INTRODUCTION

Brazil’s Health System in Context
Throughout the twentieth century, Brazil developed a Social Health Insurance, providing coverage to formal workers and their dependents. In 1988, the country implemented a health reform adopting a National Health Service model, based on three core principles: universal entitlement, equal access to healthcare, and open-ended list coverage. During this transition, formal workers recomposed their privileged access to healthcare through private health insurance, resulting in a two-tier system represented by those with private insurance and those who must rely on public services.

OBJECTIVES

Does private insurance improve access regardless of individuals’ income?

The literature that focuses on health equity in Brazil consistently points that there are relevant inequalities in utilization of health services between privately insured individuals and the uninsured. However, this literature has yet to determine whether inequalities in utilization of health services remain among insured individuals. This research aims to fill this gap, investigating whether income-related inequalities persist exclusively among privately insured individuals in Brazil.

METHODS

Health Services System

• Resources
• Organization

Health Services Utilization

• Predisposing
• Enabling
• Need

Use

• Type
• Purpose
• Unit of Analysis

The study uses Andersen’s behavioral model as a theoretical framework to analyze data from two rounds (1998 and 2008) of a national household survey. We assess fourteen dependent variables that reflect medical and hospital services across income quintiles (Table 1).

Table 1 - List of Dependent Variables

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<tbody>
<tr>
<td>Any publicly financed hospitalization</td>
<td>Any Physician Visit</td>
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<tr>
<td>Any privately (insurance) financed hospitalization</td>
<td>Number of Physician Visit</td>
</tr>
<tr>
<td>Number of publicly financed hospital days</td>
<td>Number of privately (insurance) financed hospital days</td>
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<tr>
<td>Number of privately admissions</td>
<td>Number of physician visits</td>
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1) For each dependent variable, we calculate mean utilization levels per income quintile through linear and non-linear regression models, with and without the use of controls. Measurements are standardized using age, sex, and health status proxies as confounders. We also calculate concentration indexes as a summary measure of inequality.

2) We plot concentration curves on graphs to compare the evolution of inequality over time, statistically testing for any curve dominance.

3) Finally, we perform a decomposition analysis to identify the most relevant contributors to inequality in each dependent variable.

RESULTS

Large inequality on hospital services

We find very little inequality in levels of physician services utilization, although a statistically significant positive gradient persists in both survey rounds. Publicly financed hospitalizations are a rare phenomenon among privately insured individual and strongly concentrated on the poor. Most hospitalizations among the study group are funded thought private insurance, and they are concentrated on the rich. Premium rates and income are the most relevant contributors to inequality.

REFERENCES


CONCLUSIONS

Affordable ambulatory only coverage is a viable policy option

We find that private health insurance increases utilization levels of physician services, providing comparable access across income groups. However, we also find that private coverage does not guarantee that poor beneficiaries will have access to hospital services in correspondence to their healthcare needs. The private health insurance agency could provide incentives to insurers to offer affordable private insurance with ambulatory care only coverage, increasing access to physician services to the poor, while not inducing them to pay for private hospitalizations.

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