# Brazil's Unified Health System: the fight for a universal right in an unequal country

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**Machado CV, Lima LD.**
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**Salud Publica Mex. 2024;66:726-731.**
*https://doi.org/10.21149/16309*

## Abstract

This article analyzes Brazil's Unified Health System (SUS), established by the 1988 Constitution. The papper initially presents the previous trajectory of national health policy and the context of democratization in the 1980s, which favored health reform and created a public, universal, and comprehensive health system. It then explores the advances and contradictions recorded in more than three decades of implementation of the SUS. The main advances observed were the creation of institutional mechanisms compatible with the federative arrangement and social participation, political and administrative decentralization, the national expansion of access to health, changes in the health care model, including strengthening primary care, and improvements in health indicators. On the other hand, the persistence of structural problems and disputes between different health agendas, with differences between governments, led to contradictions in financing and public-private relations in health. Despite the differences between countries, the analysis of the Brazilian case provides lessons on the challenges in building universal health systems in Latin America.

Keywords: health policies; health system; unified health system; Brazil; Latin America

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## Resumen

El artículo analiza el Sistema Único de Salud (SUS) de Brasil, establecido por la Constitución de 1988. Inicialmente, se analiza la trayectoria de la política nacional y de salud, y el contexto de democratización de los años 80 que favoreció la reforma sanitaria y la creación de un sistema de salud público, universal e integral. A continuación, se exploran los avances y contradicciones registrados en más de tres décadas de implementación del SUS. Los principales avances observados fueron la creación de mecanismos institucionales compatibles con el ordenamiento federativo y la participación social; la descentralización político-administrativa; la ampliación nacional del acceso a la salud; cambios en el modelo de atención, incluido el fortalecimiento de la atención primaria, y mejoras en los indicadores de salud. Por otro lado, la persistencia de problemas estructurales y disputas entre diferentes agendas de salud, con diferencias entre gobiernos, han llevado a contradicciones, expresadas en dificultades de financiamiento y relaciones público-privadas en salud. A pesar de las diferencias entre países, el análisis del caso brasileño trae lecciones sobre los desafíos a enfrentar en la construcción de sistemas universales de salud en América Latina.

Palabras clave: políticas de salud; sistema de salud; sistema único de salud; Brasil; América Latina

Brazil is a country of more than 200 million inhabitants, with an upper-middle income, large, federal, diverse, and profoundly unequal. It has been organized as a republic since 1889, comprising the Union, 26 states, a Federal District, and 5 568 municipalities. The presidential political system has a significant historical weight of the Federal Executive, although the 1988 Constitution promoted a better balance between

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**Received on:** August 28, 2024 • **Accepted on:** September 2, 2024 • **Published online:** September 17, 2024
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Powers and political-administrative decentralization. It is a nation marked by environmental, social, and cultural diversity, with numerous biomes and peoples and varied territorial dynamics, from the Amazon region to globally connected metropolises. Inequalities date back to centuries of colonization but were reiterated during the capitalist modernization in the 20th century, even during periods of economic growth when income concentration increased. Today, these inequalities are expressed in various dimensions - class, income, gender, ethnicity, race, territory, urban, and rural - with marked repercussions for the population's living conditions and health.

One of Brazil's peculiarities in Latin America is the existence of a public and universal health system, the Unified Health System (SUS), created during the democratization process in the 1980s. The only other country in the region with a universal health system is Cuba (since the Revolution). However, constructing the SUS in a capitalist and unequal Latin American country expresses challenges that are common to other nations. On the one hand, there are structural limits to the construction of universal social policies in countries on the 'periphery' of capitalism, dependent and unequal, in which national elites often articulate with international interests in maintaining the *status quo*. On the other hand, the intense political struggles of different social groups to extend their rights also impact health policy.

This article examines the progress and difficulties in implementing the SUS to draw lessons and identify the challenges that Brazil and other Latin American countries will have to face if health is to become a right for all.

## Background: health policies before the SUS

The organization of health policies in Brazil dates to the end of the 19th century and the beginning of the 20th century. In the First Republic, the State began to structure programs to control epidemic and endemic diseases that plagued the population and interfered with the country's economic activities.

Regarding public health, infectious disease control campaigns or programs were sometimes associated with primary health care in rural or urban areas. A peculiarity of Brazil was the creation at the beginning of the 20th century of public producers of vaccines and serums, such as the Federal Serotherapy Institute in Rio de Janeiro –which would later become the Oswaldo Cruz Foundation (Fiocruz)– and the Butantan Institute, in the state of São Paulo. In the following 120 years, these two organizations would be crucial to expanding public health actions.

From the 1930s onwards, the institutional configuration of health policy had a dual character, marked on the one hand by public health actions, with an emphasis on infectious diseases and, on the other, by the organization of health care for formal workers, linked to Social Security, in a logic of social insurance.[1] The dual trajectory of health policies can also be seen in other Latin American nations, albeit with different characteristics, timescales, and degrees of inclusion. The high proportion of informal employment in Brazil meant that Social Security included a small portion of the population. In addition, healthcare expansion was fragmented and segmented according to professional categories, which had access to differentiated benefits.

Since the 1960s, another phenomenon to highlight is the growth of private healthcare providers and companies under state subsidies and incentives. On the one hand, some Social Security institutes and later the National Institute of Medical Care for Social Security (INAMPS) expanded contracts with private hospitals to provide health care for their beneficiaries. On the other hand, private companies began to contract private health plans for their workers with tax subsidies. During the country's military dictatorship, from the 1964 coup to the mid-1980s, although access to health care improved, the "privatized medical care model" was consolidated, and the health industry grew, composed of different types of companies and market interests.

At the end of the 1970s, the Brazilian health system was centralized, fragmented, privatized, exclusionary, and ineffective regarding health results.

## Democratization, health reform, and the Unified Health System

The democratization process in Brazil in the 1980s, after 20 years of military dictatorship, included the gradual return to elections at the three government levels and intense social mobilization. The health reform movement emerged in this context, involving academics, health professionals, and several social movements.[2] While the societal actors engaged in health policies expanded, the "sanitaristas" – public health professionals – managed to occupy strategic institutional positions, promoting gradual changes within the state apparatus.[3]

Brazilian health reform was inspired by other countries with universal health systems—like the English National Health Service and the Italian health care reform—and involved critical analyses of the national health system's characteristics. An ambitious reform agenda was proposed, emphasizing health as a citizenship right. Some important milestones were the 8th National Health Conference, with more than 4 000 participants, and the work of the

National Health Reform Commission, whose proposals influenced the National Constituent Assembly.[4,5]

The 1988 Federal Constitution established, for the first time in Brazilian history, health as a right of all and a duty of the state.[6] It also recognized the importance of integrating economic and social policies to guarantee improvements in the population's living conditions and health. The Unified Health System (SUS) is defined in the Organic Health Law of 1990 as: "the set of public health actions and services, provided by federal, state and municipal public bodies and institutions, direct and indirect administration and foundations maintained by the Public Power".[7] The system covers outpatient services, hospitals, diagnostic and therapeutic support units, environmental interventions, health surveillance and quality control, research, and the production of health supplies and technologies. The SUS also includes a wide range of private organizations and services, which the State contracts out.

The principles and guidelines of the SUS include:

1. Universality of access at all levels of care: All citizens have the right to access health actions and services, regardless of their complexity or cost. This principle replaced the previous social insurance model, which limited access to certain social groups and promoted the sharing of health costs between different income groups.
2. Equality in health care, without prejudice or privilege of any kind: Access to health services must be equitable, without discrimination based on income, race/color, gender, or religion. Only differentiated health needs should guide access and technologies in health care.
3. Comprehensive care: Health care must be continuous and integrated, covering preventive and curative actions at all complexity levels. Comprehensiveness also requires the articulation of economic and social policies to address the determinants of health.
4. Community participation: The population must formulate guidelines and priorities for health policy and monitor and evaluate health actions and services.
5. Political-administrative decentralization: Decentralization implies greater responsibility and decision-making autonomy for state and municipal health authorities in implementing health policies and managing health services, which should be organized by levels of care (hierarchization) according to specific regional needs (regionalization).

Given the wide range of SUS actions and services, the state's legal responsibilities in health are extensive. These require partnerships with other sectors, such as science and technology, education, urbanization, and industrial policies. Consistent with the federative and democratic scenario, the SUS also requires intergovernmental coordination and articulation between the state and society.

## Advances and difficulties in 35 years of SUS implementation

Following the promulgation of the 1988 Constitution, the implementation of the SUS began against an adverse backdrop. The 1990s were marked on the one hand by democratization and on the other by economic liberalism. Throughout successive governments, there were conflicts between the progressive agenda of expanding rights and strengthening social policies and the neoliberal agenda, which advocated containing public spending and downsizing the state. Tensions persisted in the following decades, with government differences.[8]

Despite the disputes between projects, significant advances were made in building a public and universal system and expanding the right to health.

The first group of advances relates to constructing an institutional framework compatible with the SUS project, which considers the need for institutional unification, federative coordination, political-administrative decentralization, and social participation. The process of institutional unification began with the recognition of the Ministry of Health as the sole national health authority, with the incorporation and subsequent extinction of INAMPS. This was the first step towards coordinating public health and healthcare actions, both collective and individual, which until then had been the responsibility of different state bodies. The unification process was complex, as it involved integrating different institutional cultures, types of programs, service networks, groups of professionals, and, above all, users who were recognized as citizens with a universal right to health. The "new" Ministry of Health became responsible for several functions, programs, actions, professionals, and financial resources that until then had been dispersed. In the following decades, the structure of the Ministry of Health was successively adapted. Analogous to the institutional unification at the national level, significant organizational changes also occurred at the state and municipal levels, following the "single command in each sphere of government" guideline.

Another relevant institutional change was the creation of intergovernmental health policy coordination bodies, in line with Brazil's federative arrangement, in which municipalities are responsible for implementing health policies. In the first half of the 1990s, the

Tripartite Intergovernmental Commission (*Comissão Intergestores Tripartite*) began to operate at the national level, comprised of representatives from the Ministry of Health, state health departments, and municipal health departments. Bipartite Intergovernmental Commissions were set up within each state, with representation from the respective state secretariats and municipal health secretariats. Initially created by administrative rules, the intergovernmental committees were incorporated into the SUS legislation. The institutionalization of these bodies was important in intergovernmental negotiations regarding decentralization, division of responsibilities, and federative coordination of health policies.[9] There are differences between the state commissions regarding their institutionality and capacity.[10]

Adopting a comprehensive conception of health favored the creation of intersectoral commissions to handle the implementation of policies that required articulation between areas of government and society, such as food and nutrition security policies[11] and tobacco control,[12] among others.

Political-administrative decentralization in health has been intense in recent decades, given its presence in the two national agendas influencing health policies: the progressive health reform agenda and the neoliberal state reform agenda. In the SUS agenda, decentralization is linked to democratization and responding to the population's health needs. In contrast, this guideline is associated with reducing the State and public spending in the neoliberal agenda. The decentralization process in the SUS expressed tensions, sometimes occurring under inappropriate conditions and with discrepancies between the decentralization dimensions of power, responsibilities, services, people, and services. However, the process was firmly coordinated by the Ministry of Health through national rules and financial incentives and negotiated in intergovernmental health commissions.

Another institutional advance, in line with the guideline of social participation, was the creation of participatory health councils in the three spheres of government, with representation from users, health authorities, professionals, and service providers. The health councils are deliberative and participate in policy formulation and social control. In addition, National Health Conferences are held every four years to define health policy priorities. Formal instances of social participation have been essential for implementing the SUS and the defense of the right to health, even during times of crisis and setbacks, such as during neoliberal governments and in the face of the Covid-19 pandemic.

The second group of advances relates to expanding access to health actions and services throughout the country, changing the healthcare model, and implementing comprehensive national policies. In this sense, we should highlight the creation of national programs for community health agents in 1991 and Family Health in 1994. Both were unified and renamed years later as the Family Health Strategy (ESF), adopted as the basis for expanding access, changing the healthcare model, and strengthening primary healthcare. Its characteristics include multi-professional teams of doctors, nurses, nursing technicians, and community health workers; orientation towards the family, the community, and the territory; commitment to comprehensive care (from promotion to health care); and continuity of care, including coordination with other healthcare levels. Subsequently, oral health professionals would be incorporated into the FHS teams, and support centers would be proposed to include other health professionals.[13]

In addition to the ESF, the SUS has favored the expansion of other policies based on comprehensive care, such as the national HIV / AIDS control policy and tobacco control policies, which have projected Brazil internationally. Also significant were the transformations in mental health care, promoted since the 1980s and intensified with the SUS, including the closure of hospitals and the expansion of outpatient psychosocial care centers. Over three decades, several universal and comprehensive programs and policies would be expanded, providing gradual advances in health access. There were also increases in specialized and hospital services, including highly complex ones, with the organization of healthcare networks aimed at different problems, such as cardiovascular diseases, oncology, and organ transplants.

The third group of advances was the improvement of numerous health indicators. There was an increase in vaccination coverage and prenatal care, among other actions, favoring the reduction of infant mortality, maternal mortality, hospitalizations, and deaths from preventable causes, with an increase in life expectancy.[14]

On the other hand, the implementation of the SUS revealed structural limits and contradictions in the face of conflicting social policy projects, which still pose challenges to consolidating the SUS and reducing health inequalities.

The first limit is the difficulty in guaranteeing the availability of health professionals and strategic supplies for the SUS. The expansion of services throughout the country increased the number of health professionals in the public system and the need for medicines, vaccines, and other supplies necessary to comply with the principle of comprehensive health. However, the neoliberal State reform agenda in the 1990s hindered the expansion of professionals in sufficient numbers and adequate working conditions in the SUS. Furthermore, it led to

setbacks in the national industry that harmed domestic production and increased the SUS's dependence on imported supplies and equipment. In part, the supply of vaccines and medicines to the SUS was favored by the existence of long-standing public producers, such as Fiocruz, a federal institution, the Butantan Institute in São Paulo, and other state producers.

From the 2000s onwards, the adoption of initiatives to address these two strategic dimensions gained prominence on the national agenda. The Lula and Dilma governments used the "health economic-industrial complex" approach[15] to emphasize that the health sector can virtuously articulate development's economic and social dimensions by generating qualified jobs and encompassing dynamic and innovative industrial segments. However, difficulties would persist, given global asymmetries, the recurrence of economic austerity agendas, and corporate interests.

Another critical limitation concerns financing. In recent decades, public spending on health has stayed at most 4% of gross domestic product (GDP), except in 2020 and 2021, when extraordinary budgetary credits were provided to deal with the Covid-19 pandemic. In public spending, there was an increase in federal transfers to subnational spheres and in the participation of states and municipalities in health financing. The federal government's share of public spending on health fell from 59.8% in 2000[16] to 37.5% in 2022,[17] while that of states and municipalities reached 28.4% and 34%, respectively, in the last year.[17] While restrictions on public health financing were observed, there was an increase in private spending on health, which was subsidized by the state.

The most apparent contradiction lies in public-private relations in healthcare in Brazil. Over three decades, despite the advances made by the public system, the private sector, which had been growing since the 1960s, expanded and diversified. The SUS also depended on contracting private providers, especially hospitals and diagnostic and therapeutic support services. Health plans and insurance companies grew and became more dynamic, reaching almost a quarter of the population, with regional differences. Although state regulation, which became more structured in the 2000s, has been essential for establishing minimum rules and protecting consumers, more is needed to contain the growth of this sector. The importance of the private sector is reflected in the high private spending on healthcare in Brazil, which reaches more than 50% of total healthcare spending, which is contradictory to the existence of a public and universal system. The most significant proportion of private expenditures is spending on health plans and health insurance, especially among middle- and high-income groups. Out-of-pocket expenditures are also prominent, representing the highest proportion of private spending in low-income families, especially for purchasing medicines. The dynamism of private health markets, under state subsidies and incentives, means that different health companies seek new spaces and compete for resources from the State and families, which makes it challenging to consolidate the SUS and reduce health inequalities.

## Conclusion: challenges for universal health in Latin America

The SUS has made significant progress over the past three decades. However, its implementation was influenced by historical-structural limits and conflicting agendas that influenced social and health policies. Furthermore, differences were observed between governments with different political orientations, which affected health.[8]

Although Latin American countries have health systems with varied trajectories and characteristics, common structural problems challenge consolidating health as a right for everyone. The Brazilian experience in health provides relevant lessons about the challenges of building a public and universal health system in a large, complex, and unequal Latin American country.

The first lesson is the importance of affirming the duty of the State, strengthening public policies, and establishing the principles of the health system of universality and comprehensiveness as fundamental to the fight for rights and the reduction of health inequalities. Even in the face of limits and contradictions, the SUS allowed advances that would not have been possible if institutional segmentation had been maintained.

The second lesson concerns the relevance of adopting institutional mechanisms for coordination between spheres of government and between areas of policy to ensure articulation in the implementation of health policies. Governance bodies must also consider social participation in democratic contexts. In the Brazilian experience, intergovernmental commissions and health councils were essential to SUS governance and to avoid setbacks in contexts of neoliberal, conservative, and antidemocratic governments.

The third lesson concerns the importance of strengthening primary health care, linking to other levels of care, and expanding comprehensive policies to address various health problems in the context of demographic, epidemiological, and social changes.

The fourth lesson relates to the need to ensure stable, sufficient, and adequate public financing conditions for expanding public health services throughout the country, guaranteeing access, and reducing health inequalities. Despite some expansion of resources and the adoption of redistributive mechanisms, insufficient financing has been an obstacle to the consolidation of the SUS.

The fifth lesson concerns the recognition that expanding the public health system depends on the availability of qualified health professionals and sufficient health supplies with adequate distribution throughout the country. The SUS has weaknesses in this area, endorsing the need to build stable and well-paid public health careers and invest in the national production of strategic supplies to guarantee access and reduce dependence on imports.

The sixth lesson is the imperative to regulate the private health sector, containing its growth and subordinating it to public interests. The dynamism of private segments, subsidized by the State, is the central contradiction of the Brazilian health system. Peripheral capitalist countries need to adopt policies that contain the growth of health markets, which include international and national companies, preventing profit interests from overriding values of collectivity and social solidarity. The regulation of health markets depends on the general characteristics of State-market relations and the role of social policies in the national development model.

A final lesson is the importance of greater coordination between Latin American countries and other developing countries to address global asymmetries in health. South-South cooperation in health is essential in the struggle for a less unequal world in which all people have the right to health and decent living conditions.

## Acknowledgments

CV Machado and LD de Lima are supported by the National Council for Scientific and Technological Development of Brazil-CNPq (Research Productivity Grants) and by Carlos Chagas Filho Research Foundation- Faperj (Distinguished Scientist Grants and Research Group Grant).

*Declaration of conflict of interests*. The authors declare that they have no conflict of interests

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