The Unified Health System (SUS) in Brazil

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October | 2024

Brazil: characteristics

- ✓ Population: 203 millions (2023);
- ✓ High-middle income country;
- ✓ Around one-third of the population and Latin America´s GDP;
- ✓ Presidential republic since 1889 (periods of authoritarian rule);
- ✓ 20th century: State-led industrialization
- ✓ Federation: 26 states, a Federal District and 5570 municipalities;
- ✓ Demographic, epidemiological and social transitions;
- ✓ One of the world´s most unequal countries.

Health Policy's trajectory

- Public Health – since the late 19th century
  - ✓ State-building process;
  - ✓ Focus on control of specific diseases.
- Social Insurance – employment-based pensions and healthcare
  - ✓ 1930s – 1970s: gradual expansion for urban formal workers;
  - ✓ Since the 1960s: State incentives to private providers and companies.

- Late 1970s – early 1980s:
  - ✓ Criticism: Fragmented health system, limited and unequal coverage, ineffective health care, expanding private sector
  - ✓ Alternative proposals and local experiences

Democratic Transition and Health Reform(1980s)

- Economic crisis and democratization
- Unlike other Latin American countries, neoliberal reforms were NOT adopted;
- Public health sector actors, academics, social movements, legislators.

Constitution of 1988:

- Expansion of social rights.
- Social Security - universal: pensions, social welfare, health.
- Health as a right of citizenship and duty of the State.
- Creation of the Unified Health System (SUS)

Unified Health System (SUS): principles

- Public, universal, comprehensive;
- From health promotion to complex health care, including pharmaceutical care;
- Political-administrative decentralization, regional organization, from primary health care to tertiary hospitals;
- Social participation (from decision-making to ‘social control’);
- Tax – funded, non-contributive and free of charge;
- Strong State´s role in planning, regulation, funding and provision;
- Private services can be contracted-out by the SUS, to “complement” the public services, when necessary;
- Health private companies are free to operate but should be regulated by the State.

National Contexts (1990-2024)

- 1990-1992 (Collor) – Neoliberal reforms; crisis and impeachment
- 1993-1994 (Itamar) – Political coalition and transitional government
- 1995-2002 (FHC) – Political stability, different development projects
- 2003-2010 (Lula) - Political stability, expansion of distributive policies
- 2011-2015 (Dilma) – Strong political opposition led to increasing crisis
- 2016 – 2018 (Dilma-Temer) - impeachment – 'parliamentary coup' and neoliberal reforms
- 2018-2022 (Bolsonaro) - Neoliberal reforms, restrictions to social policies, threats to democracy; COVID-19 pandemic
- 2023-2024 (3rd Lula's term): Emphasis on national reconstruction and social inclusion

SUS – Institutional and decision-making framework

	Health Authority	Intergovernmental Committee	Participatory Council
National	Ministry of Health	Tripartite Committee	National Health Council
State *(26+DF)*	State Health Secretary	Bipartite Committees	State Health Councils
Municipal *(5570)*	Municipal Health Secretary	---	Municipal Health Councils

Health System Organization

Public	Stewardship and Regulation	Funding	Production/Delivery
Federal	- Ministry of Health - National health policies, norms and incentives; - National regulatory agencies (health surveillance, private insurance and industry)	- Around 45.7% of public spending; - Financial transfers to states and municipalities - Direct spending in strategic health programs	- Some reference laboratory and hospitals; - Fiocruz (STI; production of vacines, drugs, tests)
State (26) and DC	- State Health Secretaries - State health policies and programs	- Around 24.5% of public spending	- Some reference laboratories and hospitals; - Butantan (SP): vaccines, sérum; Other state producers
Municipal (5570)	- Municipal Health Secretaries - Contracting out & regulation of private providers	- Around 29.8% of public spending	- Primary health care, municipal hospitals;

Health System Organization

Private	Types	Funding
Health Care Services and Organizations	Hospitals, Clinics, laboratories, social organizations, individual practices	Public (SUS), private insurance and plans, out-of-pocket
Health Insurance and Health Plans	Insurance companies, pre-paid private plans and intermediaries	Private companies and individuals
Health Industry Companies	Producers of drugs, vaccines and supplies	Public (SUS), private services and organizations, individuals
Commerce (retail)	Pharmacies and others	Individuals

Health care coverage and access

- Universal right
- Increase in public healthcare services and coverage nationwide
- Expansion and changes in Primary Health Care
- Comprehensive national policies (HIV/AIDS, mental health, tobacco control)
- Creation of an agency to regulate private insurance companies

- Persistent territorial and social inequalities
- SUS-dependency on private providers;
- Expansion of private health insurance and services;
- State incentives and subsides to private sector;
- Increasing presence of big international corporations

Health financing

Increases in:

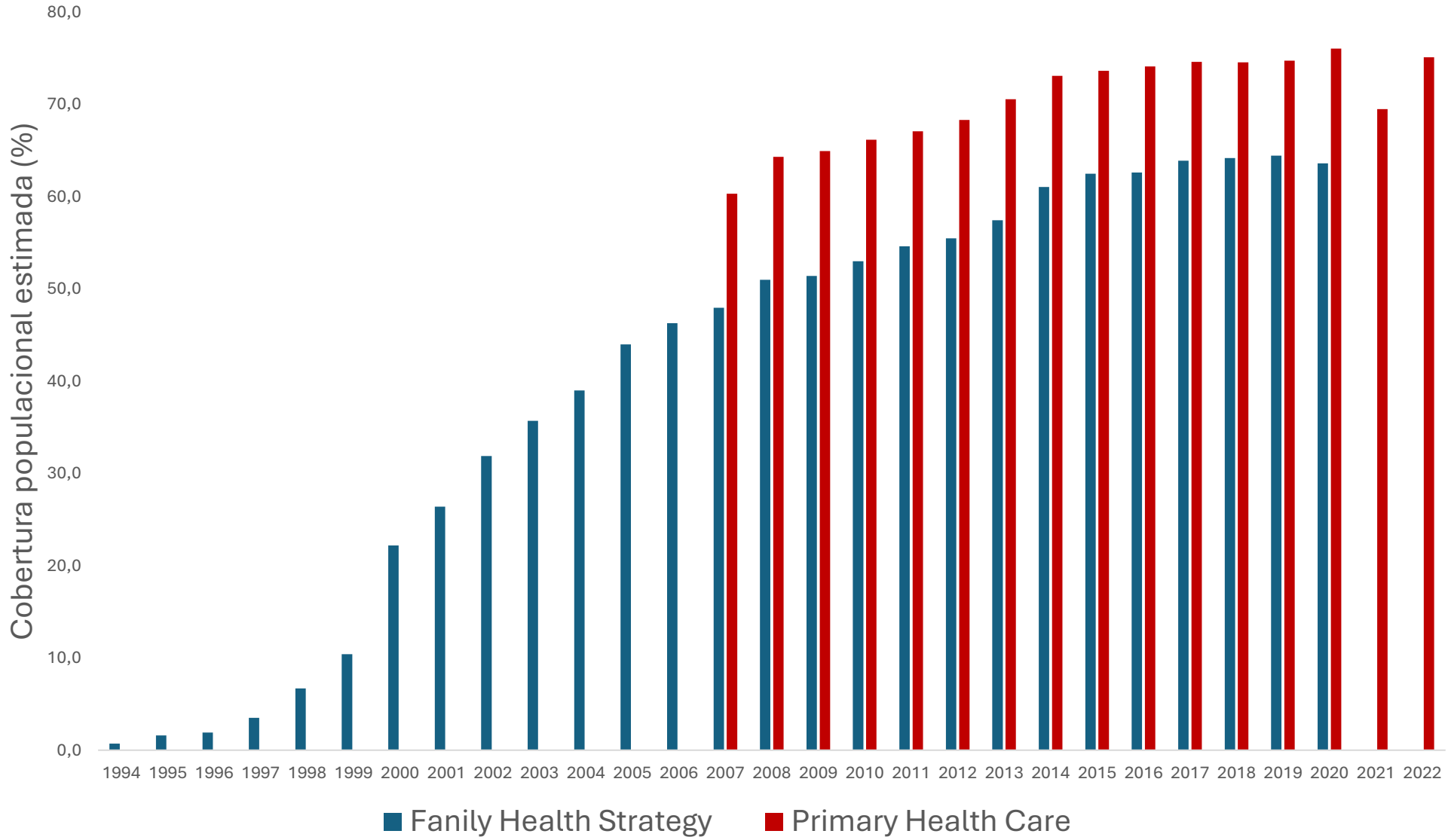
- Total amount of health expenditures
- Municipal and state expenditures in health;
- Federal fund transfers to strategic programs
- No co-payment in public services

- Public health expenditures remain low as a % of GDP (3.9%).
- Instability of financial sources and cost-containment;
- Relative decrease in federal participation in public spending
- High private expenditures in health (+50%), including out-of-pocket expenditures;
- Inequalities among regions and social groups

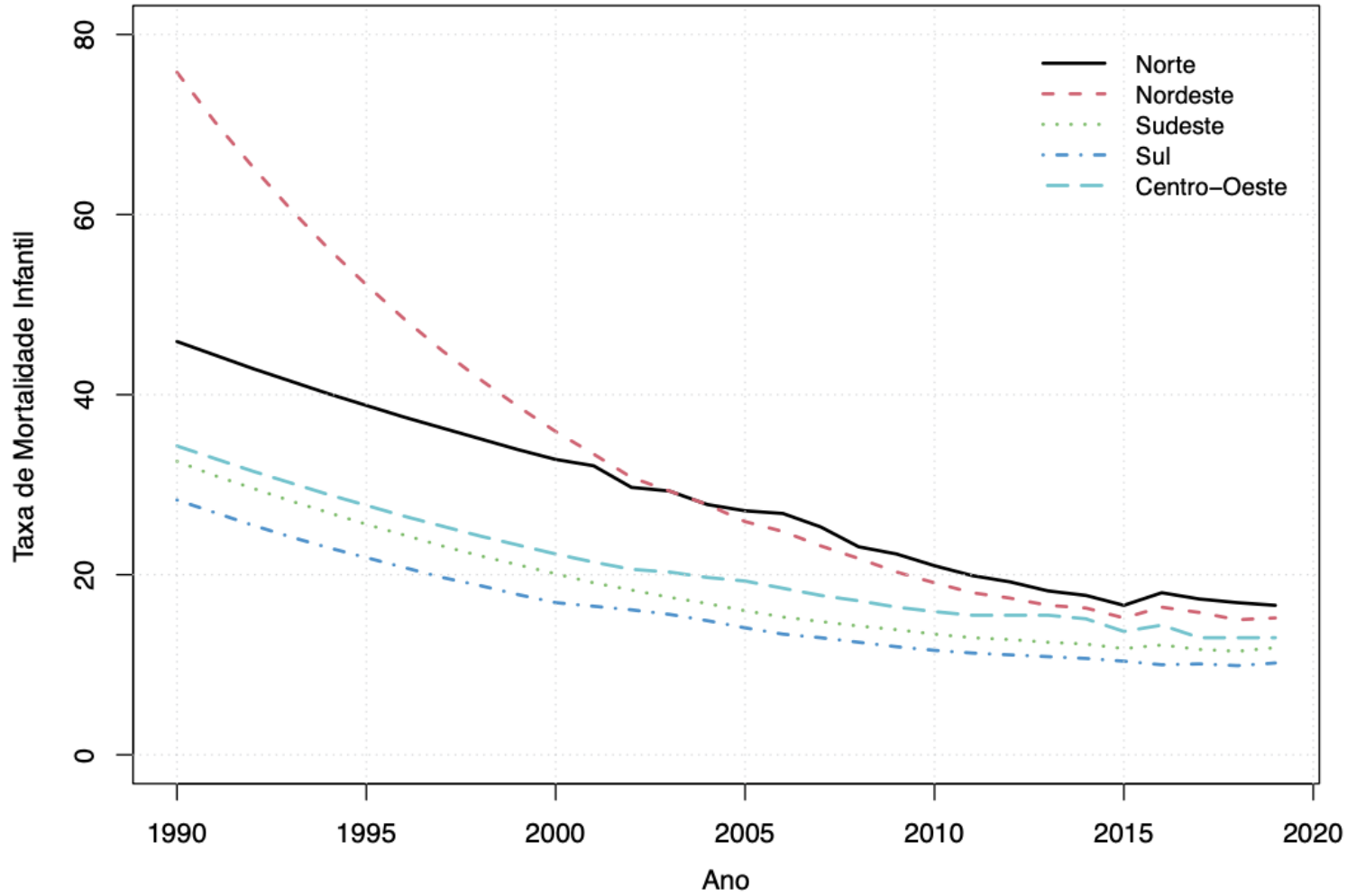
Family Health Program / Strategy

- From 1994 – priority national program; inspired by previous local experiences and the "community health agents" (ACS) program;
- Main strategy to expand and transform PHC;
- Incremental changes in health care organization, funding and delivery:
  - Multi professional 'basic' teams: doctor, nurse, nurse technician, ACS;
  - From 2001- oral health teams: dentists and dental technicians
  - From 2004 – Health Family Support Teams (Nasf) – teams of 5 specialists to support FHT
  - From 2013 – "More Doctors" Program
- Significant impact on health coverage, outcomes and inequalities.
- 2017-2022 – controversial changes in organization and funding.
- 2023 – 2024 – some previous initiatives are re-implemented (More Doctors)

Family Health Strategy and Primary Health Care Coverage Brazil, 1994 a 2022

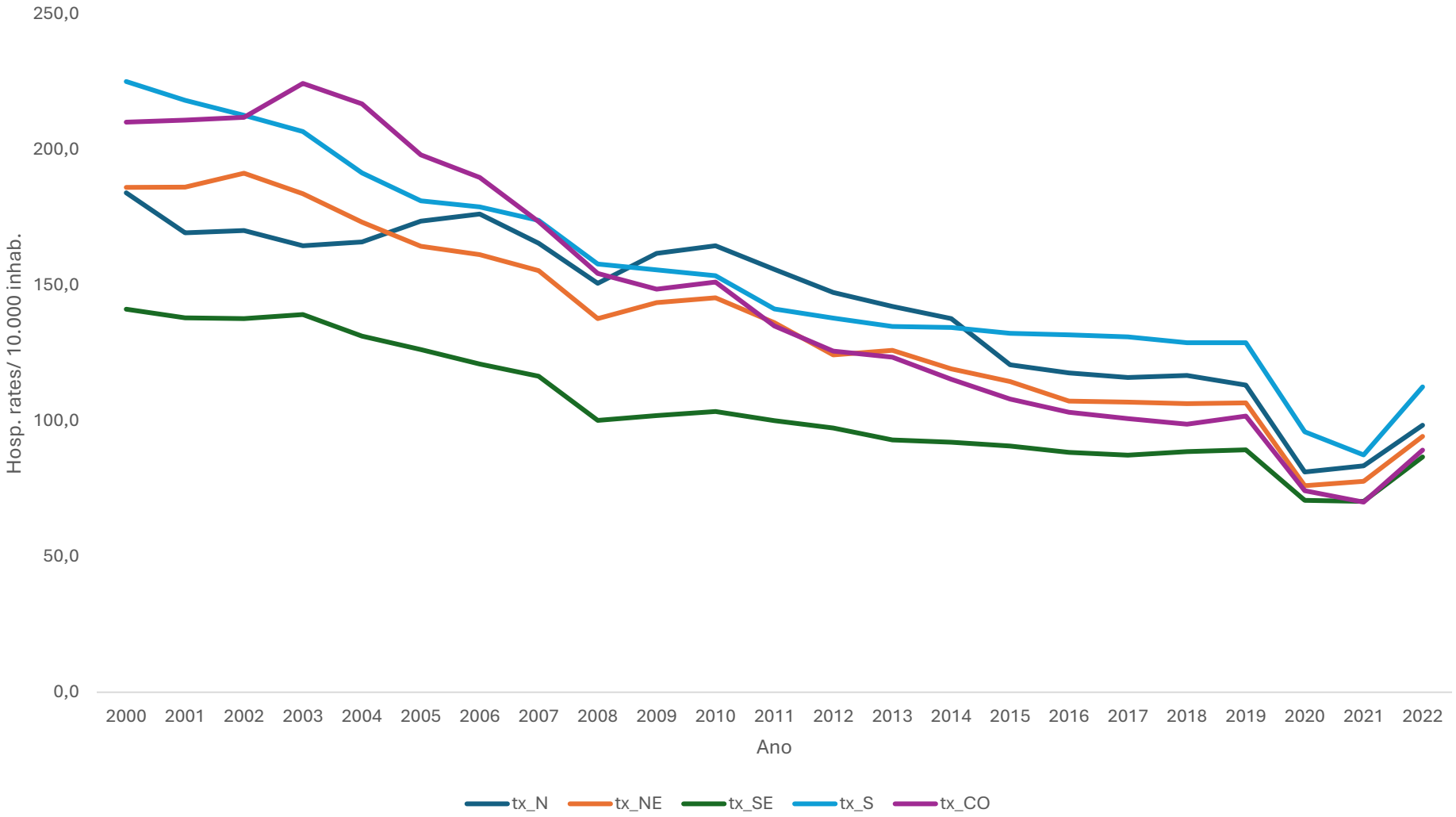


Infant mortality rates, by regions. Brazil , 1990 a 2019



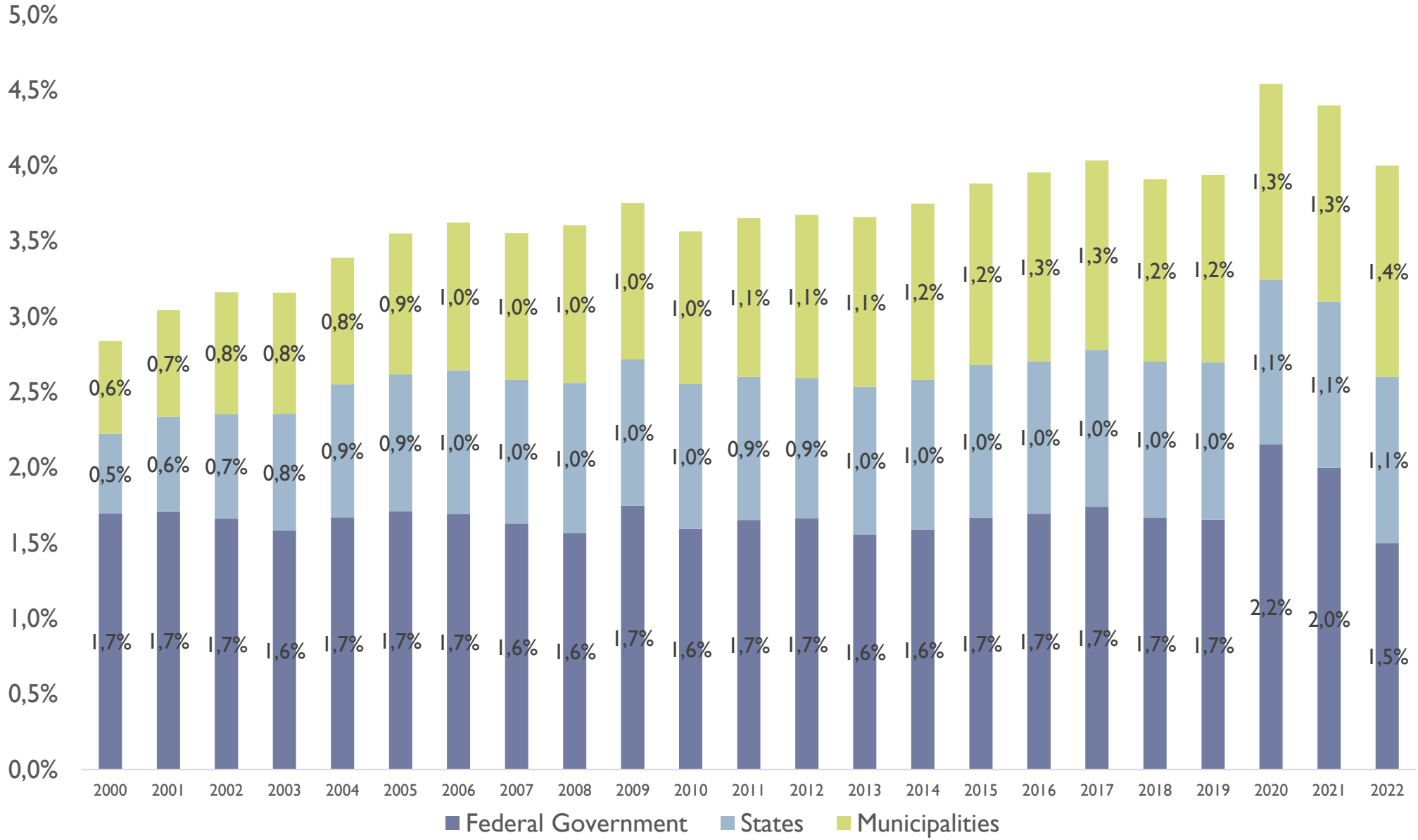
Fonte: Sinasc/SIM/Projeto de Busca Ativa.

Hospitalization rates by PHC-sensitive causes, by regions. Brazil, 2000-2022

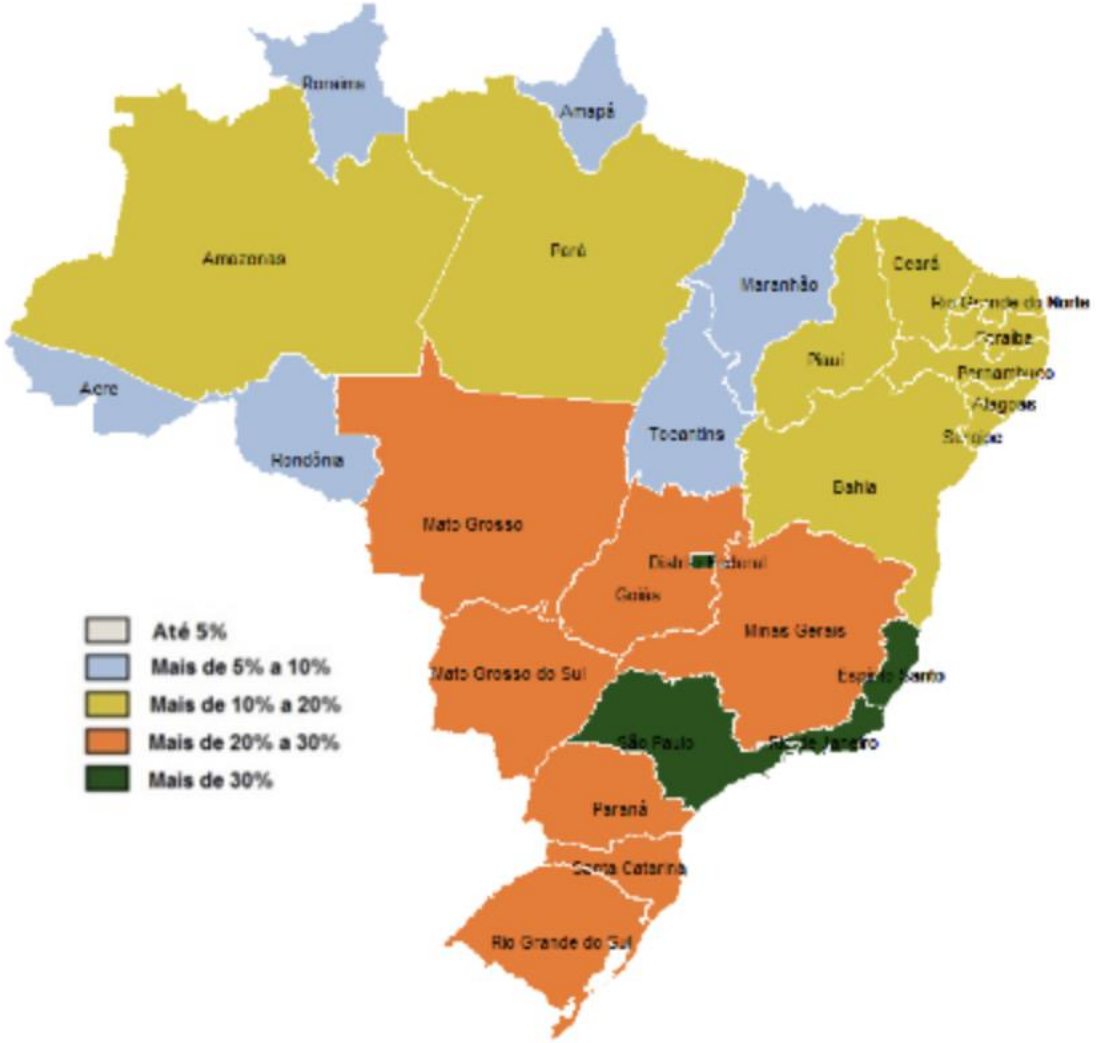


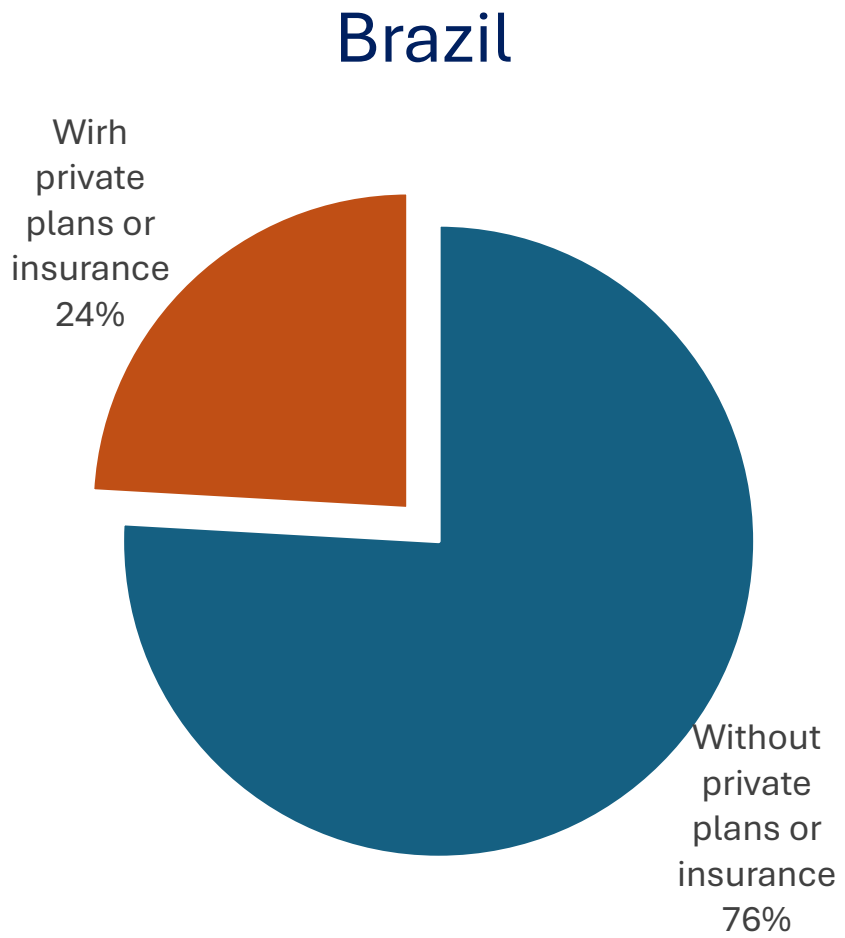
Source: SIH /Datasus (hospitalizations) and IBGE (Population). Calculated by the author's research grroup.

Public funding as a % of the GDP



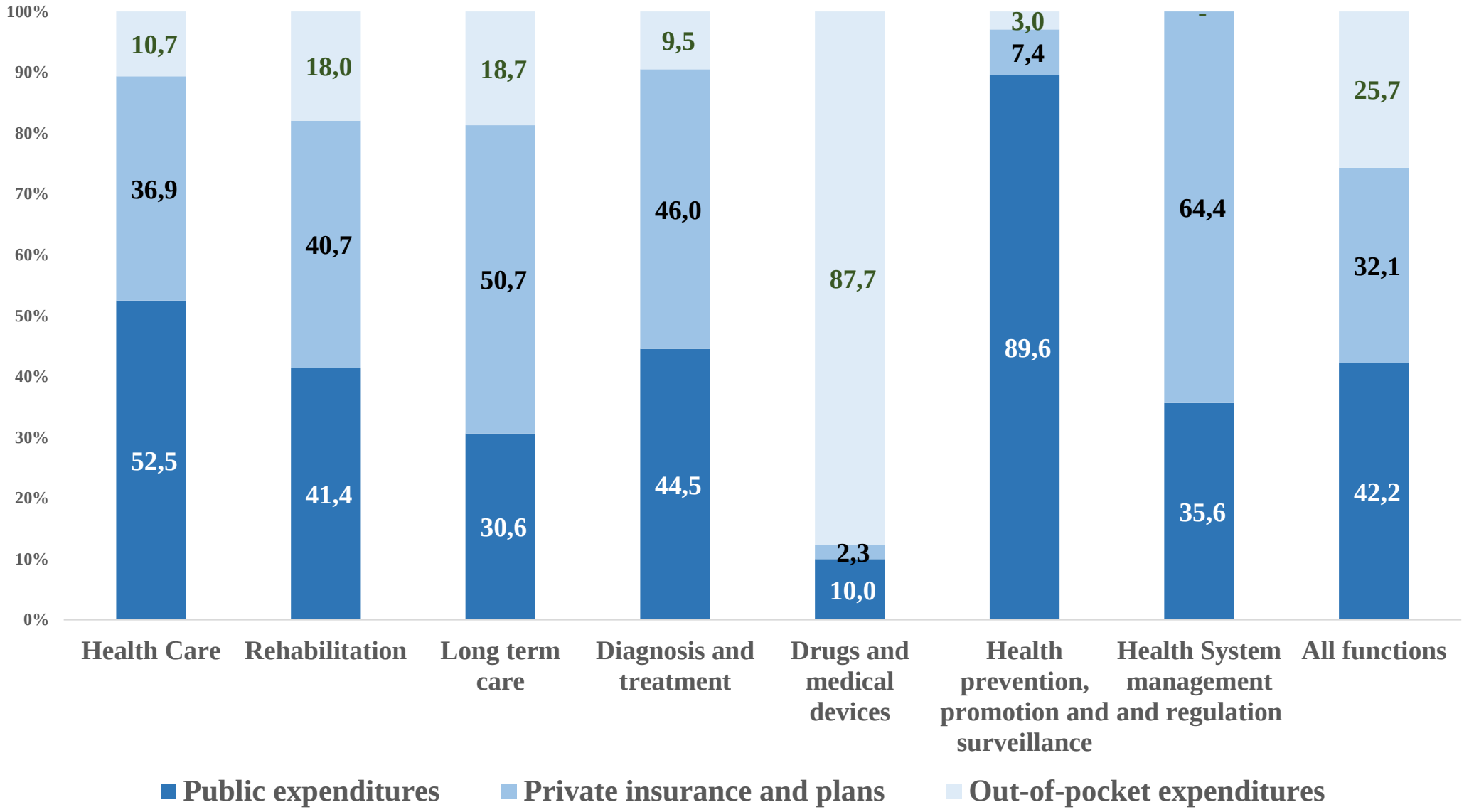
Private plans and private insurance coverage - 2020





Source: SIB – ANS/MS.

Public and private expenditures, by type. Brazil, 2019.



Source: Vieira e Benevides (2023) – Aula financiamento – Curso Introdução ao SUS, extraídos de Brasil (2022).

Final Remarks

- Advances:
  - Universal right to healthcare;
  - Institutional reforms and social participation;
  - Expansion of comprehensive policies and of public services´ coverage;
  - Improvements in health outcomes and some reduction in health inequalities.
- Insufficient public funding and the strength of the private sector have been the main obstacles to reduce health inequalities:
  - Increases in private provision in health care, subsidized by the State, parallel to the expansion of public services;
  - International and national health companies: new business´ and lobbying to expand markets and profits;
  - Persistent regional and social inequalities.
- Structural problems, private interests and politics play an important role in explaining the difficulties to consolidating the SUS.

Thank you!

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