Transforming the Health Sector: Building Health Capacity.
Focus on Emerging Economies
The Case of Brazil

Mauricio L. Barreto
Life Expectancy at Birth

Figure 3.1: The Preston Curve in 2000.

Circles have a diameter proportional to population size. GDP per capita is in purchasing power parity (PPP) dollars.
### Overview of financial health protection programmes in BRICS countries

<table>
<thead>
<tr>
<th></th>
<th>Brazil</th>
<th>Russia</th>
<th>India</th>
<th>China</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-pocket spending on health (% of total health expenditure, 2011)</td>
<td>57.8%</td>
<td>35%</td>
<td>59%</td>
<td>35%</td>
<td>7%</td>
</tr>
<tr>
<td>GNI per head (US$, 2011)</td>
<td>$11,420</td>
<td>$20,560</td>
<td>$3590</td>
<td>$8,390</td>
<td>$10,710</td>
</tr>
<tr>
<td>Annual GDP growth rate (5 year average; 2007-11)</td>
<td>4.4%</td>
<td>2.8%</td>
<td>7.8%</td>
<td>10.4%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Public expenditure on health (% of GDP, year)</td>
<td>3.3% (2005), 4.1% (2011)</td>
<td>3.2% (2005), 3.7% (2011)</td>
<td>0.9% (2005), 1.2% (2011)</td>
<td>1.8% (2005), 2.9% (2011)</td>
<td>3.4% (2005), 4.1% (2011)</td>
</tr>
<tr>
<td>Private expenditure on health (% of GDP, 2009)</td>
<td>4.9%</td>
<td>1.9%</td>
<td>2.8%</td>
<td>2.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Health expenditure (% total of GDP, 2010)</td>
<td>9%</td>
<td>5.1%</td>
<td>4.1%</td>
<td>5.1%</td>
<td>8.9%</td>
</tr>
</tbody>
</table>

BRICS=Brazil, Russia, India, China, and South Africa. GNI=gross national income. GDP=gross domestic product.

*Marten et al, 2014*
The BRICS countries show substantial, and often similar, challenges in moving towards UHC. On the basis of a review of each country, the most pressing problems are:

• raising insufficient public spending;
• stewarding mixed private and public health systems;
• ensuring equity;
• meeting the demands for more human resources;
• managing changing demographics and disease burdens;
• addressing the social determinants of health.

Marten et al, 2014
“The challenge is ultimately political, requiring continuous engagement by Brazilian society as a whole to secure the right to health for all Brazilian people.”
Brazil
Federative Republic (27 States and 5570 municipalities)
8,5 million Km²
203 million inhabitants
The Gini index is a measure of statistical dispersion and is used as a measure of inequality of wealth (e.g. income) distribution. It varies from 0 to 1, where a value of 0 corresponds to perfect equality and a value of 1 corresponds to perfect inequality.
Prevalence of undernutrition- height deficit (<5 years) by family income, 1974/5 - 2006/7

Lancet, 2011
Prevalence of undernourishment in the population (percent) in 2012-14.
Important Factors of Change

• Economic Growth
• Sustainable Increases in the Minimum Wage
• Low unemployment rates
• Improvement in Education
• Development of a comprehensive and equitable Health System
• Strong Social Protection Programs
The Health System - Introduction

• Since 1988, Brazil has developed a dynamic, complex health system (the Unified Health System; SUS), which is based on the principles of **health as a citizen’s right and the state’s duty.**

• The SUS aims to provide comprehensive, universal, preventive and curative **care** through decentralized management and provision of health services, and promotes community participation at all administrative levels.

• The Brazilian Health Sector Reform occurred at the same time as **democratization**, and was spearheaded by health professionals and individuals in civil society movements and organisations.
Federal Constitution, art. 196 (1988)

• “health is a right of all citizens and a duty of the state, granted by social and economic policies aimed to reduce the risk of diseases and the universal and equitable access to actions and services to its promotion, protection and recovery”.
Some special features of the Brazilian Unified Health System - SUS

- Social Participation
- Expansion of human manpower in health
- The “mix” public-private
- Capacity building for health research
- Mass media and health promotion
- Regulation and medicines
- Effective and equitable Primary Health Care – The Family Health Program
Figure 4: SUS policy-making and social participation process

CONASS = national council of state officers. CONASEM = national council of municipal health secretaries. CONSEMS = state council of municipal officers. Data from reference 47.
<table>
<thead>
<tr>
<th></th>
<th>R$m (%)</th>
<th>% GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taxes and social contributions</td>
<td>53 329 (39.05%)</td>
<td>3.14</td>
</tr>
<tr>
<td>Federal</td>
<td>27 181 (19.90%)</td>
<td>1.6</td>
</tr>
<tr>
<td>States</td>
<td>12 144 (8.89%)</td>
<td>0.7</td>
</tr>
<tr>
<td>Municipalities</td>
<td>14 003 (10.25%)</td>
<td>0.8</td>
</tr>
<tr>
<td>Private</td>
<td>83 230 (60.95%)</td>
<td>4.89</td>
</tr>
<tr>
<td>Family spending&lt;sup&gt;66&lt;/sup&gt;*</td>
<td>65 325 (47.84%)</td>
<td>3.84</td>
</tr>
<tr>
<td>Employer company spending&lt;sup&gt;60&lt;/sup&gt;†</td>
<td>17 905 (13.11%)</td>
<td>1.05</td>
</tr>
<tr>
<td>Total</td>
<td>136 559 (100%) ‡</td>
<td>8.03</td>
</tr>
</tbody>
</table>

Data from references 6 and 7, unless otherwise stated. GDP=gross domestic product. *Estimated from the national household expense survey 2002-03 (corrected by the consumer-price inflation index). †Estimated from information on private health plan and insurance billing provided to the national health insurance regulatory agency. ‡GDP in 2006=R$1.7 trillion.

*Table 4: Estimated health spending in 2006*
Expansion of the health-care facilities in Brazil, 1970-2010
Family Health Program

Average family health program coverage according to the municipal human development index (HDI-M) quintiles of the 5,507 Brazilian municipalities.
Family Health Program (FHP)

FHP teams

- physician (1)
- nurse (1)
- nursing staff (2)
- community health workers (CHW) (6)
- oral health professionals (1)

NASF multi-professional support teams

- NASF 1: at least five specialists linked to the minimum of 8 to 20 Family Health Teams.
- NASF 2: at least three specialists linked to the minimum of 3 Family Health Teams.
Impact of FHP : Summary

- Increase overall access and improve equity in Health Care
- Reduce overall childhood mortality and hospitalizations
- Reduce hospitalizations by causes sensitive to primary care
- Reduce mortality and hospitalizations by cardiovascular and cerebrovascular diseases
Trends in percentage of pregnant women without any prenatal visit at the moment of delivery according to quintiles of municipal HDI.

Data Source: MS/SVS/DASIS - Sistema de Informações sobre Nascidos Vivos - SINASC
Barreto et al, 2014
Evaluation of the impact of the Family Health Program on infant mortality in Brazil, 1990–2002

James Macinko, Frederico C Guanais, Maria de Fátima Marinho de Souza

Objective: To use publicly available secondary data to assess the impact of Brazil’s Family Health Program on state level infant mortality rates (IMR) during the 1990s. Designs: Longitudinal ecological analysis using panel data from secondary sources. Analyses controlled for state level measures of access to clean water and sanitation, average income, women’s literacy and fertility, physicians and nurses per 10,000 population, and hospital beds per 1,000 population. Additional analyses controlled for immunization coverage and tested interactions between Family Health Program and other factors. Setting: 27 states (1990–2002) of data from 27 Brazilian states. Main results: From 1990 to 2002 IMR declined from 49.7 to 28.9 per 1,000 live births. During the same period average Family Health Program coverage increased from 0% to 36%. A 10% increase in Family Health Program coverage was associated with a 4.5% decrease in IMR, controlling for all other health determinants (p<0.01). Access to clean water and hospital beds per 1,000 were negatively associated with IMR, while female literacy, fertility rates, and mean income were positively associated with IMR. Examination of interactions between Family Health Program coverage and child health death suggests the programme may reduce IMR at least partly through reductions in child health deaths. Interactions with deaths from acute respiratory infections are ambiguous. Conclusions: The Family Health Program is associated with reduced IMR, suggesting it is an important, although not unique, contributor to declining infant mortality in Brazil. Existing secondary datasets provide an important tool for evaluation of the effectiveness of health services in Brazil.
Fixed-Effects Models for the Bivariate Association Between Infant Mortality Rate and Family Health Program Coverage: Brazil, 1996–2004

<table>
<thead>
<tr>
<th>Variables</th>
<th>Infant Mortality Rate</th>
<th></th>
<th>Neonatal Mortality Rate</th>
<th>Postneonatal Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude RR (95% CI)</td>
<td>Adjusted RR (95% CI)</td>
<td>RR (95% CI)</td>
<td>RR (95% CI)</td>
</tr>
<tr>
<td>No FHP (Ref)</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Incipient FHP</td>
<td>0.84 (0.82, 0.85)</td>
<td>0.87 (0.86, 0.89)</td>
<td>0.90 (0.89, 0.92)</td>
<td>0.82 (0.80, 0.84)</td>
</tr>
<tr>
<td>Intermediate FHP</td>
<td>0.77 (0.75, 0.79)</td>
<td><strong>0.84 (0.82, 0.86)</strong></td>
<td>0.86 (0.84, 0.89)</td>
<td>0.78 (0.75, 0.81)</td>
</tr>
<tr>
<td>Consolidate FHP</td>
<td>0.68 (0.64, 0.73)</td>
<td><strong>0.78 (0.73, 0.83)</strong></td>
<td>0.81 (0.76, 0.88)</td>
<td>0.69 (0.62, 0.76)</td>
</tr>
<tr>
<td>Total fertility rate ≤2.4 children per childbearing-age woman</td>
<td>0.90 (0.87, 0.93)</td>
<td>0.92 (0.88, 0.95)</td>
<td>0.88 (0.84, 0.92)</td>
<td></td>
</tr>
<tr>
<td>Per capita income ≥BR$258.00</td>
<td>0.92 (0.89, 0.94)</td>
<td>0.93 (0.89, 0.96)</td>
<td>0.89 (0.85, 0.93)</td>
<td></td>
</tr>
<tr>
<td>Functional illiterates rate ≤26.0% of individuals aged ≥15 y</td>
<td>0.87 (0.84, 0.89)</td>
<td>0.89 (0.86, 0.92)</td>
<td>0.83 (0.79, 0.87)</td>
<td></td>
</tr>
<tr>
<td>Percentage of persons living in households with running water ≥96.0%</td>
<td>0.91 (0.89, 0.93)</td>
<td>0.93 (0.90, 0.95)</td>
<td>0.88 (0.85, 0.91)</td>
<td></td>
</tr>
<tr>
<td>Gini index ≤0.55</td>
<td>1.18 (1.14, 1.22)</td>
<td>1.21 (1.16, 1.26)</td>
<td>1.10 (1.05, 1.16)</td>
<td></td>
</tr>
<tr>
<td>Local hospitalization</td>
<td>0.88 (0.82, 0.96)</td>
<td>0.88 (0.80, 0.96)</td>
<td>0.94 (0.84, 1.06)</td>
<td></td>
</tr>
</tbody>
</table>
Under-five five overall mortality rates according to HDI quintiles of municipalities

Data Source: SIM
Barreto et al, 2014

Under-five mortality rates from diarrhoea according to IDH quintiles of municipalities
FIGURE 2. Percentage change between 1999 and 2007 in hospital admissions sensitive to primary healthcare (PHCSC) and nonsensitive (non-PHCSC) per 10,000 inhabitants aged below 80 years, by Brazilian Region. PHCSC indicates primary healthcare-sensitive conditions.
Fixed effect negative binomial models for crude and adjusted association between standardised mortality rates and annual coverage with Family Health Program (FHP) in municipalities in Brazil, 2000-09

<table>
<thead>
<tr>
<th>Variables</th>
<th>Cerebrovascular diseases mortality rate</th>
<th>Heart diseases mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude rate ratio (95% CI)</td>
<td>Adjusted rate ratio (95% CI)</td>
</tr>
<tr>
<td>FHP population coverage:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No coverage</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Incipient (&gt;0 to &lt;30%)</td>
<td>0.94 (0.92 to 0.97)</td>
<td>0.98 (0.95 to 1.00)</td>
</tr>
<tr>
<td>Intermediate (≥30% to &lt;70%)</td>
<td>0.79 (0.76 to 0.81)</td>
<td>0.86 (0.83 to 0.89)</td>
</tr>
<tr>
<td>Consolidated (≥70%)</td>
<td>0.71 (0.69 to 0.74)</td>
<td>0.82 (0.79 to 0.86)</td>
</tr>
</tbody>
</table>
Trends in non-communicable disease mortality in Brazil

Age-standardised to the WHO standard population,18 corrected for under-reporting, with redistribution of ill-defined causes of death pro rata across non-external causes.

Lancet, 2011
Social Protection Programs in Brazil

18 programs utilize the Cadastro Único

- Benefício de Prestação Continuada (BPC/LOAS)
- Carteira do Idoso
- Minha Casa, Minha Vida
- Isenção de taxa para concursos públicos
- Bolsa Verde
- Serviços de proteção social básica e especial (SUAS)
- Bolsa Família
- Cisternas
- Pronatec
- Tarifa Social de Energia Elétrica
- Brasil Alfabetizado
- Prog. de Erradicação do Trabalho Infantil (PETI)
- Fomento às Atividades Produtivas Rurais
- Outras ações

BRASIL
Bolsa Família Program
(Conditional Cash Transfer)

Great Expansion - 4.1 million families served in 2004 to 13.4 million in 2011 (MI, 2011), approximately 44 million people (23% of the population).

Principal axes:
• Transfer income, which promotes immediate relief to poverty
• Conditionalities that encourage access to education and health
• Additional programs to create conditions for families be out of the program.

Intended for extremely poor households

Benefits: R$ 32 to a maximum of R$ 306.
Figure: Mechanisms linking the *Bolsa Família* Programme and the Family Health Programme to child nutritional and health outcomes.
Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities

Davide Rasella, Rosana Aquino, Carlos A T Santos, Rômulo Pears-Souza, Maurício L. Barreto

Summary

Background In the past 15 years, Brazil has undergone notable social and public health changes, including a large reduction in child mortality. The Bolsa Família Programme (BFP) is a widespread conditional cash transfer programme, launched in 2003, which transfers cash to poor households (maximum income US$70 per person a month) when they comply with conditions related to health and education. Transfers range from $18 to $175 per month, depending on the income and composition of the family. We aimed to assess the effect of the BFP on deaths of children younger than 5 years (under-5), overall and resulting from specific causes associated with poverty: malnutrition, diarrhoea, and lower respiratory infections.

Methods The study had a mixed ecological design. It covered the period from 2004–09 and included 2853 (of 5565) municipalities with death and livebirth statistics of adequate quality. We used government sources to calculate all-cause under-5 mortality rates and under-5 mortality rates for selected causes. BFP coverage was classified as low (0·0–17·1%), intermediate (17·2–32·0%), high (>32·0%), or consolidated (>32·0% and target population coverage ≥100% for at least 4 years). We did multivariable regression analyses of panel data with fixed-effects negative binomial models, adjusted for relevant social and economic covariates, and for the effect of the largest primary health-care scheme in the country (Family Health Programme).

Findings Under-5 mortality rate, overall and resulting from poverty-related causes, decreased as BFP coverage increased. The rate ratios (RR) for the effect of the BFP on overall under-5 mortality rate were 0·94 (95% CI 0·92–0·96) for intermediate coverage, 0·88 (0·85–0·91) for high coverage, and 0·83 (0·79–0·88) for consolidated coverage. The effect of consolidated BFP coverage was highest on under-5 mortality resulting from malnutrition (RR 0·35; 95% CI 0·24–0·50) and diarrhoea (0·47; 0·37–0·61).

Interpretation A conditional cash transfer programme can greatly contribute to a decrease in childhood mortality overall, and in particular for deaths attributable to poverty-related causes such as malnutrition and diarrhoea, in a large middle-income country such as Brazil.

Funding National Institutes of Science and Technology Programme, Ministry of Science and Technology, and Council for Scientific and Technological Development Programme (CNPq), Brazil.
<table>
<thead>
<tr>
<th></th>
<th>BFP models</th>
<th></th>
<th>FHP models</th>
<th></th>
<th>FHP and BFP (adjusted)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Crude</td>
<td>Adjusted</td>
<td>Crude</td>
<td>Adjusted</td>
<td></td>
</tr>
<tr>
<td><strong>BFP population coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low (0.0–17.1%)</td>
<td>1.00</td>
<td>1.00</td>
<td>--</td>
<td>--</td>
<td>1.00</td>
</tr>
<tr>
<td>Intermediate (17.2–32.0%)</td>
<td>0.91 (0.90–0.93)</td>
<td>0.93 (0.91–0.95)</td>
<td>--</td>
<td>--</td>
<td>0.94 (0.92–0.96)</td>
</tr>
<tr>
<td>High (&gt;32.0%)</td>
<td>0.82 (0.80–0.85)</td>
<td>0.86 (0.83–0.89)</td>
<td>--</td>
<td>--</td>
<td>0.88 (0.85–0.91)</td>
</tr>
<tr>
<td>Consolidated (&gt;32.0% and TPC ≥100% for at least 4 years)</td>
<td>0.76 (0.72–0.80)</td>
<td>0.81 (0.76–0.85)</td>
<td>--</td>
<td>--</td>
<td>0.83 (0.79–0.88)</td>
</tr>
<tr>
<td><strong>FHP municipality population coverage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No FHP (0.0%)</td>
<td>--</td>
<td>--</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Incipient (&lt;30%)</td>
<td>--</td>
<td>--</td>
<td>0.97 (0.92–1.02)</td>
<td>0.98 (0.94–1.03)</td>
<td>0.99 (0.94–1.04)</td>
</tr>
<tr>
<td>Intermediate (&gt;30%)</td>
<td>--</td>
<td>--</td>
<td>0.89 (0.85–0.93)</td>
<td>0.91 (0.87–0.96)</td>
<td>0.93 (0.88–0.97)</td>
</tr>
<tr>
<td>Consolidated (&lt;70%) and implemented for at least 4 years</td>
<td>--</td>
<td>--</td>
<td>0.81 (0.77–0.86)</td>
<td>0.85 (0.80–0.90)</td>
<td>0.88 (0.83–0.93)</td>
</tr>
<tr>
<td><strong>Income per person (monthly, &gt;BR$380)</strong></td>
<td></td>
<td>--</td>
<td>0.94 (0.92–0.97)</td>
<td>0.93 (0.91–0.96)</td>
<td>0.95 (0.92–0.97)</td>
</tr>
<tr>
<td>Proportion of municipality population eligible for BFP* &gt;22.4%</td>
<td></td>
<td></td>
<td>1.07 (1.02–1.11)</td>
<td>1.10 (1.06–1.15)</td>
<td>1.07 (1.03–1.12)</td>
</tr>
<tr>
<td>Proportion of individuals living in households with inadequate sanitation* &gt;16.7%</td>
<td></td>
<td></td>
<td>1.10 (1.05–1.15)</td>
<td>1.11 (1.06–1.16)</td>
<td>1.10 (1.05–1.15)</td>
</tr>
<tr>
<td>Proportion of individuals older than 15 years who are illiterate† &gt;11.1%</td>
<td></td>
<td></td>
<td>1.04 (1.00–1.09)</td>
<td>1.05 (1.01–1.10)</td>
<td>1.04 (1.00–1.08)</td>
</tr>
<tr>
<td>Total fertility rate† &gt;2.32</td>
<td></td>
<td></td>
<td>1.08 (1.04–1.11)</td>
<td>1.08 (1.05–1.12)</td>
<td>1.07 (1.03–1.10)</td>
</tr>
<tr>
<td>Rate of admission to hospital (per 100 inhabitants)† &gt;4.27</td>
<td></td>
<td></td>
<td>1.02 (0.99–1.04)</td>
<td>1.02 (0.99–1.04)</td>
<td>1.01 (0.99–1.04)</td>
</tr>
<tr>
<td><strong>Number of observations</strong></td>
<td>17,118</td>
<td>17,118</td>
<td>17,118</td>
<td>17,118</td>
<td>17,118</td>
</tr>
<tr>
<td><strong>Number of municipalities</strong></td>
<td>2,853</td>
<td>2,853</td>
<td>2,853</td>
<td>2,853</td>
<td>2,853</td>
</tr>
</tbody>
</table>

Data are rate ratio (95% CI) unless otherwise specified. TPC = target population coverage. *Cutoff is median value. †Cutoff taken from Rasella and colleagues, 2010.
Successes

• Diseases preventable by vaccination
• Diarrhea
• Chagas’ Disease

Partial Successes

• HIV/AIDS
• Hepatitis A and B
• Leprosy
• Tuberculosis
• Schistosomiasis
• Malaria

Failures

• Dengue
• Visceral Leishmaniasis
Successes - why?

• Control of diseases such as diarrhea, cholera, Chagas’ disease, and those preventable by vaccination has been successful through efficient public policies and concerted efforts from different levels of government and civil society. For these diseases, policies dealt with key determinants (e.g., the quality of water and basic sanitation, vector control), provided access to preventive resources (such as vaccines), and successfully integrated health policies with broader social policies.
Failures: why?

• Diseases for which control has failed (such as dengue fever and visceral leishmaniasis) are vector-borne diseases with changing epidemiological profiles and complex transmission patterns related to adverse environmental, social, or economic, and major difficulties in treatment and lack of vaccines.

• The control of disease vectors to be successful must be fully integrated into broad policies that incorporate the mobilization of society, health and environmental education, improvements in habitation and sewerage, and attempts to avoid further deforestation.
Key messages

• Since 1988, Brazil has developed a dynamic, complex health system (the Unified Health System; SUS), which is based on the principles of health as a citizen’s right and the state’s duty. The SUS aims to provide comprehensive, universal preventive and curative care through decentralised management and provision of health services, and promotes community participation at all administrative levels.

• The Brazilian Health Sector Reform occurred at the same time as democratization, and was spearheaded by health professionals and individuals in civil society movements and organisations.
Key messages

• Implementation of the SUS has been complicated by underfunding.

• Despite limitations, the SUS has managed to vastly improve access to primary and emergency care, reach universal coverage of vaccination and prenatal care, and invest heavily in the expansion of human resources and technology, including major efforts to produce the country’s most essential pharmaceutical needs.
• Important achievement has been the improvement observed in the health conditions of the Brazilian population, the result of the synergic effect of a comprehensive set of social policies and the increase in coverage and access to the health services.
Great challenges continue to exist...

- Reach special groups
- Financing the SUS
- External dependency of advanced health technologies
- Improve the quality of care
- The challenge of human resources
- The professional corporatism
- Judicialization of health
- Urbanization and Health
- To mitigate the effects of climate changes and other environmental hazards
- Health problems with high or growing incidence
Brazil’s health system woes worsen in economic crisis

Budget cuts and political instability are exacerbating existing problems in Brazil’s public health system amid increasing patient demand. Jonathan Watts reports from Rio de Janeiro.

Austerity threatens universal health coverage in Brazil

Michael Temer, Brazil’s new interim president from the centre-right Brazilian Democratic Movement Party (PMDB), has unveiled an agenda of austerity measures to stimulate economic growth. In the manifesto Uma Ponte Para Futuro (October, 2015), he announced plans to reduce public spending, including the education and health-care sector. The minimum budget guaranteed by the constitution (3.8% of gross domestic product at present) would be abolished. The new Health Minister, Ricardo Barros, has revealed plans to end the monitoring of private health-care quality by the National Supplementary Health Agency (Agência Nacional de Saúde Suplementar), while encouraging Brazilian citizens
To conclude

The most important lesson from the Brazilian experience is that the ultimate challenge in reforming a health system and the health conditions of a population is political. It requires significant and continued effort to build capacity but in front of that the continuous engagement of the society as a whole in securing the right to health for all.
Obrigado!
Thank you!
谢谢!
謝謝!

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