

# The case of Brazil<sup>1</sup>

Simonetta Zarrilli<sup>2</sup>

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## **BRAZIL'S UNIVERSAL HEALTH SYSTEM**

According to the 1988 Constitution of Brazil, health care is an obligation for the State and a right for the citizens (Article 196). Since 1988 the health care system has been universalized and covers the entire Brazilian population in both urban and rural areas, as the *Sistema Único de Saúde* (SUS). The federal government bears more than 70% of the global costs of the public health system; the states account for around 15%, while the municipalities bear about 12%. Since the 1980s, however, there has been a trend toward increasing the municipalities' contributions and decreasing federal contributions. The main sources of revenue to finance the system are social security contributions (*Orçamento da Seguridade Social*) and

tax revenues. The latter are playing an increasingly crucial role, while social contributions are being devoted more to the support of pension funds than to the health system.

In 1996, public health expenditures (including contributions at federal, state and municipality level) per capita in Brazil were approximately US\$ 120, while global health expenditures (public sector plus private initiatives) were around US\$ 300 per capita, corresponding to 3.5 per cent of the GDP. In 1995 the budget of the Ministry of Health amounted to \$15 billion (R\$ 15.8 billion) which fell to US\$ 13.6 billion (R\$ 14.1 billion) in 1996 and rose to US\$ 18.7 billion (R\$ 20.2 billion) in 1997. Brazil is among the countries in Latin America with lowest investment rates in the health

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<sup>2</sup> Legal Officer, Division on International Trade in Goods, Services, and Commodities, United Nations Conference on Trade and Development, Geneva, Switzerland.

sector. In 1996, Argentina's global expenditure in the health sector reached US\$ 600 per capita, corresponding to approximately 6 % of the GDP.<sup>3</sup> However, considering that public health expenditure per capita in Brazil was as low as US\$ 88 in 1993, considerable—though not sufficient—improvement has taken place.

In order to increase the amount of resources available to the public health system, a tax applying to all bank transactions, *contribuição provisória sobre movimentação financeira* (CPMF), was established in January 1997. The tax, which corresponds to 0.20% of all bank transactions, was supposed to remain in force for 13 months only. However, its application was extended until the end of 1998. In 1997 the CPMF raised revenues of around US\$ 6.4 billion (R\$ 6.9 billion), which amounted to 6.1% of total tax revenues and represented 30% of the federal health budget.<sup>4</sup> The tax is not expected to solve the problem of lack of sufficient resources in the public health system, but only to provide temporary relief. Doubts have been expressed, however, regarding the actual destination of the revenues collected through the CPMF: some have speculated that revenues were also used for financing activities outside the health sector, while others have claimed that CPMF revenues were used to replace other federal contributions instead of being added to them.

The public health system is at present managed by three different authorities: 1) the federal government, which is in charge of policy development and planning at the federal level,

scientific and technological development, rule setting and coordination, and cooperation with the states and the municipalities; 2) the states, which are responsible for policy development and planning at state level, technical and financial cooperation with the municipalities and coordination of their activities, and health education; and 3) the municipalities, which are in charge of policy development and planning, implementation of health activities, evaluation and control of health services, and health education, at the local level. Municipalities are expected, however, to assume a more significant role in the actual management of health services, for a consequent streamlining of operations and greater savings. On 1 January 1998, the new plan *Piso da atenção básica à saúde* (PAIB) was put into action. Under it, municipalities would receive from the federal government US\$ 8.3 (R\$ 10) per inhabitant to provide basic health services such as vaccinations and ambulatory consultations (the former system was based on ex-post reimbursement). This will allow municipalities to plan their health services better, to enhance controls and, it is hoped, to reduce fraud.<sup>5</sup>

In general, the Brazilian public health system is regarded as inadequate to fulfill the role it has been assigned by the Constitution, mainly because of lack of adequate financing. Several factors have contributed to make the resources available insufficient, namely the emergence of new diseases—such as AIDS,—which need long and expensive treatments;

<sup>3</sup> Per capita health expenditure was 7,6% in 1996, according to the *Folha de São Paulo*, 6 January 1997.

<sup>4</sup> Source: Federal Revenue Secretariat.

<sup>5</sup> Implementation of Basic Health Care Plan. *Gazeta Mercantil*, 13 January 1998.

the re-emergence of diseases—such as cholera, —which were supposed to have been eradicated; the persistence of other diseases—such as malaria, yellow fever and tuberculosis; —longer life expectancy; the aging of the population (in 1970 only 5% of the population were over 60 years old; at present, 11% are over 60);<sup>6</sup> the so-called “globalization of illness” due to domestic and international migration; the extensive and cumulative use of technology; and the need to face serious sanitation problems. The fact that the system has become universal, while undoubtedly representing a positive step toward the achievement of the goals of the 1988 Constitution, has placed an additional burden on the public health budget, thus contributing to the deterioration of the system.

Along with insufficient financing, however, the lack of good management and appropriate controls constitutes a problem which is increasingly mentioned as one of the main reasons for the collapse of the public health system. An audit carried out in 1997 by the Ministry of Health showed that at least an amount equal to US\$ 557 million (R\$ 600 million) belonging to the federal health budget goes missing every year. Most states seem unable to supervise the activities carried out by public hospitals and outpatient clinics or to ensure compliance with the rules laid down at federal level to prevent abuses.<sup>7</sup>

## PRIVATE HEALTH CARE

Parallel to the deterioration of the public health system, a private health system has emerged, which at present

covers around 41 million people or 25.6% of the Brazilian population. The private health system raises about US\$ 13.3 billion per year (R\$ 16 billion), which corresponds to 1.6% per cent of the GDP. The private sector has expanded rapidly; the number of people who have joined a private health scheme/insurance increased by approximately 38% between 1987 and 1995. According to some estimates, by the year 2000, 57 million people were expected to be members of a private health scheme/insurance. The disparity between the public and private sectors is striking: the private sector—which has to serve only one quarter of the population—counts on around 4,300 hospitals, more than 370,000 beds, and 120,000 physicians. On the other hand, the public service—which has to provide full health care for the remaining three quarters of the population as well as for those who benefit from private health plans/insurances for treatments which are not covered by the private schemes—has fewer than 7,000 hospitals, around 565,000 beds, and 70,000 physicians.<sup>8</sup>

The private health system includes several types of arrangement: health maintenance organizations (HMOs) where the patients have access to a certain number of hospitals, clinics, and physicians that are members of the HMO (*medicina de grupo*); health cooperatives such as UNIMED; self-management systems (*autogestão*), which provide health care to the employees of large firms; and administrations (*administração*), which are health systems directly managed by large firms and health insurance. Insurances are enjoying a particularly rapid growth.<sup>9</sup>

<sup>6</sup> Source: Instituto Brasileiro de Economia da Fundação Getulio Vargas, October 1997.

<sup>7</sup> “Governo muda saúde em ano de campanha eleitoral.” *Jornal do Brasil*, 28 December 1997.

<sup>8</sup> “Setor tem 50 mil médicos a mais que o SUS.” *Gazeta Mercantil*, 22 September 1997.

<sup>9</sup> *Gazeta Mercantil*, 22 September 1997.

In June 1998 the parliament approved Law No. 9.656 on private health and insurance plans. This law foresees the creation of a supplemental health council to address matters related to health services rendered by private health and insurance administrators. Critical issues, such as minimum plans and programs coverage, minimum operating capital and minimum quality requirements for services rendered, are subject to regulation. The main purpose of the law is to establish clear rules by which private health plans and programs should operate. The expected result would be a fairer and more competitive market.

#### **RELATIONSHIP BETWEEN THE PRIVATE AND PUBLIC HEALTH SYSTEMS**

The relationship between the public and private health systems is rather conflictive. In particular, the private sector tends to believe that the public sector is incapable of fulfilling its obligation to provide the whole population with health care. Therefore, it would prefer to see it concentrate its efforts on the basic health needs of the country, such as vaccinations, prevention campaigns, actions against epidemic diseases, sanitation, and providing health care only to that section of the population that is unable to join any private health plan. In other words, the private sector would like to see the public health system reduce its role as direct supplier of health services, while increasing that of regulator and overseer. In particular, most feel that there is a need in the market for clearer regulations to ensure fair competition.

On the other hand, the public health system is very attached to the role it was given by the 1988 Constitution. Therefore, it is reluctant to accept privatization of the health system and commercial exploitation of health care. From its point of view, the privatization of health care would lead to further exclusion of the rural areas and would be of no benefit to the majority of the Brazilian population who have to rely on the public health system.

#### **TEMPORARY MOVEMENT OF CONSUMERS**

##### **Care of foreign patients**

Despite the high quality of health treatment that a number of Brazilian hospitals can provide, the very good image that some of them have (some Brazilian hospitals have already been awarded the International Standards Organization 9002 certificate on quality management), and the luxurious accommodations they can offer, the presence of foreign patients in Brazil is sporadic.

Usually, foreign patients are either visitors who are in Brazil for working purposes or tourism and happen to need health care, or foreigners who live in Brazil. The case of foreigners who go to Brazil looking for health care is rare. In most cases, these patients come from other South American countries and are relatives or friends of physicians who have studied in Brazil and are still in touch with their former professors and colleagues. In other cases, foreign patients are sent to Brazil to receive health treatments not available in their home countries.

In these cases, the patient's health insurance usually pays for the treatment. However, when the foreign insurance refuses to pay and the patient cannot afford the cost of the treatment, the SUS bears the cost.

The general lack of interest shown by potential foreign patients in the health care provided by Brazil can be attributed to the fact that those hospitals that would appeal to them are usually very expensive private institutions. In São Paulo, for instance, the best hospitals charge fees that are sometimes higher than those charged by well-known hospitals in the United States. Some health insurances are even offering Brazilian patients the option of receiving health care in the United States since, in certain cases, the costs of transportation and treatment in the United States are lower than getting the same treatment in São Paulo. Amil, an HMO, has included in its network of health institutions a number of hospitals in the United States. It is also offering, through the Amil International Health Corporation based in Miami, Florida, assistance to Brazilian clients who choose to be treated in the United States (e.g., translation, interpretation, and transportation from the airport to the hospital).<sup>10</sup> *Transmédico*, another company based in Florida, was set up in 1993 to help Brazilians who wish to obtain medical treatment in the United States.<sup>11</sup> Several large hospitals in the United States are also targeting the Brazilian market by recruiting doctors and administrators that speak Portuguese, sending brochures to

Brazil, and offering preliminary consultations by fax.<sup>12</sup>

The main reason for the situation described is the lack of sufficient health infrastructure in the country. Even though the number of those who can afford to pay for health treatments in a private structure is limited, it nevertheless exceeds the facilities available. Consequently, the best Brazilian hospitals can charge fees equivalent to or higher than those charged in most developed countries, knowing that they will still have enough patients (in the best Brazilian hospitals the occupancy rate is around 85%). Because of the high occupancy rate, in general private hospitals have not developed any strategies aimed at attracting foreign patients.

As far as the public system is concerned, the shortage of facilities for the local population has made it impossible to think of developing such strategies to attract foreign patients, even though some of the public hospitals are in a position to provide highly advanced health treatments. There are, however, some exceptions. In Rio de Janeiro, for instance, a famous plastic surgeon attracts a substantial number of foreign patients (40% of his patients are foreigners), and has greatly contributed to the establishment of the good reputation of Brazilian plastic surgeons in general.

### **Foreign students in the health professions**

Some of the most prestigious Brazilian hospitals—usually those linked with

<sup>10</sup> "Mercado global da saúde, uma realidade lá fora." *O Globo*, 13 July 1997.

<sup>11</sup> The company helps Brazilian patients to find the right doctors and hospitals, and takes care of bureaucratic formalities. It is reported that, on average, *Transmédico* takes care of 1,000 Brazilian patients per year.

<sup>12</sup> "Tratamento mais barato é a nova atração do exterior." *O Globo*, 13 July 1997.

the best universities—receive a number of foreign doctors, especially from other South American countries, who are usually interested in postgraduate courses. However, Brazil has never tried to make it a profitable activity; foreign physicians are charged the same tuition as local doctors attending the same specialization courses. Doctors from Portuguese-speaking African countries usually benefit from scholarships in the framework of technical cooperation agreements.

### **TEMPORARY MOVEMENT OF BRAZILIAN HEALTH PERSONNEL**

Even though a number of Brazilian doctors go abroad for postgraduate qualifications (especially to the United States and some European countries), they usually return to Brazil after finishing their studies. A foreign diploma or a period of training abroad may facilitate their career and provide them with access to better working opportunities.

A specific case is the migration of Brazilian dentists to Portugal during the 1980s. This was, however, linked to a series of particular circumstances: namely, the economic crisis that Brazil faced in the 1980s; the fact that at that time immigration laws in Portugal were quite favorable to Brazilian citizens; the shortage of dentists in the Portuguese market; the special nature of the dentistry profession in Brazil, —where, unlike in Portugal, a dentist does not need to be a doctor, since the two professions are quite separate—, and cultural affinities.

Brazil faces a shortage of nurses, especially highly-qualified ones, therefore the phenomenon of nurses moving abroad has not occurred. On

the other hand, Brazil is not attracting foreign nurses, since the working conditions and salaries are not competitive.

Foreign physicians have difficulties in establishing themselves in Brazil, since the procedures for assessing the equivalency of diplomas are rather complicated. Additional conditions may be requested by the professional associations, since foreign health professionals have to pass very strict qualification tests. Like several other large countries, Brazil faces the problem of a shortage of health professionals in rural and remote areas, but it does not appear that foreign professionals will overcome that shortage.

In the framework of MERCOSUR, a Committee has been established to deal with the health sector. One of the issues the Committee is supposed to address is the free circulation of physicians, but this seems to be a particularly difficult subject, especially since the professional associations also have their own position which does not always coincide with the government's position. As a result, it seems that the Committee is giving priority to other questions where there is a better chance of reaching an agreement. In December 1997, the four Member countries of the group signed a framework agreement, which envisages the liberalization of trade in services within the bloc, to be negotiated in successive rounds of offers (including exceptions). However, at present it is not known how health services will be handled within this context.

The same Committee is also discussing the issue of reimbursement of the cost of health treatments for citizens of a MERCOSUR Member

country receiving health care in another MERCOSUR country. According to the proposal under discussion, an agreement should be set up among the public health systems of the four countries allowing citizens of one country to receive health care in another country in the same conditions as at home. At the end of each year, the national health systems of the four countries would calculate the costs they have borne for providing health care to foreign citizens and, if necessary, ask for compensation. The main obstacle to the implementation of this proposal is the lack of similarity among the four national health systems. On the other hand, it seems that in the framework of private health plans, in particular medical cooperatives, some initiatives are being taken to allow patients enrolled in a medical cooperative in one country to be treated in another country by "sister" medical cooperatives.

### FOREIGN COMMERCIAL PRESENCE

Under the 1988 Constitution, foreign firms and foreign capital were not allowed in the health sector, unless there was a "Brazilian Government interest" or, in specific cases, as regulated by law (Article 199,3 of the Constitution and Article 52 of the Transitional Provisions).

This situation changed in May 1996, when the Minister of Finance asked the President of the Republic to open the Brazilian market to foreign capital and companies in the field of health insurance. The main justification for this request was the government's commitment to give consumers further protection by improving the quality of services,

lowering their prices, and establishing a fair level of competition in the market.

As already mentioned, the private health system in Brazil has evolved in a rather peculiar way. While the number of people interested in participating in the private system has increased at a very fast rate, the supply of health insurance and other kinds of private health plans have not been expanding at the same speed, thereby generating lack of competition, high prices, and rather inefficient management.

In May 1996, the President of the Republic authorized the opening of the market to foreign firms and capital in the field of health insurance, while the Brazilian market remained closed to foreign participation as far as private health plans are concerned. This means that, at the moment, only about 11% of the private health market is open to foreign competition. The market in hospitals and clinics is also closed to foreign participation.

Since the health insurance market opened, around twenty transnational companies have established themselves in Brazil, either through joint ventures or acquisitions.<sup>13</sup> North American insurance companies seem to be the most successful in penetrating the Brazilian market, probably because of their expertise in the sector. European insurance companies with less experience in the health sector are, nevertheless, showing interest in the Brazilian market, especially because if they start activities in the health sector they are also allowed to operate in the areas of life insurance and pension funds.

It seems that the presence of foreign insurance companies has

<sup>13</sup> "Golden Cross recebe US\$ 200 mi." *Gazeta Mercantil*, 17 December 1997.

already produced some improvement in the Brazilian market; namely, companies are now offering insurance packages that provide better coverage and they are also beginning to save on administrative costs. However, prices are not going down as expected. The main reason seems to be that foreign insurance companies are still not allowed to invest in hospitals, clinics, etc., and they have to operate in a market characterized by a shortage of health infrastructure and very limited competition.

### **CROSS-BORDER TRADE**

The best public and private hospitals have established links with each other and with hospitals, laboratories and universities abroad. The availability of technological communication tools is of great importance in a vast country like Brazil, where there are still difficult to access areas, with very scanty health infrastructure. However, at the moment only the best and largest hospitals are able to benefit from improved communication facilities. Hence, trade through this mode of supply has not really evolved in Brazil.

### **TRADE IN GOODS**

Private hospitals and the best of the public hospitals are well equipped from a technological point of view. Patients who have access to the private health infrastructure usually expect to find the latest medical equipment available, therefore private hospitals generally make large investments in this area (for instance, in 1995 a big hospital in São Paulo invested US\$ 25 million in technology). This is to provide high quality treatment for patients, but also to meet their expectations and maintain a certain image. Public

hospitals, especially those linked with universities, are usually well equipped from a technological point of view, since they need updated technology not only for treatment but also for research. The use of technology in public and private hospitals in Brazil is expanding and following the same trend as in developed countries, with a significant impact on the cost of treatments. In Brazil, as well as in other cases, some doubts can be raised regarding the real need for such extensive use of highly sophisticated health technology.

Some of the medical equipment is produced in Brazil, but most of it is imported from the United States, Europe, and Japan. In the past, interest was shown in Chinese and Cuban medical equipment, but the main obstacle to switching to this technology, which would be less expensive, is the lack of after-sales services. Public hospitals and private philanthropic hospitals are allowed to import equipment free of duty. Nevertheless, they must go through some administrative procedures. In particular, they have to demonstrate that equivalent equipment is not produced in Brazil (*exame de similaridade*). If it is, the hospital has to choose whether to buy the domestic product or to import the foreign one, but in the latter case, it has to pay import duty.

National firms produce basic medicines, usually not covered by patents and mainly used in the public sector, while transnational corporations produce patented medicines. However, medicines produced domestically (by both national and transnational firms) do not satisfy internal demand and therefore Brazil imports medicines from large pharmaceutical companies in Europe and the United States. The

Ministry of Health keeps a list of “approved medicines” and only those medicines that are registered can be imported. In order to keep prices under control, some public hospitals are producing some of the medicines they need. Usually they import the raw materials and manufacture the final products in Brazil.

Brazil has developed great expertise in the production of vaccines. However, most of these are for domestic use and utilize foreign technology. Vaccines are exported to the Portuguese-speaking countries in Africa and to some Latin American countries (for example, Bolivia and Nicaragua) in the framework of technical cooperation programs. However, Brazil is starting to consider the option of using its expertise and facilities (a Foundation in Rio de Janeiro is building the biggest plant in Latin America for the production of vaccines) to produce vaccines for commercial purposes, in particular for the MERCOSUR market.

## CONCLUSIONS

Brazil is facing several problems in the area of health care. The public health system does not have sufficient resources to meet the needs of the population; therefore, it is offering a service which in most cases is not adequate from either a quantitative or a qualitative point of view. The deterioration of the public system and the improvement of the economic conditions of a (limited) number of the population have led to the development of a parallel private health system. Coexistence of the two systems is not easy. However, it is clear that there is no alternative to it, since those who can afford to join a private health

scheme/insurance will continue to do so, because they do not trust the public health system. On the other hand, a large proportion of the Brazilian population does not have the means to participate in any private health initiative and has to rely on the services offered by the SUS. Moreover, a number of areas such as prevention campaigns, sanitation, and vaccinations—which are very relevant for the country—clearly fall under the responsibility of the public health system. In 1996, the government decided to start opening the Brazilian health market to foreign investments in order to cut costs and improve quality; for the time being, however, the opening is limited to health insurances. Discussions are proceeding on the possible opening of the market also in the segment of private health schemes.

The challenge is, therefore, how the public and private sectors can coexist, benefiting from each other’s presence, bearing in mind that, whereas for the public sector the ultimate goal is to protect citizens’ health by ensuring equitable access to health services and appropriate quality, for the private sector, the final goal is profit.

The lack of a sufficient number of hospitals in the country has led to a situation where in the public sector patients frequently have to remain on long waiting lists before receiving the treatment they need, with all the risks that this implies. Patients in the private sector, on the other hand, have to pay extremely high fees to obtain access to the private infrastructure, while the real beneficiaries of the situation seem to be the private hospitals and private health plans which operate in a situation of virtually no competition (partly owing to the fact that the

Brazilian market is still closed to foreign investment in these fields) or regulations.

The fact that all the best public and private hospitals have an average occupancy rate of around 85% plus the high fees they charge make Brazil completely unattractive to potential foreign patients. This happens despite the fact that Brazilian hospitals are among the best in South America and, in some cases, from a technological point of view, they are as advanced as the well-known hospitals in the United States and Europe.

There could be an interest in exploring the option of further opening of the Brazilian market to foreign firms and capital. The presence of foreign-owned hospitals might alleviate the problem of bed shortage, increase competition in the market, and result in a decrease in prices and an improvement in the quality of care. More affordable prices could make the private health structure both accessible to a number of people who cannot afford it at the moment—thus reducing the pressure on the public health system—and appealing to foreign patients who, for the time being, may find prices in most developed countries more attractive than in Brazil.

The public sector would also benefit from such a situation. Part of the population would shift toward the private structure, leaving more human and financial resources available for those who stayed with the public health system. Moreover, if public hospitals were under less pressure, they could sell some of their services for profit.

This is already occurring in some prestigious public hospitals, but on a small scale. Even though they are public and therefore, in principle, they cannot devote part of their facilities to

private patients, they do so. The fees they charge private patients serve to pay part of the costs that cannot be borne by the traditional financing of the public system. Thus, those public hospitals can guarantee high-quality treatment, attract prestigious doctors, and benefit from advanced technology, despite the very scant resources made available to them by the public health system. The challenge is to find the right balance between the number of facilities to be offered to the private sector in order to generate extra financial resources and the need to have a sufficient number of beds, doctors, equipment, etc., available to public sector patients. At the moment, this balance is very difficult to achieve, considering the pressure under which public hospitals operate. However, the situation could improve if there were more hospitals available in the country and fewer patients that relied on the public system. At this point, public hospitals could also start thinking about a strategy to attract foreign patients to Brazil.

Future opening of the market to foreigners in the field of health schemes (as opposed to health insurance) and the setting-up of clear rules in this sector might also be beneficial to the country. Foreign competition would most likely encourage private health schemes to become more efficient and offer competitive packages, while regulations would oblige them to include fairer conditions in their proposals in regard to coverage, premium increase, renewal of contracts, and contractual conditions for the elderly and the unemployed. In particular, broader coverage would have the effect of both encouraging customers to join private health schemes and allowing them to use the private infrastructure for

virtually all their health needs. Consequently, the public system would have more room for those patients who have access only to it.

However, the likelihood of further opening of the Brazilian health services market to foreign companies and capital being beneficial to the local population has more of a chance of materializing if this process is accompanied by the laying down of appropriate rules. Regulations might establish minimum criteria for the entry of foreign companies into the Brazilian market, indicate the minimal coverage that private plans and insurance should offer, and include some conditions for the presence of foreign firms in Brazil. In other words, if Brazil wishes to open its market further to foreign competition, it needs to provide an adequate framework. Large firms and transnational corporations operating in the areas of hospitals, insurance, and health plans may abuse market power and take advantage of the lack of rules. To ensure that the process of increasing

competition and fairness in the market is carried out in the most efficient way, the State may consider playing a less prominent role as provider of health services and source of financing, while expanding its regulatory role. The law approved by Parliament on June 1998, aims at solving this problem. This would be in line with the State reform undertaken since the mid-1990s, which envisages the withdrawal of the State from its role as provider of goods and services in many sectors (leaving that space for private suppliers) in favor of strengthening its role as regulator (although the State would keep a key role as services provider in the health sector, unlike the case for some utilities). Given the economic, social, and political complexity of such a process, however, the disengagement aspect of this reform has been privileged, while the process of setting up regulatory bodies and institutions has in many cases lagged behind. These features can also be observed in the field of health services.

