A Comparison of Healthcare between Brazil and the United States

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There is a common belief among many Americans in the United States that we have the best healthcare system in the world. However, in a recent study the United States fell to somewhere in the Mid-forties among the top fifty healthcare systems in the world, and the time has come to re-evaluate how our healthcare system stacks up against other types of healthcare. In addition to this, it is important to note that the United States is one of the only developed countries that does not have a national healthcare system of some sort. Examples of countries that institute these systems successfully are England, France, Norway and Switzerland. One good example of yet another country choosing to go the route of standardized healthcare would be Brazil, and it is an interesting comparison because Brazil, at this point in time, contains both a standardized healthcare system as well as the option for people to buy private health insurances.

In Brazil, the main form of healthcare coverage is the standardized system abbreviated SUS. This was established in the 1988 Constitution as a universal right and a responsibility of the state to ensure that right (E. Barbosa, personal communication, August 2007). There are five basic principles that SUS was founded on. First is universality, the belief that everyone is to be covered regardless of their ability to contribute financially to the healthcare system. The second is equity, an equal distribution of resources based on need. The third is an integral approach, priority for prevention as a critical point in their approach to healthcare. The fourth principle of the SUS system is decentralization, a sharing of management and responsibilities between the federal and municipal levels of government. The fifth and final principle is community participation, which allows people of the community to participate in the decision-making process.
within the SUS system. When it comes to SUS coverage, Elizabeth Barbosa stated that 90% of the population uses some sort of SUS services. 29% uses exclusively SUS services, 62% uses SUS services and private services combined, and 9% of the population uses no SUS services, solely private insurances. This is an interesting situation because for patients that utilize private insurance, there are some instances that arise where high complexity ailments such as cancer treatment are not covered under the private insurance they have and the patient then turns to the public system to manage their health. It seems like one of the drawbacks to the system is that patients who have private insurance can use the public health system to “fill in the cracks” of their private healthcare company.

On the topic of the number of healthcare professionals in the SUS system of Brazil, there are approximately 300,000 medical doctors, 200,000 dentists, 110,000 registered nurses, 487,000 licensed nurse auxiliaries, 196,000 Licensed Practical Nurses, and 195,000 community health workers. The community health workers are an integral part of the Family Health Program in Brazil, which was established in 1993. This is a program in which there are teams that are responsible for approximately 800 – 1000 families. Each team has to have at least a doctor, a nurse, a Licensed Practicing Nurse, and four to six community health agents. These professionals provide primary care services and referrals to other levels of care as needed. They also understand social processes in the territory they provide care within and are proactive in the community. They work together on clinical and public health issues including health promotion and
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prevention. When the community health agents are hired, a set of criteria must be met. They should live and work in the same area so that they can better know the main problems faced in their community. It is also important to be able to improve and facilitate the connection between primary care professionals and the community. They focus not only on illness but also on preventive care and act as the core members of the Brazilian primary healthcare strategy.

The healthcare system in the United States is set up in a much different way than that of Brazil. Our system is based on the private health insurance system, with those who cannot afford or are not eligible for private insurance being picked up by the government systems Medicare and Medicaid. Medicare treats people age 65 years and older, people with certain disabilities, and people experiencing end-stage renal disease. Currently, there are approximately 46 million Americans in the United States with no healthcare coverage, with this mainly consisting of the working poor and others who somehow “fall through the cracks” of the healthcare system. For these people, hospitals often set aside profits made from treating insured patients into a fund that they can retrieve money from in order to cover their losses when they treat patients that will not be able to pay their hospital bills. Another interesting aspect of our healthcare system is that there are many insurance companies that have changed the traditional format of healthcare from the physician charging what they feel is the appropriate amount of money for a particular procedure or hospital stay. Instead, with the idea of saving money and containing costs, insurance companies have now taken to a pattern of determining a fixed amount that they are willing to pay a hospital or physician for a particular procedure or surgery, and then it
is up to the professionals to take care of the patient in a timely and cost-effective manner in order to profit themselves.

In addition to this information, it is important to also realize that in the United States, healthcare is a substantial amount of the gross domestic product. “The US spends more of its GDP on healthcare than any other developed nation. In 2001, the US spent 13.9% of its GDP on healthcare, compared with 7.8% for Japan, 9.4% for Canada, and 7.6% for the United Kingdom,” (Uretska, 2005, p. 1). It is in relation to this that the United States often depends on not-for-profit health promotion organizations to meet many public health goals mainly because there is no place for the money to come from otherwise, with both ends of the spectrum (physicians and insurance companies) trying desperately to make a profit.

With a brief overview of how each healthcare system works, it is important to point out the advantages and disadvantages of each system. In the United States, a 2004 quality report highlighted that the system had many positive aspects. One example would be that, “Most women are screened for breast cancer (70% over age 40 within the past 2 years),” (Clancy, 2004, p. 11). In addition to this, the report conducted in 2004 by Dr. Clancy also found that almost 90% of in-center kidney dialysis patients receive quality dialysis and approximately 83% of women have prenatal care within the first trimester (p. 11).

In addition to these positive aspects, there are many areas that could use improvement. First, “The rate of children who are admitted to a hospital for asthma is 29.5 in every 10,000 which is more than double the rate for adults,” (Clancy, 2004, p.11).
Also, other needs for improvement cited by Clancy were that only 20% of patients prescribed medication for depression took it according to the directions and came back for their follow-up visits, only 25% of people with high blood pressure have it under control, and nearly a third of children and adults are not prescribed primary therapy medications to control their asthma (2004, p. 11). It is possible to see how all of these problems could possibly be alleviated by a change in the structure of the healthcare system. Since physicians are forced to see patients for less time each visit because they have to meet a quota for the day in order to make a profit, they have less time to stress to patients the importance of medication compliance like in the depression statistics. Also, an inability to conduct a full and thorough medical assessment of a patient’s asthma and cholesterol issues while making the proper decisions about medications that might be necessary for them is a crucial issue. Going along on that topic, if a proper assessment of the children that came to the doctor for asthma had been made, it may have been possible to avoid such a high child admittance rate to the hospital for asthma.

The Brazilian healthcare system also has its own positives and negatives. Along the positive aspects would obviously be that healthcare is free to anyone who needs care. Also, they have integrated a groundbreaking health promotion and prevention program by creating the community health groups to go into individual homes and help people be educated about their illnesses as well as their possible risk factors.

There is only a short list of places that need improvement when it comes to Brazilian healthcare. First, it seems that there is an inequality between SUS patients and private insurance patients. Although they receive the same care from the same doctors in
hospitals, SUS patients will find themselves in rooms with twice as many patients in them as privately insured patients. “Notwithstanding the health provisions of the 1988 Constitution, the SUS and the SSAM reproduce in a perverse way the mechanisms that create social exclusion and social inequalities,” (Eduardo, 2003, p. 46). The most difficult part of this is also that when those who purchase private insurance must have a complex procedure that the insurance they purchased does not cover, SUS is left to pick up the bill. Also, while in Brazil many of the professionals that worked within the SUS system explained that there was a desperate need for intervention in the many levels of government corruption that takes place before the SUS funds reach the public sectors. Finally, though it is advantageous to the public that one of the SUS fundamentals is public participation in policy decisions, it is not as collaborative as it may seem. “Thus far the councils have extended hegemonic power to representatives of government while representatives of society typically raise narrow demands that are of little general interest,” (Eduardo, 2003, p.47). The professional goes on to state that the councils simply always endorse the decisions made by the government, so though the council exists it does not actually place as much power in the hands of the people as it was created to do.

There are a few similarities between these two opposite healthcare systems. First, both systems have many preventative and promotion programs to try and educate the public about how lifestyle can affect their health in the future. For example, Brazil has the community health teams as well as many public clinics that patients can go to and receive education pertaining to birth control, sexually transmitted diseases and the signs
and symptoms of regional infectious diseases such as Dengue fever. In the United States, these programs are usually where the not-for-profit organizations intervene to provide flu clinics, educational programs, and facilities such as Planned Parenthood for family planning programs. Aside from this common point, each healthcare system has used cutting RN nursing staffing and hiring less qualified professionals to do their jobs as a way to save money. In Brazil, an RN explained to me that it is difficult to find a job in her area because hospitals hire one RN to act as supervisor for every fourteen nurse aids they hire to actually carry out the care for less money. In the United States, hospitals use the same method to cut costs in staffing. “Over the last decade there has been a decrease in enrollment in nursing schools coinciding with the fact that hospitals have been cutting costs by using less-trained people in patient care,” (Landreanau, 2003, p.19). This is an unfortunate situation for a couple of reasons. The Registered Nurse is the one who is educated on proper assessment and planning for a patient and limiting their patient contact makes it much more difficult for the RN to conduct a proper assessment and thus can result in the risk of the nurse missing crucial information about the patient. This can put the patient at risk as well as the hospital in a legal and moral sense. Aside from this, the decreases in U.S. nursing school enrollment does not correlate with the current nursing shortage crisis, but it makes sense that there would be less motivation since the news is always discussing hospital “rightsizing” and mergers that equal nursing jobs being eliminated in the interest of cutting costs.

Aside from a few similarities, there are a lot of differences between these two systems and also a lot of controversy about whether the nationalized healthcare is best for
a nation or if public and private insurances are more effective. As far as the public and private healthcare systems, there are many critics of the system, chiefly because it leaves many people uninsured with no good explanation of how to fix this problem. In addition to this, even the insured feel the strain of healthcare costs in the private sector. In an article written by Andy Stern in March 2007, he cites that,

“By 2008, according to McKinsey and Company, the average Fortune 500 Company will spend as much on healthcare as it will make in profit. In the past five years alone, the percentage of businesses offering health benefits has plummeted to 60 percent from 69 percent. That’s not surprising when you consider that by 2010, family healthcare coverage will cost companies $17,552 per worker per year,” (p. 73).

This situation, Stern theorizes, is a problem because unlike the nationalized healthcare system, “We are in this dilemma because our healthcare system is not structured on access but on cost,” (2007, p. 74). This can cause problems that are being experienced by the United States especially.

Ultimately, a decision must be made by each nation about whether to institute a national health system or allow it to be an economic entity in the private sector. The United States currently has reached a crossroad on this subject. Personally, upon continual contact and education about nationalized healthcare while in Brazil, it is my opinion that a national healthcare system would benefit the United States more than our current system is as of now. I am not alone in this feeling, as there are many healthcare professionals and economists that feel that the sooner we end healthcare as a money-making endeavor the better. “It starts with a universal system that provides affordable coverage, choice of physicians and insurance plans, core benefits and shared financing
among employers, employees and government,” (Stern, 2007, p. 74). Although most of
the professional articles that I have read agree with this, they realize that this will not
come without issues. Political conflict is to be expected, considering, “how difficult it is
to get the political leadership to agree on much of anything, let alone having the different
parties of political leaders faced with the need for reconstructing a sector of the economy
that is approaching 15% of the gross domestic product,” (Landreanau, 2003, p.18).
Another important point is that many Americans may have an issue with this change in
healthcare, especially those that take care of their body and health. “The question of
whether a person with the healthy lifestyle should pay increased taxes to support the
person with the unhealthy lifestyle is a real issue in today’s financing of health care,”
(Landreanau, 2003, p. 20). In discussing such a controversial issue it is difficult to
foresee the future decisions that will be made in the United States and how our healthcare
system will change over time.

In conclusion, Brazil is a crucial example of a developing country that has
managed to implement a healthcare system which, despite some flaws, takes excellent
care of the people within it. It seems that the United States would have converted years
ago, but with big business having such a huge percentage of its earnings in our healthcare
system the way that it is currently, it is no wonder there has been so much resistance to
change thus far. But, in the end, we must all remember that, “Cost issues should not cost
lives if other means are available,” (Landreanau, 2003, p. 20). This is the bottom line that
all Americans should consider. This is the quality of life that we all value so much that
we are discussing, and only we have to power to tell the government what change needs
to take place. It is extremely difficult to force politicians to take a definitive stance on any issue that faces our country, especially not one that is such a financial powerhouse that also supports many political agendas all on its own. However, it is my opinion that it is only a matter of time before our country falls into step with all of the others who have already discovered the immense benefits that a standard healthcare system will supply to their citizens and their quality of life.
References


