

immunization and antenatal government programs and the targeted Pastorate of the Child program, PSF reaches the poor at a higher rate than other groups. The evaluation of the PSF program suggests that maintaining a focus on the poor, increasing awareness through individual and community educational efforts as well as increasing service reach through home visits as well as well-placed service sites, can produce greater participation by the poor in the health system. Future studies geared at identifying factors that drive the various pat-

terns of usage may provide some insight into these issues and help to foster the development of even better approaches geared at improving service utilization in the poorest sector of the population.

Brazil: Are health and nutrition programs reaching the neediest? In: Gwatkin DR, Wagstaff A, and Yazbeck AS. *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What doesn't and Why*. Washington, DC: World Bank; 2005, 353p.



REACHING THE POOR WITH HEALTH SERVICES

2008

Brazil

Reaching the Poor with Health Care—Filling the Cracks in Universal Coverage

National Universal Programs in Health

Universal health care programs are typically created with the objective of improving access to care among the poor and addressing persistent inequalities. The experience of Brazil described here suggests it is possible to conclude that achieving equality in health outcomes requires complementing universal coverage care with other strategies geared at improving utilization of available services by the poor.

Brazil is among the 12 countries in the world with the greatest income inequality. Inequality in health outcomes has been recognized as a leading health problem in the Americas. Brazil has undertaken a number of health initiatives geared at improving access to care among the poorest members of the society. These include: universal primary health care programs, targeting of specific health programs to the poor; programs that provided cash incentives/rewards to municipalities who provide care to the poorest families; and cash incentives to the poorest families of municipalities for the proper utilization of available health and education public services.

Brazil's National Immunization Program was established in 1973 as a universal health services program delivered through the primary care preventive services at public health centers and polyclinics. The Antenatal Care Program is one of the most traditional of health care services delivered through Brazil's primary care. The PSF family health program was created in 1994 in an effort to reorganize the primary care services. It was proactive in nature, and service was to be provided through a team of health care providers. In 1998 the creation of the Sistema Unico de Saude (SUS—United Health System) under the constitution, provided universal health care—health as a right for all regardless of income. This effort was meant to address inequality that resulted from inability to pay for services.

Alongside government efforts, non-profit initiatives have also tried to reach the poor. An example of this is the Pastorate of the Child—a program launched in 1983 by the Catholic Church targeting undernourished children and the poorest children.

Universal Care but not Reaching Majority of the Poorest

Brazil's National Immunization Program, established in 1973 is a universal program for the entire population to eradicate vaccine preventable diseases, e.g., polio, measles, BCG and DPT. Services were delivered through the primary care preventive services at health facilities. To amplify program penetration, national immunization campaigns were carried out to increase awareness of the importance of vaccines in preventing diseases. In addition, availability of services was also enhanced through expanding delivery sites to include places that the poor usual visit or congregate—such as supermarkets, malls and community centers.

Results of Brazil's immunization efforts showed that while there were significant increases in vaccine coverage in the 1994–2000 period, the prevalence of incomplete immunizations had its highest concentration in children living in households in the poorest 20% (or lowest quintile) of the population. In Sergipe, a city in northeastern Brazil, a study conducted in 2000 found that children living in the poorest 20% of households in the population received the least benefit from the services provided, as opposed to children in the highest 20% of households—reflecting inequality in coverage. Table 1 illustrates the consistency in inequality for the poorest households with national data from 1996 and the Sergipe study.



The long-established National Antenatal Care Program also comes up short with respect to reaching the poorest women in Brazil. National utilization of antenatal care services is high, with more than 90% of women having at least one check up and on average, the number of consultations per person is more than six. Whilst the overall coverage of the antenatal care program is good, mothers living in households of the least poor seemed to have benefited more from the services provided—reflecting inequality in coverage. The greatest concentration of women receiving inadequate antenatal were from families in the poorest quintile—reflecting poor focus (Table 2). Both the pro-poor focus and level of coverage of the antenatal care program were found to be less than that of the immunization program.

Despite achieving major improvements in the nation's ability to address the issues associated with incomplete immunization and inadequate antenatal care, inequality persisted. The families in the poorest 20% of the population were consistently among those who did not receive services at all or the services received were incomplete or inadequate in comparison to families in higher income groups.

The Pastorate of the Child is an example of a non-governmental initiative targeted specifically to the poorest children. Launched in 1983 by the Catholic Church, this program is built on volunteer leaders, mainly women, recruited from the local community who give one day a month, delivering information and advice on maternal and child health care—including immunization. The Pastorate of the Child targets undernourished children and children from the poorest families. Despite its mission, research has demonstrated that this program had poor coverage overall and the greatest concentration of children benefiting were not from the poorest households nor were they children that were the most undernourished. This program operated outside the existing public primary care structured system, was built on a foundation of volunteerism, and selected volunteer leaders from within the communities being served. This approach puts communities with the least developed organizational capacity and infrastructure, usually poorer communities, at a disadvantage with respect to benefiting from the service offered.

Addressing Access Barriers

Against this background, in 1994 the government of Brazil created the PSF family health program in an effort to reorganize the primary care services and improve service to the poor. The principal objectives of PSF were to reach out to the

Table 1. Prevalence of incomplete immunization among children 12 months and older, by asset quintiles and concentration indexes for DHS/Brazil (1996) and Sergipe Study (2000)

| Wealth quintiles | DHS (1996) n = 3827 | Sergipe (2000) n = 1436 |
|------------------|------------------------|----------------------------|
| 1 | 33.4 | 28.0 |
| 2 | 16.4 | 20.4 |
| 3 | 14.2 | 20.6 |
| 4 | 11.9 | 15.5 |
| 5 | 15.3 | 17.8 |
| All | 19.3 | 20.5 |
| | p < 0.001 | p = 0.176 |
| | CI = -21.8 | CI = -10.8 |

DHS Demographic and Health Survey ; CI Concentration indexes.
Sources: BEMFAM, DHS/Brazil 1996 and J.A. Cesar, Sergipe Study 2000.

Table 2. Proportion of mothers receiving inadequate antenatal care by asset quintiles and concentration indexes for two studies.

| Wealth quintiles | DHS (1996) | Sergipe (2000) |
|------------------|------------|----------------|
| 1 | 70.0 | 49.1 |
| 2 | 43.5 | 48.3 |
| 3 | 27.4 | 35.3 |
| 4 | 19.1 | 30.2 |
| 5 | 13.6 | 18.7 |
| All | 38.4 | 35.7 |
| | p < 0.001 | p < 0.001 |
| | CI = -31.7 | CI = -18.3 |

DHS Demographic and Health Survey; SUS Unified Health System;
CI Concentration indexes.
Sources: BEMFAM, Brazil/DHS 1996; NA Neumann; JA Cesar, Sergipe Study 2000.

universal population and particularly, the poor. Two pro-poor features of the program are:

- I. *Location of Phased Expansion:* As the program was implemented, it focused first on the poorest areas, as well as those that had never before received primary care service, and

II. *Outreach*: PSF program services were provided by health teams, each tasked with overseeing the health of selected households and families. Unlike traditional care giving where the patient/family would visit health facilities seeking services for specific problems, the teams reached out to their clients through home visits as well as community activities.

The teams were constructed so as to facilitate the identification of the factors that represent possible threats to health in the community. Interventions were designed to address these threats as well as to educate community members about how these health threats can be prevented. Team staff included a general practitioner, a registered nurse, a nurse assistant and four community health workers. A monetary reward was offered to municipalities, through the Ministry of Health, based on their ability to maintain 70 % coverage of the population.

The PSF program has been implemented in phases across Brazil and in 1996 the national coverage was estimated to be between 49.8% in the Northeast Region and 26% in the South East Region. In Porto Alegre in 2003, where the PSF program was newly implemented, the proportion of its facilities located in areas with families living in households from the poorest quintile was highest with minimal representation from households at the highest income quintile (Figure 1).

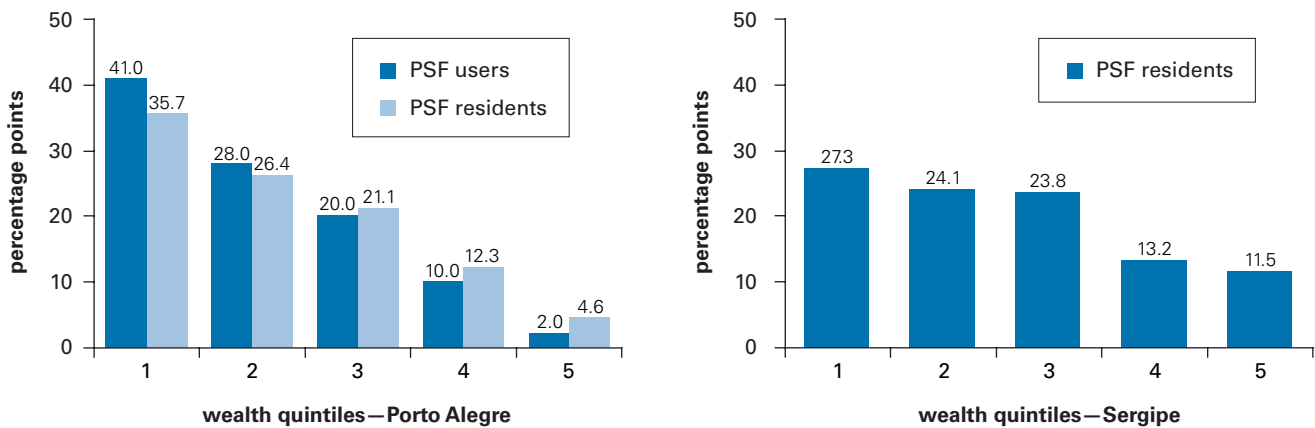
The Sergipe program, in existence since 1996, had the highest concentration representation of families from the poorest quintile although participation by families from the highest income quintile also had increased considerably.

While both cities had a pro-poor focus, the focus of the Porto Alegre program was higher. Here, the poorest households were nine times more likely to benefit from the program than the least poor. In Sergipe, the benefit ratio in favour of the poorest quintile was only 2.5 times greater. The differences observed are likely due to the different stages of implementation of the program in the two sites. At the beginning, coverage is low and the pro-poor focus is high, as observed in Porto Alegre. Later on, with increased overall coverage, pro-poor focus decreases, but coverage is still higher among the poor.

Conclusion

Universal programs many times refer to the intention to make services available to all and not necessarily the actual coverage of all in a country. Brazil's universal programs for immunization and antenatal care highlight the fact that reaching the poor requires specific pro-poor actions to improve access to the poor and vulnerable. The PSF family health program provides an excellent example of how to do this by improving targeting of universal programs. Compared to the evaluated

Figure 1. Distribution of wealth status for residents of areas covered by the family health program (PSF), Porto Alegre and Sergipe, and for PSF users, Porto Alegre



Source: Neumann and others 1999.