

system, many incentives align such that the default approach is to provide more aggressive care, even near the end of life. In this sense, I agree with Jenkins and Warrillow et al. — our patients and the health care system would be much better served by shifting this default to providing palliation for patients with advanced dementia. In the meantime, there is much room for providers to improve the end-of-life experience of their patients with advanced dementia. With greater attention to judicious and compassionate counseling, coupled with the option to

receive high-quality palliative care, I believe that aggressive, burdensome, and costly treatments can be avoided for most of these patients.

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Since publication of her article, the author reports no further potential conflict of interest.

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Brazil's Family Health Strategy

TO THE EDITOR: The Perspective article by Macinko and Harris (June 4 issue)¹ encourages us to contribute to the debate over health care in Brazil in order to clarify several key points. First, Brazil's community health agents have no specialized technical training, which prevents them from fully exercising the functions intended for them. Second, both physical facilities and human resources are inadequate, and examination quotas are insufficient to meet the demand. Health care coverage is often inefficient and provides low-quality services.² Third, poor integration between primary care and secondary and tertiary care overloads emergency departments. Fourth, underfunding by the federal government transfers responsibility to the states and municipalities,² which have to comply with a mandate to spend a particular percentage of total revenue on the health sector, but the fiscal-responsibility law prevents them from spending above the permitted limits. Fifth, there are an increasing number of lawsuits over obtaining medications and medical procedures that are not covered by primary health care. Access to medications and procedures is supported by the Brazilian constitution, which says that "Health is everyone's right and the duty of the state." Although the *Sistema Único de Saúde* (SUS) has positive indicators, there are many issues facing a system that is permanently under construction.

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No potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: Macinko and Harris present Brazil's Family Health Strategy (FHS) as successful. However, the authors describe the SUS as it is proposed in Brazilian law; that proposal is, regrettably, far from a reality. Even if their description were trustworthy, it must not be forgotten that the FHS does not work as a single entity apart from the whole system. In Brazil, the secondary-care and tertiary-care systems have failed.¹ Patients wait months for simple examinations, and they may wait years for many elective surgeries and consultation with some specialists.² Care is provided to sick patients in emergency departments, which are overcrowded, exposing patients and health care professionals to unsafe and unhealthy conditions.³ Specific FHS experiences do not represent the reality of the

SUS of this country, which has continental dimensions. The SUS is an excellent health assistance plan in theory; however, it has never worked as it was designed, and it is still far from doing so. Caution must be exercised before stating that the Brazilian system should be emulated by other countries.

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1. Justiça federal pode de decretar estado de emergência na saúde do Ceará (<http://g1.globo.com/ceara/noticia/2015/06/justica-federal-pode-decretar-estado-de-emergencia-na-saude-do-ceara.html>).
2. Consulta com especialistas no SUS chega a levar 4 anos em São José (<http://g1.globo.com/sp/vale-do-paraiba-regiao/noticia/2014/08/consulta-com-especialistas-no-sus-chega-levar-4-anos-em-sao-jose.html>).
3. “Me senti no dever do cumprimento da cidadania,” diz médica que desabafou por ajuda em hospital (<http://noticias.r7.com/rio-de-janeiro/noticias/-me-senti-no-dever-do-cumprimento-da-cidadania-diz-medica-que-desabafou-por-ajuda-em-hospital-20120603.html>).

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THE AUTHORS REPLY: Our primary objective in writing the Perspective article was to highlight innovative components of Brazil’s approach to primary care (the FHS) for U.S. audiences. An unexpected outcome was the lively debate the article stimulated in Brazil, as evidenced by these letters and extensive discussions on social media.

Trevisol and colleagues correctly note that community health agents receive limited technical training, but we disagree that this is a problem. The role of community health agents is explicitly nontechnical to ensure that they maintain their strong community-level identity and relationships. Their function is not to provide clinical care but to provide basic health promotion and act as community advocates and health system navigators. If local-level implementation of their training varies, the problem lies not with the policy but with local institutions and should be addressed at that level.

We agree with Trevisol et al. that resources are scarce in the Brazilian public health system (known as the SUS), and in our article we highlight this point as one of the principal weak-

nesses of the FHS. Geographic variation in funding, human resources, and quality is nearly a universal law in health care; Brazil is no different in this regard than many other countries. Although our article did not address secondary or tertiary care, its scarce supply or ineffective delivery could indeed erode the effectiveness of the FHS.

We take issue with Zavascki’s statement that our description is not “trustworthy.” Numerous high-quality, peer-reviewed articles document improvements in access,^{1,2} equity,³ and health outcomes^{4,5} among Brazilians served by the FHS. These findings stand in stark contrast to sensationalized media portrayals of the Brazilian health system, such as those Zavascki cites in his letter. As persons who have worked for over a decade in Brazil (J.M.) and in providing clinical care within the FHS itself (M.J.H.), we find it unfortunate that few people are aware of the hundreds of scientific articles documenting the important contributions of the FHS. This substantial body of scientific knowledge also does not shy away from highlighting the substantial needs of the FHS (and the SUS) for further improvement. Still, we remain hopeful that our article will encourage even more debate about the importance of community-based primary care in Brazil and elsewhere.

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Since publication of their article, the authors report no further potential conflict of interest.

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