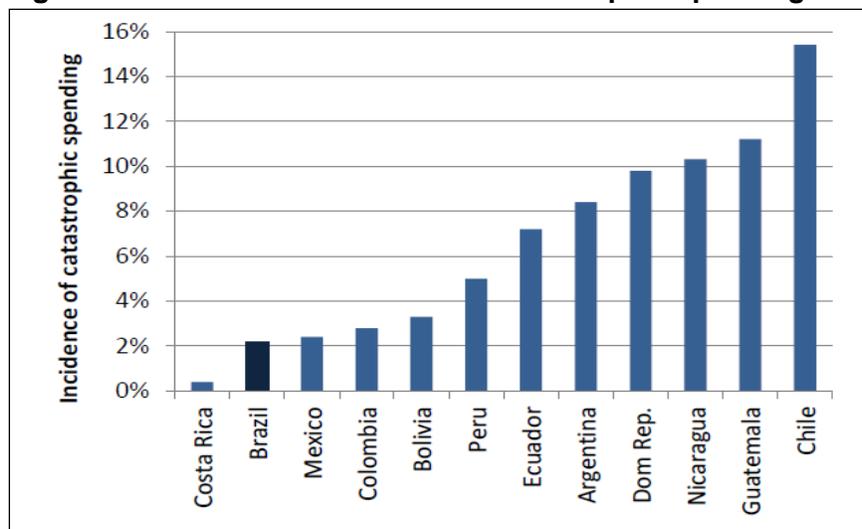
Source: DATASUS/Ministry of Health of Brazil.

The achievements of the SUS are indisputable, but the health system faces important challenges, the most significant relating to the remaining coverage gaps in primary care, barriers to access specialist and high-complexity care, weak quality and coordination of care, and continued high reliance on private spending. For example, there is ample evidence that long waiting times are a source of considerable frustration among users of the SUS (Gragnolati et al. 2013). There are also recognized problems in access to diagnostic procedures and specialist care. Taking the example of cancer treatment, delays in diagnosis mean that 60 percent of cancer patients are diagnosed at a very late stage, a problem compounded by delays in accessing treatment (Gragnolati et al. 2013). Several factors contribute to the problem, including a lack of capacity in the system, insufficient staff with qualifications in relevant specialties (e.g. pathologists), weaknesses in referral and counter-referral systems, and payment rates that in some cases may not match costs of services- all of which illustrate broader challenges in the health system.

Although the SUS reforms did not establish any explicit goals for private spending, the SUS reformers expected that the supplemental health system would decline in importance as the national health system expanded and matured. This has not happened, however. Indeed, despite intentions to the contrary, private spending has remained stable over the last 15 years or so. The share of direct out-of-pocket spending has declined over time, but still accounts for around 30 percent of total health spending, while the share of spending on private plans has been increasing, and now stands at just over 20 percent. Recent evidence suggests an incidence of catastrophic spending of 2.2 percent if all household health spending is considered,

and 1.9 percent if spending on private plans is excluded, which is low compared with other countries in the Latin America and Caribbean region (Figure 2).⁹

Figure 2: Brazil's low incidence of catastrophic spending



Source: Gragnolati et al., 2013.

A large share of this burden can be attributed to spending on drugs, which affects the poor more: for the bottom deciles of the income distribution, it accounts for 60–70 percent of total health spending, while for the upper end it accounts for only 25–35 percent (Gragnolati et al. 2013). The government has taken many measures to reduce household health spending on drugs, but the issue persists for several reasons. First, availability of drugs in public pharmacies is a problem (sometimes as much as 40 percent of drugs prescribed in public primary care are not available). Second, much drug spending appears to be on prescriptions for drugs that are off the SUS essential drugs list, typically by non-SUS providers or self-medication. Finally, drug prices for key drugs seem relatively high (Gragnolati et al. 2013).

Government health expenditures are characterized by considerable institutional complexity, reflecting the arrangements defined in the health reform: health care was envisaged as a tripartite responsibility, with municipalities taking on a leading role in the delivery of health services, states and federal government maintaining responsibility for some referral/services, and financing being shared across the three levels.¹⁰ Funds are collected and pooled at each level of government. The minimum amount of resources to be allocated to the Ministry of Health (MoH) and state and municipal health secretariats has been defined by Constitutional Amendment No. 29/2000, which defined minimum levels of health spending by sphere of

⁹ There is however a wide range of estimates on the incidence of catastrophic spending, reflecting differences in data sources and methods. See Gragnolati et al. (2013).

¹⁰ In principle, municipal governments should, through their municipal health funds, be the main provider and purchaser of health services. However, because most municipalities are small and have limited technical or financial capacity, many facilities and a large part of SUS finance remains in the hands of state and federal governments.

government.¹¹ Between 1980 and 2009, participation of municipalities and states in health financing increased, particularly from the early 1990s, reaching 28 percent and 27 percent respectively in 2009. The participation of the federal government fell from over 70 percent to 45 percent in the same period. This change in the financing pattern is consistent both with the process of decentralization of service delivery, one of the organizational principles of SUS, and with the new financing structure defined by Constitutional Amendment No. 29. While health spending has increased substantially in absolute and per capita terms, the share of government spending in GDP has grown more slowly, and there is a strong link between government health spending and the economic cycle, with increases during expansions and sharp cuts during downturns. This had been a typical feature of public financing before the SUS and remained after its foundation, even though “stop–start” financing was one of the key concerns of the health reform.

Resources from the MoH to state and municipal health secretariats are allocated through different resource flows known as financing “blocks,” including primary care capitation system known as Fixed and Variable PAB (Piso da Atenção Básica—Basic Health Package);¹² intermediate and specialized outpatient and inpatient care; health surveillance; and pharmaceutical assistance. In each block, funds are transferred to states and municipalities based on different allocation-formulas, from per capita calculations to ex-post reimbursements. In states and municipalities, resource allocation is based on priorities defined in their health plans and the Integrated Programming (Programação Pactuada Integrada—PPI), a planning instrument that states and municipalities use to define the quantity of health service actions and other initiatives for their populations (based on parameters defined by the MoH for demand and supply patterns).

B. Human resources for health (HRH) policies

HRH shortage and maldistribution represent a major bottleneck for achieving UHC goals. Brazil had 1.8 physicians per 1,000 population, fewer doctors than countries of a similar level of development, such as the Russian Federation (4.3 physicians per 1,000 population) and Mexico (2.0 physicians per 1,000 population), and well below the OECD average of 3.2 for 2011 (OECD 2013). Furthermore, the geographic and sector distribution of medical doctors is marked by inequalities, as many physicians work in urban areas in the private sector or in specialized care. In 2010, 1,304 municipalities had a shortage of physicians, especially those in rural, peri-urban, or difficult-to-access areas (Girardi et al. 2011; Dal Poz 2013).

Table 2: Current status of HRH

	Current	Entry	Exit
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¹¹ The amendment earmarks to health care services a minimum of 15 percent of the municipalities’ total budget, no less than 12 percent of the states’ total budget, and the previous fiscal year’s amount adjusted by the nominal change in GDP in the case of the federal government.

¹² Under the PAB the share of the health budget received by each municipality is calculated according to a formula with a fixed and a variable component. The fixed component is a fixed per capita transfer that guarantees an amount for basic care for all individuals. The variable component depends on the number of family health teams and the population coverage achieved in each municipality.

	number per 1,000 population	Qualifications	Government determines the number of new entrants	Number of entrants per year	Number of years of education	Number of newly licensed per year
Physicians	1.8***	High school graduate	No	10,000*	6 years	N/A
Nurses	10.1**	Nurse Technician Auxiliary	No	32,000*	Nurse: High school graduate Technician: 18 months of training (average) Auxiliary: 12-15 months of training (average)	N/A
Midwives	0.22**	N/A	No	N/A	N/A	N/A
Community health workers	244,000**	N/A	N/A	N/A	N/A	N/A

Source: * Machado et al., 2010 (data from Ministry of Education, 2007); ** WHO 2012; *** OECD 2013.

Disparities in health worker densities have narrowed greatly through expansion of the family health services, but recruitment and retention remains a problem, especially in the rural Northern and Northeastern states. The government introduced the Enhancement Program for Professionals in Primary Health Care (Programa de Valorização dos Profissionais na Atenção Básica -PROVAB) in 2011 to develop various incentives for health professionals (monetary as well as bonus points in examinations for admission into medical residency programs and the specialization course in family health) to work for a minimum of one year in PHC in areas designated as underserved by the federal government.

Recently, given the persistence of vacant posts in remote and underserved areas, and in response to a wave of popular protests against the low quality of care, the Brazilian government decided to recruit doctors trained abroad through the “Mais Médicos” (“More Doctors”) program. This program seeks to recruit thousands of foreign and local doctors to underserved areas where Brazilians do not want to work. The program, which has attracted doctors from countries as diverse as Argentina, Cuba, Portugal, and Spain as well as Brazilians trained abroad, offers a three-year contract in family medicine at market value (10,000 reais/US\$4,250 a month), plus housing and continued education. It also provides medical training and infrastructure improvements. So far, the vast majority of doctors enrolled are from Cuba through an agreement involving the Pan-American Health Organization, and the Cuban and Brazilian governments. In addition to these Federal initiatives, at municipal level administrators adopt different types of incentives to recruit health workers, most often by raising salaries and introducing flexible working hours.

Staff-mix and task-shifting are topics of constant debate in Brazil.¹³ Distorted skill-mixes have been reported in primary care and in hospitals. Although the laws regulating nursing practices and national guidelines allow nurses to conduct consultations and prescribe specific drugs and exams in primary care units, professional and institutional resistance curtail these practices, often resulting in legal confrontation. In hospitals, for instance, the work environment has become hostile and constrained for nurses to provide care for women during childbirth with reported difficulties in relationships between professional categories. On human resources management, one of the main factors resulting in inefficiency is providers' lack of autonomy.

As with other countries, Brazil is facing both cost and human resource constraints to address the burgeoning problems related to chronic diseases. Timely diagnosis and effective management of chronic diseases require well-functioning primary care, effective coordination with diagnostic services and higher levels of the health system, and appropriate skills and incentives at different levels of the system.

Part II. Lessons To Be Shared

Brazil's strong political leadership committed to new investments in national health care and UHC policy reforms, as well as the growing public demand for these services, played an important role in the expansion of health coverage. Despite many financing and service delivery challenges, it is one of the few developing countries with a health system based on general taxation with free and universal health care for its entire population. The status of universal health coverage as a constitutional right embodies this commitment and facilitates the design, development, and implementation of UHC by providing a legal basis and institutional foundation for all UHC initiatives.

The strong emphasis on health as a citizens' right, together with a high level of engagement by civil society and the impact on health policies in Brazil represent important lessons learned for other countries addressing their own health challenges (Kleinert and Horton 2011). On the other hand, the implementation of SUS principles raised new challenges. The principle of comprehensiveness, according to which every citizen has the right to have all of his/her needs and demands perceived and treated by the health system, originated in a new phenomenon known as *judicialization* – in which patients request the Judiciary to enforce the right to access drugs and procedures that are not included in the basic list provided by the SUS. The *judicialization* creates significant administrative costs for the system, particularly for state and municipal health secretariats. To confront this challenge, one of the strategies adopted by SUS has been to strengthen the process of incorporating new technology into the system - essential to guarantee financial sustainability and to inform judges' decisions (World Bank 2012).

Other achievements of the Brazilian system that can be considered as useful lessons for countries are: the emphasis on PHC through its ESF (Box 1), the decentralization of the system, and social participation in health policy making and accountability. Since mid-90's, the development of PHC has been one of the main public health care strategies in Brazil. As discussed above, the ESF grew rapidly between 1998 and 2010, both in terms of the number of teams (six-fold increased approximately) and population enrolled (10 times approximately, covering around 50 percent of the Brazilian population). The decentralization process in the health system was linked to a wider process of political transition and the redesign of the

¹³ The physician: nurse ratio is 3.89 in the private sector, and 2.56 in the public sector.

Brazilian Federation, which was started by democratic political movements in the 1980s and later shaped by macroeconomic adjustment programs (Paim et al. 2011). With the decentralization inherent in the new institutional arrangements, the municipalities became more independent. At the same time, federal support expanded and with that increased oversight through financial and regulatory actions. Despite the problems with smaller municipalities that lack technical and institutional capabilities to implement the decentralized policies and programs, the system is generally well coordinated among the three levels of government and across Brazil's 27 states and over five thousand municipalities.

To manage such a decentralized system, the existing frameworks for government decision making were expanded, together with social participation in policy making and implementation at each level of government—one of founding principles of SUS. Such participation, a requirement for resources to be transferred from the federal level to state or municipal governments, occurs in health councils, which exist at each of the three levels of government and have deliberative character. Health council members come from the government and civil society, including users and producers of health services (Elias and Cohn 2003). These political structures were groundbreaking innovations in Brazilian governance structure because they enabled a greater number and variety of stakeholders to take part in the decision-making process (Paim et al. 2011).

Despite its achievements, there are challenges for the consolidation and maintenance of SUS and its achievements. The chronic underfunding of the SUS, especially when compared to other national health services systems and even to other Latin American countries (Ocke-Reis and Marmor 2010), combined with management weakness, has constrained improvements in the quality of services and access pushing a significant share of the population into the private insurance market, creating a segmented two-tier health system. This segmentation generates social injustice that is difficult to address and that is reflected in many ways. For example, there is reportedly a quality gap between the public and private sector; those who access care through private insurance report better quality of services access to preventive services and higher service utilization than those relying on SUS (Farias 2001; Araujo 2010). Another example of segmentation is in the distribution of the health workforce: health workers are attracted by higher salaries and better working conditions in the urban and affluent private sector. This, in turn, has contributed to critical shortages of primary care physicians in rural and poorer regions of the country. Addressing these geographic imbalances in the health workforce availability and reducing inequities in quality of care are high on the agenda for ensuring equitable access to health care for the entire population.

Box 1. PHC contracting models in Brazil: The cases of Bahia and Rio de Janeiro

As discussed above, the Family Health Strategy became the mainstay for expanding SUS coverage in the country. Under this Strategy, the Federal government defined the financial incentives to be provided to the municipalities for expanding health coverage, and launched a series of supporting programs to increase financing, provide in-service training to health workers, and assess quality of services provided. Altogether these actions influenced the rapid expansion of PHC coverage in Brazil over the last decade.

As part of the decentralization process of the SUS, the responsibility for managing and administering health services was devolved to the municipalities. However, municipalities are required to hire professionals through the public administrative system, and to abide by civil service employment rules. Additionally, the Federal Law of Fiscal Responsibility (*Lei de Responsabilidade Fiscal*) limits municipal spending on personnel to a maximum of 60 percent of the municipal budget, which indirectly imposes a significant barrier to the expansion of social services, including health care personnel. Under these conditions, most municipalities faced considerable fiscal and administrative constraints in expanding PHC services.

In the face of these restrictions, many States and Municipalities have been implementing a series of initiatives to redress these problems. They have included contracting third party entities to manage PHC and hospital services to avoid the constraints imposed by public sector administration. In the state of Bahia the aims of expand coverage of the Family Health Strategy and improve quality of services were limited by the difficulties in attracting and retaining qualified health professionals. Rigidities in the process of public hiring led to a number of isolated contracting initiatives at the municipal level and diverse, often unstable, employment contracts. The state and municipalities decided to centralize the hiring of health professionals, in order to offer stable positions with career plans and mobility within the state, and for that created the State Foundation for Family Health Care in Bahia (or *Fundação Estatal Saúde da Família da Bahia* - FESF). The FESF is a state-owned, not-for-profit institution that integrates indirect public administration, but operates within private law and with private sector governance mechanisms, such as employment contracts. The most important function of the FESF was to contract health professionals, in particular doctors, nurses and dentists, for primary care on behalf of participating municipalities. Results have been mixed, due to a lower than expected municipal involvement that resulted in relatively high administrative costs and consequent default on municipal financial contributions. The FESF is undergoing a governance reform and has now diversified the areas of work beyond hiring for health workers for primary care.

The municipality of Rio de Janeiro had, until recently, relied on an expansive hospital network for health care delivery. In 2009, the municipality implemented the program Saude Present, which concentrated efforts to expand primary health services. In response to the difficulties faced in their earlier efforts to expand coverage due to the cumbersome recruitment and procurement processes and restrictions on municipal spending on personnel, the municipal government took decided to break with direct management, and opted instead to contract with Organizacoes Sociais - (Social Organizations - SOs) for the delivery of PHC services. The SO's are not-for-profit institutions that operate outside the public administration and are regulated by private law with private sector governance mechanisms. This move has succeeded in expanding coverage significantly, from 8 percent in 2008 to 41 percent in 2013. In It has also resulted in considerable increase in funding for primary health. Initiatives to improve performance, however, still need further fine-tuning and implementation of more reliable information systems to enable more rigorous evaluation of service quality and other dimensions of health system performance.

These two experiences from Bahia and Rio de Janeiro are examples of innovative efforts to overcome the existing constraints within the public system. While the results to date have been mixed, they offer important insights into possible pathways to reform that could help the country expand effective primary health coverage in an inclusive and sustainable manner (see Araujo et al., forthcoming, for more details on these initiatives).

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