

People or Profit: A Comparison of Health Care in Brazil and the United States

Fr. Alexandre A. Martins, MI, Ph.D.
 Assistant Professor, Department of Theology
 Marquette University
 Milwaukee
Alexandre.martins@marquette.edu

This essay offers a reflection about the increasing influence of profit in Catholic health care. Based on Jesus' teaching that shows that the need of the wounded person on the street comes first (Luke 10: 25-37), Catholic health care ministry has the challenge to create services where people, not profit, come first.

To illustrate this, two cases deserve our attention. The first is from Brazil with the conflict between its public and private health care system. The second is from the United States with a recent scandal involving a heart surgeon performing unnecessary surgeries. These two cases will serve as narratives representing the challenges of the health care market and public services, and how Catholic health care institutions are challenged to be financially sustainable while serving the poor. Briefly, I will describe the cases, raise some issues, and conclude with some questions for Catholic health care in these contexts.

Case #1. The Brazilian Constitution of 1988 determined that "health is a right of all people and a duty of the state, guaranteed by social and economic policies that reduce the risk of disease and other adversities and by universal and equal access to actions and services."¹ This allowed the creation of the Unified Health System, known as SUS

(Sistema Único de Saúde), a public health system of universal coverage grounded on three pillars: *universality*, *integrality* and *equity*. These principles are embodied in a public system of democratic participation from primary to tertiary care (see *Leis Orgânicas de Saúde*).² However, this is not the only health system operating in Brazil. Lobbying by private interest groups made sure the 1988 Constitution also permits private initiatives to offer health care as "complementary services" to the public system. This created opportunities for the establishment of private health systems, which are hospital-based and focused on tertiary care (unlike the public system that is community-based, focusing on primary care).

From the beginning, tensions and conflicts have plagued Brazilian health care with the public and the private systems going in opposite directions. While the SUS targets population health, the private system targets the well-to-do sick as consumers. Currently, 75% of the Brazilian population uses public services and 25% are in private services (the latter is growing).

The present federal administration grabbed power through a parliamentary coup and appointed as ministry of health a representative who was elected with his

campaign sponsored by private health care companies. Since the beginning of this administration, the commitment to the private health sector has been clear. The federal government cannot simply end the SUS because it fulfills a constitutional mandate. So, the administration decided to weaken and dismantle the public system through executive actions and new policies. This had the effect of pushing some people into private services and insurance, creating a large opportunity to the private sector. The most significant action against the SUS was the approval of legislation which froze the public investment in the SUS for 20 years. At the same time, the administration ended regulations meant to control the private system, especially insurance policies. This has facilitated the activities of insurance companies and private hospitals, a sector that has been growing in the country, even amid an economic crisis.

These actions against the Brazilian public health system have shifted health care from a right to a privilege. Good, high-quality health services have become a luxury for those who can pay, while the SUS is becoming a synonymy for precarious services for those who cannot. This also has changed the health priority of the country from population health to services targeting sick people; from a community-based system to a hospital-centered health care.

This shift from public to private health systems abandons the promotion of well-being and a healthy population. It also reduces community participation. Without funding, the public sector of SUS, which is a participatory system, enters a downward spiral.

Case #2. Considering this health care shift in Brazil, I think it is interesting to look at the U.S. system, a country that has know-how in

private health care. In the U.S., most health care is privately held and operates according to principles of the free market. Even the services provided and/or supported by public funds function inside this market. One can see some benefits in this way of structuring, such as availability of high tech medicine, tertiary care, and quick access to medical services. The U.S. is the only developed country that does not offer universal health coverage for its citizens, so that these advantages are often a privilege for those who have insurance and can afford them, just as in Brazil's private system. The American approach has influenced Brazil. Let me illustrate this point with a case reported by the *Milwaukee Journal Sentinel* on February 16, 2018. The article shows a scandal involving a heart surgeon and the Medical College of Wisconsin (MCW).³

A surgeon hired by the MCW and Froedtert Hospital was accused of doing unnecessary heart surgeries. When colleagues of this surgeon alerted the dean of the medical school about this misconduct, the dean acknowledged that this was not an ideal situation, but that they had to take into consideration the revenue that this heart surgeon was bringing to the hospital and his team. So, the MCW did not take any action against the surgeon and kept him working for a few years, until allowing his contract to expire. It is not clear whether this contract was not renewed by the MCW, or if it was the physician's own decision to leave.

This story became public after a group of physicians brought a lawsuit against the MCW and Froedtert Hospital (that function together as partners). The article presented some documents provided for the lawsuit including emails showing that leaders of the MCW knew the practice of this surgeon and did not act because of the enhanced revenue. Patient well-being did not seem to play a

major role; indeed, some cases showed no symptoms supporting the necessity of a surgery. Another physician said that the patient's symptoms suggested a more conservative treatment including physical therapy and outpatient services. Unfortunately, this unnecessary surgical procedure resulted in complications that significantly affected the patient's quality of life. This appears to be a case in which revenue displaced patient care. It could even be described as a kind of institutional violence.

Overemphasis on revenue takes advantage of patients who have limited knowledge and who trust their physicians to act on their behalf. Health professionals are vulnerable because their judgment can be influenced by system protocols and culture. For example, U.S. doctors are in a culture that tends to over-test patients for fear of litigation. Unnecessary procedures and tests makes medical services more expensive, increasing financial and emotional dramas for patients and families.

Excessive focus on revenue can make patients into mere consumers. This logic is totally opposed to human rights logic, in which the dignity of every person is intrinsic and inviolable.

In this profit-driven logic, everybody is vulnerable, but the poor are the first and foremost to suffer as victims of structural violence.

In both Brazil and the United States, Catholic health care has a significant presence, and Catholic institutions are an important part of the "safety net" for marginalized populations, especially the poor. Overemphasis on financial sustainability, increasing revenue, decreasing expenditures, and being competitive in the

market, can lead CEOs to a hospital-based approach to health care which neglects community involvement and the focus on population health. This has a significant impact on the mission of Catholic health ministry and creates failures in the commitment to the poor and vulnerable. Referring to the use of the word 'ministry' in Catholic health care and considering this context in the health market one ethicist said, "Our common use of the 'ministry' in reference to Catholic health care is meant to convey that, while health care must be run in a business-like way, it is first and foremost a work of the Church that is rooted in the health mission of Jesus." This leads us to ask whether the influence of the profit-driven logic of the market is forcing the *business-like way* to overcome the Catholic health care commitment to healing mission of Jesus, the identity of the mission, and to what Benedict XVI calls "the logic of gift."⁴

Saint Camillus Health (São Camilo Saúde) is the largest Catholic health care organization in Brazil with 51 hospitals plus numerous clinics and primary care centers. Its *Letter of Principles* says, "The prophetic mission that we received from the Gospel and Saint Camillus is to follow Jesus in the Samaritan's care for the sick, 'I was sick and you visited me' (Matt. 25:36), and to witness Christ's love for the sick in the world." And quoting Pope Francis, this letter adds: "Embodying a creative fidelity to our Charism, we go to encounter of those who are in 'the geographic and existential peripheries of the human life.'"⁵ The same spirit can be seen in Ascension Health, the largest Catholic health care organization in the U.S.: "Rooted in the loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable."⁶

Although the mission of Catholic health systems is the embodiment of Jesus' ministry to the sick and his special attention to the poor and the vulnerable, Catholic institutions must deal with the health market, public-private partnerships, the instability of health legislation, and the dominant perspective of health care delivery. Consequently, the promotion of social well-being and the fight against health inequalities are hardly addressed. Perhaps Catholic health institutions fail in addressing the profit-driven system and, operating inside it, become complicit with the lack of a people-centered perspective. This situation becomes even more complex when one witnesses the presence of for-profit Catholic health institutions. This exists in the U.S. and has a tendency to expand. Can a for-profit Catholic health center care for the poor? Or "will Catholic identity become just a matter of compliance to the *Ethical and Religious Directives*?"⁷

Serving the poor is a complex endeavor, especially when this service must be done from Jesus' loving ministry for the destitute sick. As Pope Francis said: The Catholic Church is not a "well-organized NGO."⁸ All services provided by Catholics and their organizations must be meaningful, possessing a meaning that is rooted in Jesus and a message addressed to the poor, who are privileged recipients of the good-news (Luke 4:16-18).

I conclude with what I heard from an administrator of a Catholic hospital. He told me that he was in an executive board meeting when a sister from the sponsoring congregation said: "We must help the poor. This is our priority, and we have to figure out how we can do it better."

-
- ¹ Presidência da República, *Constituição da República Federativa do Brasil de 1988*. <http://www2.planalto.gov.br/acervo/constituicao-federal>
 - ² Legislação Básica do SUS, <http://bvsmms.saude.gov.br/component/content/article?layout=edit&id=155>
 - ³ Mark Johnson and Bruce Vielmetti, "Medical College of Wisconsin knew doctor was accused of performing unnecessary surgery," in *Milwaukee Journal Sentinel* (February 16, 2018), <https://www.jsonline.com/story/news/investigations/2018/02/16/medical-college-wisconsin-allowed-doctor-accused-performing-unnecessary-surgery-treat-patients-3-vea/342295002/>
 - ⁴ Charles E. Bouchard, O.P., S.T.D., "The Meaning of Ministry in Health Care" in *Incarnate Grace: Perspectives on the Ministry of Catholic Health Care* (St. Louis: Catholic Health Association of the United States, 2017), 201.
 - ⁵ São Camilo Saúde, *Cartas de Princípios Camilianos*, <http://www.saocamilosaude.com>
 - ⁶ Ascension, *Mission, Vision, and Values*, <https://ascension.org/our-mission/mission-vision-values>
 - ⁷ Bouchard, *op. cit.*, 204.
 - ⁸ Pope Francis, «Church as a Mother Not a NGO» in *Vatican Radio* (06/17/2014). http://en.radiovaticana.va/news/2014/06/17/pope_francis_church_a_mother_not_a_ngo/1101850