Brazil's health catastrophe in the making

Brazil's political and economic crises are diverting attention from the resumption of a neoliberal model of health care by its government. Here we briefly summarise the health reforms and their likely long-term implications. The new policies can be seen from three perspectives: austerity, privatisation, and deregulation.

Firstly, the country's government introduced one of the harshest set of austerity measures in modern history. The constitutional amendment passed in December 2016, called PEC-55, freezes the federal budget, including health spending, at its 2016 level for 20 years.[1] Furthermore, in 2017, for the first time in nearly 30 years, the government undershot the minimum health budget guaranteed by the Constitution by R$692 million (approximately US$210 million).[2,3] Other health-related sectors, such as education and science, also face spending cuts: up to 45% cuts in scientific research and 15% in public universities.[4–6]

Brazil's government is gradually withdrawing from the key social protection plan, Brazil Without Extreme Poverty (Brasil Sem Miséria), which has provided financial support, access to basic goods, and services to vulnerable populations through over 70 specialised programmes. Many social assistance programmes, supplementing preventive health care and reducing inequalities, are experiencing budget cuts. In 2017, over 1 million families were excluded from the Family Allowance Programme (Bolsa Família), aimed at the eradication of poverty and famine by direct, conditional cash transfer to the poorest households.[7] According to prognoses by Rasella and colleagues,[8] austerity measures suffered by the programme are likely to exacerbate child morbidity and mortality within the next decade. The National Programme for the Strengthening of Family Agriculture (PRONAF), which involves functions such as rural education, water supply, and job creation, and was one of the main forces behind Brazil's removal from the World Food Programme's global hunger map, has now been seriously compromised.[1] The Water Tanks Programme (Programa Cisternas), bringing access to safe drinking water to impoverished, rural communities, has lost over 90% of its funds.[1] Given that one of the leading causes of violent crime in rural communities is conflicts over access to water, shutting down the programme poses a serious threat to the security of these communities. Funding for the Acquisition of Food Programme (Programa de Aquisição de Alimentos), purchasing food produced by family farms for redistribution among the poor, has been reduced by 99%.[1] Such drastic changes in the direction of social policies will probably reverse the social progress that has been made over the past two decades, which has brought 28 million people out of poverty and 36 million into the middle class.

Secondly, the government plans to introduce commercial health plans (Planos Populares), meant to replace functions previously performed, free of charge, by the National Health System (Sistema Único de Saúde [SUS]).[9] Commercial plans offer a narrower scope of services than the minimum offered by SUS and are subject to less regulatory scrutiny, which generally results in poor service quality and high out-of-pocket costs.[10]

Thirdly, states and municipalities have so far been obliged to invest federal resources, via so-called financial blocks, in strategic areas of health care, including primary health care and sanitation. New regulations free the regional administrations from adhering to such spending discipline[11] by investing specified amounts into strategic areas of health care, which might contribute to the deterioration of SUS and to regional health inequalities. Moreover, new regulations diminish the obligatory numbers of doctors in emergency wards[12] and of personnel in primary health units,[12] including the reduction of the obligatory number of community health agents. Such reorganisation of primary care not only gives more power to the private sector than before by diminishing the quality of public services but also reduces SUS's capacity for effective emergency management, prevention, and health promotion. The weakening of the public sector has also taken a toll on vaccination coverage and sanitary surveillance, resulting in a recent outbreak of measles.[13]

These actions show that the Brazilian Government is backing away from the core principles of universal health care, despite it being a constitutional right. Neoliberal health policies, combined with the deregulation of labour laws,[14] amid severe economic crisis are not only working against the idea of social justice but are also likely to exacerbate two major public health concerns of the country: sociospatial and socioeconomic inequalities in health and the high homicide rate. We hope that this letter will stimulate debate on the systemic crisis of health care in Brazil and contribute to rigorous scrutiny of neoliberal trends in public health policies and their effects around the world.[15]

We declare no competing interests.

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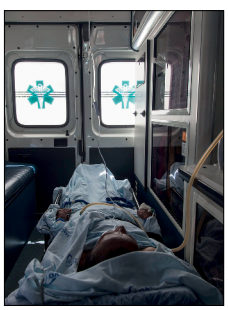

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Women's work in UK clinical trials is undervalued

This is a parody of clinical trial research: an investigator (usually a man) drafts a protocol; this is not particularly demanding and, indeed, for National Institute for Health Research-funded trials, the commissioner does almost all of the thinking; the investigator then passes the protocol to a trial manager (usually a woman), who then has the extraordinarily demanding task of turning his words into reality.

Having worked on clinical trials for 25 years, I have no doubt that the most intellectually challenging part of a clinical trial, the part that determines success or failure, is the part between protocol development and data analysis. Most trials are orders of magnitude too small. Only the most intelligent, industrious, and imaginative clinical trial managers can pull off big trials—the ones that change clinical practice. The data are then handed to the statistician (usually a man), who does some calculations. The results are published. The investigator and statistician are named, promoted, and lauded.

This is structural inequality. The people (mostly women) who run trials are clinical trialists, not managers. They are methodologists to the same extent as statisticians. They deserve a proper career structure, with pay consummate with the intellectual demands and social importance of their work. The discrimination that they face within university career structures must stop. If we want reliable results from adequately powered trials, we need a cadre of high-class clinical trialists who can deliver the answers that patients need.

I declare no competing interests.

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CDC autism rate: misplaced reliance on passive sampling?

We welcomed *The Lancet*'s Editorial (May 5, p 1750)[1] about the release of the seventh US Centers for Disease Control and Prevention (CDC) Autism Developmental Disabilities Monitoring Network (ADDM) report.[2] This report is based on surveillance of health and education records of samples of more than 300 000 children aged 8 years from 11 US states since 2000. The latest CDC report for 2014 documents a further increase in the prevalence of autism spectrum disorder, from 14·4 per 1000 children in 2012, to 16·8 per 1000 in 2014. The Editors attribute the narrowing of disparities in rates of diagnosis in white and ethnic minority children between 2012 and 2014, which has not occurred previously, and the increase in autism rates to "better awareness and detection among minority ethnic groups" (although we question whether this increase could be an anomaly). The CDC ADDM relies on passive sampling and case identification of institutional records collected for purposes other than research. Without active case finding, how can we be sure of these claims?

Two representative community surveys and one intellectual disability population survey in England[3] have used validated[4] versions of the Autism Diagnostic Observation Schedule,[5] to do direct assessments in probability samples of adults aged 18 years and older, with no upper age limit. The results of these three surveys show that autism rates appear to remain similar across age groups, with the suggestion of a slight decrease of 1% in the odds of autism for each extra year of age. This trend suggests that the proportion of people born each year in the past 70–80 years who meet criteria for autism is stable. We call on the USA to mount a comparable