

# Public and Private Health Insurance in Brazil and European Union Countries

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**Abstract** The following article is a recent bibliographic review of supplementary healthcare policies in Brazil and EU. The main focus is analyzing healthcare policies for the private sector in Brazil, within the context of Brazil's Unified National Health System (SUS), with the profile of the private sector in European Union countries, which have long had public systems integrated with social security. Our work is based on research conducted in the second decade of the 21st century. It is our understanding that comparing positions and progress made by the private sector, the growth of private and copayment health insurance and consequently the shrinking of public healthcare systems allows us to better understand the reach and meaning of those changes. We will initially analyze healthcare policies of Europe's private sector. Then we will discuss the supplementary healthcare system in Brazil, which is the main goal of this paper. Finally, we will compare cases according to progress and delays in private and public healthcare systems.

**Keywords:** *public policy, public health, private health plans, Brazil and European Union countries*

## 1. Introduction

The following article is a recent bibliographic review of supplementary healthcare policies in Brazil and EU. The main focus is analyzing healthcare policies for the private sector in Brazil, within the context of Brazil's Unified National Health System (SUS) and the profile of the private sector in European Union countries, which have long had public systems integrated with social security. Our work is based on research conducted in the second decade of the 21st century.

It is our understanding that relative positions and progress made by the private sector, the growth of private and copayment health insurance and consequently the shrinking of public healthcare systems allows us to better understand the reach and meaning of those changes. In Brazil there has been a gradual loss in universal coverage integrated into three levels of care: primary, medium and high complexity, organized into a unified health system such as provided by the 1988 Constitution, post-authoritarian regime. In post-war Europe the expansion of social-democratic welfare states brought along the establishment of social rights, among them healthcare as a rightful benefit and the State's obligation to provide it.

However, recent alienation from the right to healthcare as a universal citizenship right has been developing in both contexts due to common and hegemonic economic policies which mean that social policies based on society's welfare are shrinking, as well as income distribution through the social security system. We believe that very similar processes do not necessarily entail equal results, as we will see below.

Changes that have been made to private systems in both contexts and the incidence on the public healthcare system, especially in Brazil, will be analyzed according to the following categories:

- Public institutions and private system
- Agreements and contracts with the private sector
- Attributions of private plans
- Production, installed capacity and public/private financing
- Regulation and reimbursement of the Unified National Health System by private health plans

We will initially analyze healthcare policies of Europe's private sector. Then we will discuss the supplementary healthcare system in Brazil, which is the main goal of this paper. Finally, we will observe this cases according to progress and delays in private and public healthcare systems.

## 2. European Countries

In member states of the European Union (EU), health coverage is public and universal as part of a broad social protection system. European social security systems resulted from the need to rebuild Europe after the economic and social catastrophe (economic destitution and the growth of workers' movements and left-wing political parties) following World War II. European social security was based on two fundamental principles: social citizenship, as the basis for social, public, and universal protection policies; and national economic development based on full employment and social security, as modalities for income distribution and training and occupation of labor.

In this political and economic structure, health policy is part of social security and is formulated on the same principles: it is public and provides universal coverage grounded in social citizenship. Although with the changes that began in the 1970s, especially in the United Kingdom with the Thatcher government, there was a certain cutback in benefits, the policy itself was not changed substantially.

For Thomson & Mossialos, 2009, “the dominance of statutory coverage means that markets for Private Health Insurance are heavily shaped by the rules and arrangements of the publicly-financed part of the health system” [1].

The following table, prepared by Mossialos E. & Thompson [2], shows the three modalities of relations between the public and private sectors according to the role of the private sector and extent of coverage:

**Table 1. Role of the Private Sector in Health Systems in European Union Countries**

ROLE	COVERAGE EXTENSION
Substitutive	Targeted towards persons that were excluded in 2006 from some or all of the benefits of public coverage, as in the case of high-income families in the Netherlands. Option to choose between public or private coverage, for high-income families in Germany.
Complementary	Services recently excluded from public coverage, such as dental or ophthalmologic services, or very expensive services that are partially covered by the state.
Supplementary	Freedom to choose providers and enjoy quick access to services.

According to Thompson & Mossialos [3] there are only two financing policy designs in relation to the modalities presented in the table prevalence:

- minimal financing and considerable regulation of the supplementary market, focused on the companies' solvency; and
- price and product control and severe regulation of the substitutive market.

In both modalities, the purpose is to both protect consumers from insurance companies' insolvency and use regulation to guarantee access to care.

Meanwhile, for complementary health care, governments make a free choice of the most appropriate ways to subsidize and regulate private services in each national context.

In other words, in reality there are different combinations of financing and provision of health services in the sphere of national states, a situation that becomes more complex due to the need to promote integration among European Union states.

There is a consensus among authors that changes occurred in European countries cause the regulatory framework introduced in 1992 by the European Commission to become problematic today. Such framework operated under the assumption that regulations would be able to protect healthcare users when their legal rights were threatened.

Several reasons have been cited [4]:

- there is no evidence to suggest that the expected benefits of competition will materialize. As always, such benefits are only a myth.
- private insurance premiums have increased in many countries, often exceeding inflation in the health sector as a whole.

- the increased separation between economic activity and social security tends to jeopardize the statutory rights sustained in a full employment economy.

- it becomes extremely difficult to preserve social security institutions from issues with public finances under such conditions.

Most of the countries run systems with universal coverage; however for asylum-seekers or illegal immigrants, healthcare coverage can be non-existent in practice. The erosion of coverage in the public healthcare system for ophthalmology and dental care has increased, and in the case of extended care, health services demand proof of the patients' means of subsistence. But, indeed “we did not find any stronger evidence for cutbacks and retrenchment introduced in health care provision”, Ingalill Montanari & Kenneth Nelson, 2011 [5].

Even so [6], private health care through various types of plans and insurance provides substitutive care that corresponds to less than 5% of total health expenditures. In some countries, private insurance also contributes with substitutive or complementary coverage vis-à-vis public coverage, and expenditures are somewhat higher, between 10% and 20% of total health expenditures.

According to data presented in a recent article [7], European healthcare systems depend on a combination of contribution mechanisms that fund healthcare which in most countries, according to the law, is public and universal (or nearly universal). Therefore most spending on healthcare in terms of proportion of the Gross Domestic Product (GDP) is also public. In 2008 total spending on healthcare reached 9.0% of the gross domestic product, while public sector spending corresponded to 76.6% of total spending on healthcare [8]. It should be noted here that the use of private health plans, OECD 2008, show that most subscribers come from high income groups [9].

The location of health services, which could be a significant barrier to access due to costs related to transportation time, still remains equitable. According to a study [10], on average 48% of the population in the 25 member states have access to a hospital in less than 20 minutes (and in less than 15 minutes for approximately 53% of the population in the 15 old member states and approximately 35% of the population in the 10 new states).

Among organizational barriers to access, the most significant one is the waiting list. Waiting lists were adopted in England, Ireland, Italy, Poland, and Germany. Only the United Kingdom and the Netherlands succeeded in reducing their lists, by increasing their financing, restructuring provision, and reformulating reimbursement.

Other barriers to access can become significant when private health insurance plans coexist with the public system and both provide coverage for the same services. France, Germany, and Ireland have non-equitable access. Even in the United Kingdom, where private insurance plays a minor role, the presence of private medicine has led to long waiting lists in the public sector.

Concerning access, a distinction must be made between the availability and the utilization of services. Availability is merely a potentiality, but not proof of access. The relationship between socioeconomic status and healthcare services utilization has been widely studied in the European context, showing minor inequity in the use of

general practitioners but major inequity (in favor of higher-income groups) in the use of specialists.

The presence of universal coverage for a wide range of healthcare services, either through the public systems or private insurance for part of the population, expresses the health systems' accommodation to the restrictions imposed on social security by globalized economies.

Still, social rights have already been incorporated into society through a complex array of benefits belonging to social security, such that European countries' approaches to regulation of private health insurance remain legally undefined [11]. There is no agreement as to how the European Court of Justice defines the law, namely the "common good". When and how the principle of the "common good", referring to the protection of health system users, should prevail, and how governments should intervene in private health insurance. Or again, the significance of complete and partial public and universal social security systems and the type of state intervention that can be considered socially appropriate and fair.

When distinguishing private health insurance as a partial alternative to the public system (defined in Article 54.1 of the Justice Commission of the European Union), the difficulty appears to lie in identifying under which situations private insurance plans play, (versus do not play) a substitutive role [12].

Thomson & Mossialos, consider that an important part of the analysts "argue that the performance of the statutory health system – notably the degree and distribution of patient satisfaction – is a key determinant for private health insurance. Often-cited aspects of performance that may influence demand for private health are reductions in the breadth and depth of statutory benefits as well as the timely availability of publicly financed health care [13].

### 3. Brazil

In the Brazilian experience, unlike that of European countries, the private healthcare sector historically preceded the formulation of the Unified National Health System. Historically, various arrangements for financing and provision of healthcare services were proposed to cover public and private health, laying the foundations for an extremely fragmented health system [14] Public and private sectors shared both public financing and ownership of the country's hospitals. To mention a few references illustrating the private sector's presence throughout Brazil's healthcare history [15] the 1936 [16] Medical and Healthcare Survey reported 1,044 healthcare establishments in the country (447 public and 597 private). In 1950, 53.9% of hospital beds in Brazil were private, but dominated primarily by mutual aid and charitable organizations, supplementing the government-owned systems. In 1960 62.1% of hospitals were private, of which 14.4% were for-profit.

The consolidation of a private entrepreneurial health system launched a dispute over segments of clientele and specializations, with an attempt by the private sector to guard its bases of public financing through a strong and increasingly organized presence in the decision-making arenas, and an increasingly significant market presence.

In fact, the private sector hiring, contracting-out, or outsourcing system was maintained, as a carryover from

the now-defunct INAMPS (National Institute of Social Security Medical Care), whose policy was to expand services and coverage and consolidate the private health sector, which thereby reaps the benefits of hiring direct provision of health services with financing from the public sector.

When the Unified National Health System (SUS) was created and INAMPS was extinguished [17] there were clear moves by the medical business sector to offer simplified plans to the state. Important examples include proposals by the Brazilian Federation of Hospitals (FBH), the National Federation of Healthcare Establishments (Fenaess), the Brazilian Association for Managed Care (Abramge), the National Managed Care Union (Sinange), and the National Confederation of Health Workers, all of which proposed to finance these plans with social security funds [18].

This trend characterized an important vacuum in proposals for public healthcare and a crisis in the funding base due to the drop in social security pay-in for health financing [19] The public system plunged into a state of deterioration, as expressed by serious problems with infrastructure, equipment, and installations and huge difficulties with access; meanwhile, the private sector grew unchecked and with blatant overlapping of healthcare services in relation to the National Health System.

Relations historically guided by public and private healthcare institutions constrain or limit a new institutionality for the public sector and healthcare services comprising the SUS at the Federal, State, and Municipal levels.

The problem's size is illustrated by the formulation of regulatory policies for the private health plan sector, defined by the 1988 Constitution as complementary to the Unified National Health System, in the context of a health system that Article 198 of the Constitution defines as public, unified (or "single"), universal, and decentralized. The problem becomes even worse if we consider that the country's installed private hospital capacity was not created as "complementary" to the public system, but essentially to respond to a "market niche" where the public sector was deficient. Private health plans have shown a systematic increase in the number of policyholders and now cover 20% of the Brazilian population [20].

According to recent data [21], when comparing March 2000 and March 2008 the number of medical assistance insurance contracts increased by 22.5%. Medical cooperatives expanded in both relative and absolute terms the number of beneficiaries (there was a variation of 43%). The number of beneficiaries belonging to group medical plans as well as plans provided by philanthropic organizations grew by 22.11% and 16.6%, respectively. According Bahia, 2012, while the increase in revenues tripled between 2001 and 2009, public expenditure increased less than twice [22].

The charitable (non-profit) healthcare sector has also grown considerably by extending its business, serving private health insurance clientele and incorporating its own insurance plans as a ramification/expansion of the hospital sector itself [23].

Thus, what are the jurisdictions of these three levels of the National Health System, and how does one formulate

policies that ensure governability with highly differentiated stakeholders and roles within an institutional setting that is able to exercise integrated management of the health system?

Although health policies in both Europe and Brazil originate from principles similar to those of social security in European countries, there is little proximity in their implementation in the two contexts, considering the different historical/institutional trajectories and political, social, and economic realities of European countries and Brazil, respectively.

Brazil implemented a late public and universal health system in an adverse international context in relation to the state's role in the provision of universal social benefits resulting from citizens' social rights and economic policies based on national development. The latter were replaced by economic globalization, neo-liberal tendencies towards market liberalization, and lack of state interference in the market, except for the necessary safeguards for optimizing the financing of the market itself.

When comparing both institutional contexts, encroachment by neo-liberalism demanded that European governments defend the safeguards for social health rights, while in Brazil the underlying principle that remained in social security was only dealing with the country's huge health inequalities.

Considering the differences between European and Brazilian experiences, one can identify similarities between the two, resulting from the political context of the 1990s, as long as one properly interprets these similarities as relative rather than absolute and/or resolves the consequences.

Healthcare spending in the country in terms of proportion of the Gross Domestic Product totals 8.3% [24], that is, it is very close to that of EU countries. With respect to healthcare spending items, we observe that the proportion of public spending, 48.3% in 2006, is smaller than private spending, which corresponds to 51.7%. That figure includes private plans and direct spending incurred by families [25].

As for health services allocation, in Brazil the decrease in hospital beds led to serious problems with access to hospital services, since there was no rationalization in the distribution of these services in remote, isolated regions, far from large cities. In some municipalities and states, inequalities in access persisted, especially for medium and high complexity procedures. Waiting lists, which are an important tool for universal coverage and help improve access, are rarely implemented; there are only waiting lists for high complexity procedures like transplants.

Barriers to access related to the coexistence of private plans that cover the same services as the National Health System, especially for outpatient care, pose a serious problem for both the SUS and users, who pay insurance for a service which is often covered by the public system itself. As Soares, Ugá & Porto, 2008, show there are inequalities in the supply and use of services in pro of the population with health insurance due to the peculiar insertion of supplementary sector, which provides supplemental coverage and doubled the public system [26]. This problem has been addressed by regulatory policies. The relationship between socioeconomic status and use of services in the Brazilian context shows relatively less

inequity in the use of general practitioners, given the priority assigned to the Family Health Program since the late 1990s, but there is major inequity in favor of higher-income segments of the population when it comes to access to specialists.

### 3.1. Public Institutions and Private Healthcare System

The political format of the Unified National Health System, as defined constitutionally, is subject to conflicts involving widely divergent interests in relation to the system's public and universal nature. There is no consensus concerning the system's policy guidelines or the motivation of the various political stakeholders, thus resulting in strong segmentation of the system, subject to the impacts of oscillations in the political and economic context and the legacy of past policy choices [27].

The segmentation of public and private healthcare services is present in health policies themselves. On the one hand, the public system uses primary care as its flagship (with family health targeting the poor population that uses the SUS) but is not involved in the quality of medium and high complexity hospital services contracted out to private hospitals. The latter are analyzed in the results of recent research on the control and regulation of private hospital care providers.

On the other hand, research measuring the satisfaction of private beneficiaries of health plans provided by charitable hospitals has detected the illegitimate use of the National Health System for referring patients holding cheaper plans of inferior quality. Additionally, this practice does not include any reimbursement of the National Health System by these private plans, so the public sector indirectly subsidizes private plans and encourages their segmentation.

Since primary care is the public system's main focus and entryway, it is taken for granted that access to other levels of care flows naturally within the SUS, even when, coincidentally, a hospital has beds hired out by the SUS and its own plan or beds hired out under a private plan, whereby each modality has its own accounts, limitations to access and usage, etc. Yet interests clash precisely in the area of mandatory legal provisions and the absence of control and evaluation, and whether the result is confrontation or accommodation, the public sphere becomes a gray area, permeated by private interests.

### 3.2. Agreements and Contracts with the Private Sector

A research [28] about private healthcare providers for managed care was based on the hypothesis that there was a micro-regulation written into the contracts between managed care companies and this hospital segment. The questionnaire, applied to the hospitals in the sample, included several questions on provision of services to the SUS. The analysis of the findings demonstrates the significant role of these hospitals in providing services to the SUS, as observed below.

- 72% of these private hospitals are contracted out by the SUS and thus belong to the system's network of services.

• There is a limited presence of healthcare management qualification structures and practices in these hospitals as a whole, and it is precisely these hospitals (which provide services to the SUS) that invest the least in quality of care.

According to the research report's conclusions:

"Provider hospitals that provide services to healthcare plans do not constitute parallel (or supplementary) health micro-systems in relation to the SUS; rather, there is a vast range of private hospital providers, mostly linked to the SUS, that do not feel that they belong to any network of private providers, but which are subject to heavy regulation in the use of their services, exercised by private health plans. These are merely commercial contracts with little or no incorporation of aspects pertaining to the quality of this outsourced care... during rare evaluation visits reported by the hospital, information like patient reception, waiting time, and patients' rights received little attention, and there were hardly any of the basic committees like those involving Medical Ethics, Case Reviews (in case of deaths), or Hospital Infection Control. Finally, little importance was ascribed to mandatory legal aspects such as the National Registry of Healthcare Establishments, Health Surveillance, or the Qualification System of the National Agency for Supplementary Healthcare [ANS]."

All of these essential issues for guaranteeing quality care for users of these plans express not only the negligence of health plans towards their clients, but also a much more sensitive problem, located at the heart of the Unified National Health System. It is a public health policy that not only refrains from regulating the private sector but also commits the public sector itself to guaranteeing the provision of quality healthcare by the state, as a universal citizen's right.

It should be noted that services provided by private hospitals to the SUS far exceed the care these same hospitals provide to private plans, as follows:

"... in the first semester of 2006, the mean proportion of services provided to the SUS was 74.5%..., while the mean proportion provided to private plans was 19.7% ...," [29]

The Unified National Health System should not neglect its obligations to regulate quality, evaluate and monitor the outsourced hospital services, and supervise their functioning in practice. While private plans appear to be interested merely in the production and utilization of low-cost services, the public sector should not adopt the same logic. On the contrary, recognition of the market's existence requires that the state set limits on private health sector activity, so as to not violate the constitutional principles of the Unified National Health System.

### 3.3. Attributions of Private Plans

In a study [30] measuring user satisfaction with private health plans provided by charitable hospitals did not include specific questions on the SUS, but the issue emerged spontaneously and repeatedly, allowing researchers to infer several aspects related to use of the SUS by holders of private health policies. Another study [31] detected the multiple use of the public system, whereby private health insurance policyholders turn to public health establishments for higher complexity procedures not covered by their plans. Thus,

"promiscuous" relations are observed between these private plans and the Unified National Health System. As noted Bahia, in 2009, although legislation exists to regulate the action plans, the National Agency of Health faces resistance plans to complying with the law and even today makes contracts outlaw [32].

In fact, the "blind eye" policy further allows utilization of the SUS by private health plans by facilitating a double entryway for private patients into the private hospitals hired by the plan and outsourced by the SUS.

The lack of policies for micro-regulation of hospital service providers by either the health plans or the National Health System favors the segmentation and/or specialization of the private hospital services market, but without a joint healthy competition through improvement, qualification, and better quality services provided by the private hospital sector.

The lack of incorporation of virtuous healthcare practices as a decisive factor capable of impacting the supply and allocation of healthcare services to the SUS appears to result in a captive market (to the detriment of citizens' health) and the search for maximizing the cost-benefit relationship between the parties.

## 4. Production, Installed Capacity and Public/Private Financing

An analysis of data on the installed capacity and production/use of healthcare services in Brazil shows that in 2005 [33], 62% of the country's entire hospital complex was private, including charitable institutions (for-profit and not-for-profit). The opposite was true for outpatient services, or smaller units, generally involving lower complexity and without patient admission, with 74% public outpatient services and 25.4% private. As for provision and use of services, according to the data in the following table for the year 2006 [34] provision of outpatient services through the SUS shows major differences when comparing public and private outpatient clinics:

**Table 2. Provision of Outpatient Services under the Unified National Health System - 2006**

Outpatient Services Provision	%
Public Outpatient Provision	92,3
Private Outpatient Provision	6,4
Charitable Provision	1,3
Total	100,0
Hospital Services Provision - 2006	
Hospital Services Provision	%
Public Hospital Provision	39,0
Private Hospital Provision	51,0
Charitable Hospital Provision	10,0
Total	100,0

Source: IBGE, 2007.

Further analysis of SUS data on financing shows that in 2005 the "Fund for High Complexity Exceptional Procedures" accounted for 15% of total health financing, compared to 52% for primary care and 33% for medium and high complexity procedures [35].

The Fund for High Complexity Exceptional Procedures, created in 1999, has grown considerably in recent years and finances an important share of services provided by the private sector: renal replacement therapy, exceptional drugs, AIDS kits, transplants, and incentives for charitable

hospitals. The fund does not follow any specific allocation criteria, and maintains the outsourcing logic used by the former (non-defunct) INAMPS (National Institute of Social Security Medical Care), such that high complexity is linked to a specific fund and ends up favoring private or public institutions with a double entryway [36].

Finally, the incorporation and concentration of more advanced technologies by health services are illustrated by data on the distribution of higher complexity diagnostic equipment in public and private institutions.

**Table 3. Diagnostic Imaging Equipment in Health Establishments, Brazil - 2005**

Type of Equipment	Public	Private
Gama chamber	85	502
Lithotriptor	65	464
Stereoaxial mammography	119	584
Fluoroscopic x-ray	295	958
Bone density x-ray	64	970
Angiography x-ray	96	441
Magnetic resonance	264	1697
Computerized tomography	49	500

Source: IBGE, 2007.

These data corroborate the idea of segmentation of the SUS, with the public sector “specializing” in lower complexity products in a deficient hospital system, thus fostering the expansion of contracts with private hospital services. This shapes a modality of hospital care that is complementary to the SUS, with the private sector consolidating its specialization in higher technological complexity.

## 5. Regulation and Reimbursement of the SUS by Private Plans

During the administration of President Fernando Henrique Cardoso in the 1990s, the National Agency for Supplementary Healthcare (ANS) was created under Law 9565/98<sup>24</sup>, with the aim of regulating private health plans. The public sector reform carried out during this same period defined regulation as a state policy. The justification was to foster the growth of the private sector and exempt the state from the obligation of enacting social security policies, and as a consequence, of promoting public and universal health policies.

Health policy was thus targeted at “the poor”, namely those strata of society that were “incapable” of paying out-of-pocket for their healthcare and thus merited a minimum basket of health benefits or “primary healthcare procedures”. This led to the creation of the Family Health Program for “the poor”. Brazilians that could afford to pay for their own healthcare had the option of purchasing whatever plan they could afford on the private market. Translated in terms of health benefits, the more expensive the plan, the more extensive the healthcare, both for technologies included and access to medium and high complexity procedures.

Within the sphere of public sector reform, the regulatory policy for health plans is limited to non-interference by the state in market matters and establishing necessary guarantees for the market to function smoothly. Since its creation, the Agency has issued several rulings

targeting private health insurance companies. The ruling passed on April 10, 2002, deals with a problem that is still unresolved, namely the reimbursement of the Unified National Health System by private health plans. This is one of the conflicts situated at the interface of interests between public and private spheres and relates to the previously discussed “double entryway” for beneficiaries of private plans. Referral to the SUS is a frequent procedure for health plan operators and essentially involves utilizing public services without reimbursing the public system for them [37].

The problem of reimbursement of the SUS by health plans is not lack of legislation, since the ANS issued a normative ruling to deal with it, but rather one of enforcement. A conflict persists to this day that has become so old and routine that it will soon be forgotten. Various attempts to enforce such reimbursement have failed, even though the ruling specifies the operational procedure.

Some of the obstacles to effective enforcement of the normative ruling are administrative, such as resolving the time lag between provision of the service and entry of the corresponding data into the registry. In addition, the ANS registries themselves probably contain flaws, given the precarious information system in private hospitals [38].

We believe that the core issue lies in the failure by health plans to respond to the notification to reimburse the SUS. If the health plans fail or refuse to comply with the notification to pay, the Agency lacks the authority over these regulated parties. The matter of mandatory compliance with the normative ruling is also unclear, and in cases of non-compliance, there are no clear sanctions for when the SUS is not reimbursed.

The historical choices made until these moments tend to persist and constrain subsequent options, unless a sufficient force emerges to overcome this organizational inertia or “stickiness” [39].

## 6. Conclusions

The analysis of health policies and regulation of private plans in European countries as compared and Brazil’s health policies appeared relevant to us to explore the role of institutional trajectories of state regulatory policies in defining policies for supplementary healthcare.

The restrictions imposed on welfare policies in European countries due to economic policy changes, unemployment, and the resulting budget constraints on social security systems are hardly significant when compared to the constraints and consequences in Brazil resulting from similar economic policies.

Therefore public healthcare spending in the EU remains extremely high while supplementary healthcare spending by the private sector is extremely low (5%). Even if there are countries where private insurance provides substitutive or complementary coverage, there are no instances where that sector’s spending exceeds 20% of total healthcare spending. Studies about the EU reveal that there is little inequality in terms of general practitioner usage and significant inequalities in favor of higher income sectors in terms of specialist usage.

Even if in Brazil healthcare spending as a proportion of the GDP differs by less than one per cent (Brazil 8.3% and

EU 9.0%), public spending in relation to total healthcare spending is very low (48.3%) while private spending, made by insurance plans and privately by families, is very high (51.7%). Data regarding provision/usage show a different trend in public spending; they reinforce unequal usage of services. Public outpatient services usage is 92.3% of the overall provided by healthcare services in private and charitable networks (7.7%). On the other hand, with respect to usage of hospital care services of higher complexity than outpatient ones, public usage is 39%, private 51% and charitable 10%.

In European Union countries the location of healthcare services remains equitable: maximum travel time for access to services is less than 20 minutes to the nearest service. Among organizational barriers to access, the most significant one is the waiting list. Waiting lists have been adopted in several countries and few have been able to reduce them with measures such as increasing funding, restructuring provision and reorganizing reimbursement. For European Union researchers, barriers to access became significant when private health insurance companies coexist with public social security and both provide coverage for the same services. The presence of private medicine has led to long waiting lists in the public sector. Long waiting lists cause public access to become non-equitable, including in countries where private insurance plays a small role.

In Brazil average travel time to get to the nearest healthcare service is not considered an impediment to access. This is due to how irrationally healthcare services are scattered across the entire country; depending on the state and municipality, people may have to travel six hours or more if they live in isolated from large urban centers. Indeed, inequities faced by the population when attempting to reach healthcare services in some states and municipalities are extreme, especially with respect to medium and high complexity services. Waiting lists, which are an important tool for universal coverage and help improve access, are rarely implemented; there are only waiting lists for high complexity procedures like transplants. Barriers to access regarding supplementary healthcare where private insurance plans provide coverage for the same services as the National Health System are common. In addition to being a burden to the SUS and users, who pay twice for a service that is provided by the public system, this creates inequalities in public service usage. Similar to what occurs in EU countries, with private plans there are longer waiting lines for care provided by general practitioners in the public service.

The relationship between socioeconomic status and use of services shows less inequity in the use of general practitioners and major inequity in favor of higher-income segments of the population when it comes to access to specialists. This occurs both in Brazil and the EU.

As such benefits were incorporated into the structure of European societies, their withdrawal becomes controversial and highly problematic among European governments and citizens. This situation does not affect recent immigrants not included in EU social security systems.

Conversely, in Brazil there is a gradual decrease of the right to healthcare as a universal right of all citizens. This translates into: expanded primary healthcare without a system that integrates different levels of healthcare

complexity; difficult access; lack of adequate assessment and control, both public and private; and insufficient public funding.

Lack of control and evaluation of healthcare quality, little incorporation of technologies in private services outsourced by the Unified National Health System, and an increasing number of beneficiaries of cheaper plans that are unable to provide appropriate care are all factors that contribute to growing waiting lines for care in the National System.

There are two basic forms of regulation in terms of government regulation over the private sector in the EU: minimum operating policies and considerable regulation over the supplementary market focusing on company solvency and control over prices and products, as well as severe regulation over the substitutive market. The main role of regulatory mechanisms is to protect consumers and to guarantee access. With respect to complementary healthcare, governments choose what they believe is the most appropriate way to subsidize and regulate private services - this is a legal prerogative of each country and not the EU.

Regulation in Brazil is limited to the principle of non-interference from the government on market development and guarantees necessary for its operation. Within the context of Government Reform and privatization of public sectors, regulatory agencies were created. In terms of healthcare, the National Health Agency [Agência Nacional de Saúde - ANS] was created to regulate private healthcare plans and to prevent the market's monopoly tendencies; this guarantees that healthcare operators can develop freely. Ever since then the private healthcare sector has been growing considerably without any SUS control. The sector today is characterized by economic concentration and this results in a market that "combines oligopoly elements with the existence of a wide range of small companies in the outskirts of large cities and countryside towns" [40]. This regulatory framework goes against Constitutional principles. It is a dilemma that exists to this day. Private healthcare sector interests put significant pressure and, on the other hand, the public healthcare sector is unable to increase funding and provide comprehensive healthcare services to the Brazilian society as an essential citizenship right.

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