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HEALING PEOPLE, PART II

Brazil on $300 a Year

Jeb Blount

RIO de JANEIRO—My wife and I got used to Lourdes' annual departures. Our maid's happy chatter would transform into vague grumblings and complaints about *dores nos ossos*—the pain in her bones. She'd start in on her cachaça-drinking husband, the alcoholic, and her many humiliations at the hands of the mouthy, pregnant teenage girls who roam Caju, the drug gang-dominated Rio de Janeiro slum, or favela, where she lives. Lourdes would say she missed her elderly mother in Paraiba, a poor state in Brazil's northeast. She'd say it was time to retire. Then we'd pay her and chip in a few extra hundred reais for the four-day bus ride to Paraiba and she'd leave.

A few months would pass before Lourdes returned and, after a year, the cycle would repeat itself—the pain in her bones, the humiliation of Caju, the visit to her mother. Then, six years ago, Lourdes didn't come back. We had all but given up hope of ever hearing from her again when her husband Francisco called. "Please, can you help? Lourdes tried to burn down the house and then ran away."

Deep in rural Brazil, Lourdes had been put in a mental hospital. Conditions were appalling, and Francisco helped her escape. But back in Rio, she had another episode. Francisco took her to another mental hospital for observation, and she was committed and diagnosed with bipolar disorder. Since then, all of her treatment—including drugs and once-a-month counseling—have been free. Today, she is living at home and working for us a few days a week. We give Francisco odd jobs, too. On her meds, Lourdes is her charming old self.

All in all, Lourdes's story wound up a happy one, but her diagnosis might apply to the system that tried to help her: it's bipolar. While new hospitals open throughout the country, the failure to provide the staff or the budget to maintain them has facilities falling into neglect just weeks after ribbons are cut. Thousands of Brazilians who have government—but not private—health coverage wait years for surgery. Doctors ditch their low-paying government jobs to see private patients, and don't show up for work at public clinics or hospitals. First-class emergency rooms and trauma centers are attached to underfunded, under-staffed, dirty and disorganized hospitals. Universal drug programs for AIDS, hepatitis and tuberculosis exist alongside wasteful and destructive pharmacy subsidies. Through corrup-

tion and bad management, hundreds of millions of dollars in antibiotics and other important drugs are lost every year.

Hey Big Spenders

In 2009, Brazil's government spent $367 per person on health care, according to the United Nations Development Program. That's one-fourteenth as much as Luxembourg's government, the world's biggest per-capita spender. It's less than one-eighth the $3,074 spent by the U.S. government. Brazil's federal government spends 3.6 percent of the nation's gross domestic product on health care, according to Sérgio Piola, a researcher at Ipea, Brazil's Applied Economics Research Institute. That represents some $56 billion out of the $2.03 trillion GDP that Brazil, the world's eighth-largest economy, generated last year. According to Piola, Brazil must spend at least 6.5 percent of its GDP, or $132 billion a year, if it wants to fulfill its goal of a functioning universal health care system.

Even compared to the rest of Latin America, Brazil's government is well down the list of health spenders. Neighboring Argentina allocates more than twice as much —some $758 per capita annually—while Cuba spends $329 and Mexico $327. All three countries have better health care ratings and higher UN social-development rankings than Brazil. In the private sector, when private health care outlays are added, Brazil's spending leaps to 8.4 percent of gross domestic product—about $855 per person. In other words, this developing economy spends almost the same percentage of its national income on health care as the developed countries that form the OECD, where spending is about 9 percent of GDP.

What does Brazil get for its money? Free health care—in theory. The 1988 constitution stipulates that health care for all is a fundamental right, and for nearly two decades, Brazil has provided many essential drugs to all who need them at no charge. Brazil's power as a single national buyer helps cut costs during negotiations with drug companies. Programs to provide free or subsidized drugs to the poor through public health clinics—"people's pharmacies"—or as part of special programs in privately owned drugstores have been expanded by federal, state and local governments in recent years. Packaging laws and awareness campaigns promote access to low-cost generics, and the generic drug companies take out ads on prime-time TV. Corinthians, Brazil's second-most popular soccer club, is financed by a generic drug company. When Brazil is unable to get a good price for essential medicine, it overrides drug patents, buying or legalizing the purchase of copies from regulated generic drug producers around the world.

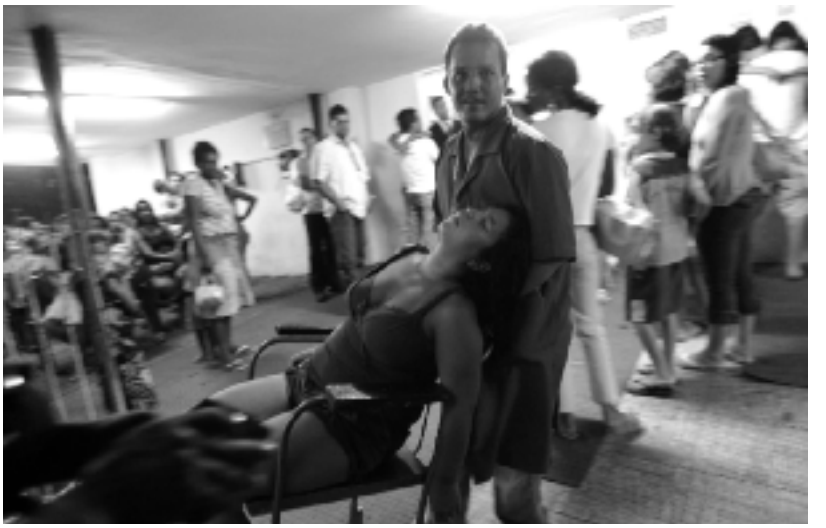
Public health programs such as free condom distribution, neo-natal counseling and triage in poor communities are reducing infant mortality and the spread of HIV. Vaccination for diseases such as measles and polio is mandatory and free. Public support for these programs is unanimous. "Nobody here thinks that it's wrong to have the government involved in health care," says Alexandre Barros, a top Brasilia-based political risk consultant.

The results have also been dramatic. Life expectancy at birth has jumped 10 percent, while infant mortality has fallen by 59 percent. Still, making health care a free and universal right has hardly created a system where everyone receives quality care. Despite its merits, too often the system is inefficient or simply broken.

Limits on the System

Lourdes didn't have to pay a penny for her month-and-a-half stay in Rio's public mental institutions, but the care was nothing to brag about. The hospital that first admitted her after her return from Paraiba is regarded as one of Brazil's best public mental facili-

ties, but it didn't have enough money to provide soap and toiletries. Francisco and I had to bring them each week along with extra food. The walls of the building were covered with graffiti. Inside, it was poorly lit and the plumbing was in disrepair. Private rooms shouldn't be a standard for care, but the public wards and group rooms were almost devoid of staff. Every time I visited Lourdes, drugged and desperate women, some in diapers, tried to grab my crotch or violently rub themselves against me.



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The waiting is the hardest part in Rio.

After checking her in for observation, no one would tell Francisco when or where Lourdes would be transferred for longer-term treatment. The doctors only addressed me—a foreigner with some means—while Francisco listened. Still, the doctors seemed to recognize the system's limits and were ready to try to work around them where they could. I was surprised that the doctors let me, as someone who is not a family member, participate in her care. They shared her personal information with me, answered my calls when I rang and provided me with information no American doctor would offer. When I asked if that was proper, the doctor was blunt. "Sir," he said, "her husband doesn't really understand her condition; you do. You can explain it to him; I don't have time. I have too many patients. Frankly, if you don't get involved, I don't know who will, and if you don't get involved, it's unlikely she'll be able to deal with this. What I'm doing is in the best interest of the patient." The system was too weak, he said, to worry about adhering to the letter of doctor-patient confidentiality. "She needs your help, and I've decided she can't get help without you."

Lourdes was saved by my family's connections—that doesn't say much for the country's commitment to universal care. We were able to pull a few strings and get Lourdes transferred nearby to a longer-term unit with good doctors. Lourdes was assigned a specialist to provide her with free, government-purchased medicine to manage her disorder; follow-ups adjusted and changed her drugs; and she gets occasional counseling when she goes to pick up her medicine. But Lourdes is one of the lucky ones.

Health care in Brazil claims to be universal, but good health care is not.

Building Consensus

In a country as large as Brazil—larger than the continental United States, a third of it blanketed by the Amazon jungle and river basin—the federal government has had difficulty providing care to all, or even figuring out where care is needed. Poor communities often lack basic health clinics that can provide access to immunizations, neo-natal care and preventative medicine. A national bureaucracy isn't as agile as local representa-

tives. When money was scarce, Brazil's health care failings weren't a major strain on the nation's budget or expectations. Now, these expectations have risen substantially, along with national wealth. No longer is $300 per person per year adequate. The political system is out of step with the nation's needs and desires.

Marcos is a doctor in northeastern Brazil. Two years ago, after working in public and private health clinics in a poor region outside Salvador, Brazil's third-largest city, he jumped at the chance to effect what he thought could be some real change. He accepted an appointment as secretary of health in a municipal government.

Marcos, who asked that his full name not be used, planned to purchase equipment for faster and more accurate diagnoses, saving money through preventive education. With the extra funds, he could create programs and facilities for some of the region's most serious problems, such as high blood pressure and diabetes. He was told he would be given a federal ATM card to pay for his approved programs. But once he received the card, he realized that the mayor was the only one with the access code, and he refused to pass it along to Marcos. Every request for funds involved discussions about who would receive contracts to supply goods and services for the programs. Requests for funds for the city's clinics were mostly rebuffed, and eventually Marcos turned the card over to the mayor. "In the end, I was not allowed to do anything," said Marcos. "I had responsibility, but no authority. It was the worst six months of my life. I quit."

The problem was not a lack of funds, Marcos explained. Money was being spent, but was being wasted or diverted. Decisions were made based almost entirely upon the division of spoils from the federal government and the repayment of political debts. The health program came second. "We were getting great supplies in large quantity, the best available," Marcos said. "But instead of using them wisely, or buying something cheaper that would do just as well, the doctors would waste valuable resources. They'd use twice as much suture thread as they needed or give out unnecessary medicine."

While Marcos's case isn't an isolated incident, it's not indicative of local health programs either. The problem is deeper than that, and its roots can be traced to irresponsible spending. For example, Brazil has large funds set up to build sewage and water systems. While most Brazilians now have clean water, few cities have sewage treatment. Waterborne diseases still account for nearly a quarter of all illness in Brazil. Years of reliance on antibiotics have reduced interest in what was once a key part of health care planning: building waste treatment systems, properly storing food and mobilizing agencies to fight diseases like malaria, leprosy, dengue fever, Chagas disease and cholera. While Brazil led the world in public health programs against AIDS, dengue fever returned, more than doubling to 585,000 cases in 2008 from 230,000 in 2000. Stopping dengue means wiping out mosquito breeding grounds in cities and addressing the lack of responsible water treatment head on. It means house-to-house visits.

Educating Patients

"Ignorance is probably our greatest problem," Marcos said. "Lots of people come to the clinic with the flu and feel cheated if they don't get some sort of medicine. They need to go home, drink fluids, take aspirin or Tylenol and sleep. But you need to put on a show or they don't take you seriously. Many of my patients don't have any idea about their bodies, about basic simple science. People want treatments, actions, facilities, when much cheaper things might do." But such ignorance does not end with the patients. For every serious cold or infection

in Brazil, doctors immediately prescribe antibiotics. About 20 percent of the money spent by the country's clinics and hospitals on retail drugs is wasted or destroyed by poor management regulation and supervision, according to Brazil's Federal Pharmacy Council. That's 1 billion reais ($570 million) that could go to better health care.

A block from my house sits the Hospital da Lagoa—a partly empty and decaying 10-story building. Designed by Oscar Niemeyer, one of the architects who designed the UN headquarters in New York, the building was a stunning modern structure when it opened in 1959. Once one of the best hospitals in Brazil, today it's a shadow of its former self. In 2000, Almir Munioz went to the Hospital da Lagoa, seeking medical care. A diabetic, his disease eventually progressed to the point where he needed to have his foot amputated. Wheeled from the operating room to the recovery area after surgery, he began hemorrhaging. He bled to death without anyone noticing. He lived across the street from the hospital with his wife and infant daughter. They were my neighbors.

Nearly 46 million Brazilians—almost a quarter of the population—have private health insurance. A case like Almir's is the reason. Even public servants and employees of state-owned companies get supplemental insurance, paid for by the government. The very people who administer Brazil's public systems don't trust the system themselves. This parallel system, too, is running into problems. In April, the special government secretariat that regulates the private system estimated that 11 percent of those paying for such insurance are receiving sub-standard benefits. My wife, my daughter and I pay about $600 a month for our private coverage— double the amount Brazil's federal government pays per person each year for its free public systems.

Bipolar Imbalances

The failures of the supposedly universal public system drive people into the private system, so taxpayers pay twice for their care:

> "Public hospitals do one thing very well—trauma care. If you are shot in Rio, pray you're taken to a public hospital."

once when they pay income and sales taxes and again when they buy insurance. This is the classic bipolar imbalance of the Brazilian system. While there are some limited income tax write-offs for private insurance or medical bills, this only reduces the potential revenue available for the public system. And because large parts of Brazil's poor and lower middle class are exempt from income tax, they can't write off their private health costs. While they don't pay income tax, even poor Brazilians are still paying twice. Nobody is exempt from sales tax.

Nearly a third of all those who live in Brazil's rich southeast, where Rio de Janeiro and São Paulo are located, have private plans. They're designed to make sure that if they ever have to go to Hospital da Lagoa, the public hospital where my friend Almir died, they will have supplementary care. This public hospital, less than two blocks from the homes of two of Brazil's top politicians, has enough money for armed security guards, supplied by a company that has won large contracts to protect a wide range of government facilities. Though only a block from my house, public and free, I've never set foot inside Hospital da Lagoa. Since I moved to the neighborhood in 1998, the

hospital has closed its emergency room. In the 12 years I've lived in my neighborhood, I've never seen or heard anyone stand up for the hospital or seek to have it improved, and I live in a place where everyone gets quite worked up about bus noise or late-night Samba parties.

Public hospitals in Brazil do one thing very well—trauma care. The government has also expanded paramedic ambulance services in major cities, which has allowed it to buy thousands of Brazilian-built ambulances from its auto industry, the country's largest sector, and emblazon them with the federal government's logos. If you are shot in Rio, which is one of the world's most violent cities—2,155 people were murdered here in 2009—pray you're taken to a public hospital. Hospitals can treat dozens of gunshot wounds a night. In addition to experienced cardio-thoracic surgeons, Brazil has developed specialties in orthopedic surgery, which stems the loss of limbs from bullets. If you end up in a public hospital and you haven't been shot, it is quite often another story.

Denis Wright had a car accident in Rio in April. Unconscious and suffering from burns, he was pulled from the wreck by firefighters and paramedics. As he came to, he was given a neck brace, carefully placed on a backboard and loaded into a modern ambulance filled with intensive care equipment. When he got to Miguel Couto Hospital, home to some of the world's finest trauma surgeons, it became a nightmare. He was transferred to a folding, wheeled stretcher for transport to the emergency facility. Within seconds the cart collapsed on itself and he tumbled onto another patient waiting on a mattress in a hallway packed with victims of car accidents, stabbings and other tragedies from a Saturday night in Rio. Orderlies re-extended the cart and put him back on it, only to have it collapse again. This time, he injured his head on the floor. Bruised from the fall, he was once more hoisted onto a new cart and sent on his way to the triage area, but the orderlies rounded a corner so quickly that the cart tipped over. By that time a friend had arrived. Despite his aching head and burns on his body, Wright got up, walked out and visited a doctor the next day.

Stopping Short of Universal

Brazil is succeeding in many areas, but it's a long way from providing the comprehensive, universal care its constitution promises. It may do well to scale back its goals and focus on what it does well—serving the poor first, until it has the money and skills to reach more ambitious ends. It needs to take a less comprehensive and more realistic view of what its constitutional health rights entail. Brazil can write all it wants into a constitution (and, indeed, the 1988 document includes a whole potpourri—from the right to "sports justice" courts for athletes to permanent federal railway police) but if it can't even manage or pay for universal health care, disappointment will be inevitable and long-lasting. ●