



The Potential and Challenges of A Unified Health System

Ulysséa Leal D*

Federal University of Vicosa, Brazil

***Corresponding author:** Daniela de Ulysséa Leal, Federal University of Vicosa, Brazil, Email: dulyleal@gmail.com

Editorial

Volume 7 Issue 1

Received Date: February 06, 2024

Published Date: February 12, 2024

DOI: 10.23880/jqhe-16000362

Keywords: Unified Health System; Primary Care; Secondary Care; Tertiary Care

Abbreviations: SUS: Unified Health System; WHO: World Health Organization; SADT: Diagnostic and Therapeutic Support Services; ESF: Family Health Strategy; HRH: Human Resources for Health.

Editorial

The Covid-19 pandemic has claimed more than 700,000 victims in Brazil since 2020, putting the world's largest public health system to the test. The Brazilian Unified Health System (SUS) has provided medicines, beds, rapid tests and laboratory surveillance free of charge, playing a significant role in tackling this health crisis. The current Brazilian Constitution, promulgated in 1988 and also known as the Citizen Constitution, for having extended essential rights to society, established a dynamic and complex health system, the Unified Health System (SUS). The SUS serves more than 190 million people every year, fully and free of charge. It aims to provide comprehensive and universal preventive and curative care through decentralized management and provision of health services, promoting community participation at all levels of government.

The SUS represents an achievement of society and of movements to reform the Brazilian health sector, which had been organized since the early 1970s, along with democratic aspirations in the midst of the dictatorship. There was a call for public policies of a social nature that would promote equal and universal access to health, the demands of a plurality of historical subjects, of various clashes between the intentions of social subjects and structural limitations. The Health Reform movement relied on mobilization in universities and user organizations and was led by groups of doctors and other professionals concerned about public health, who developed theses and took part in political discussions [1].

Health care systems have been defined by the World Health Organization (WHO) as a set of activities whose primary purpose is to promote, restore and maintain the health of a population. Regardless of how they organize their health care systems, two fundamental beliefs prevail in countries in general: health has an intrinsic value for people and health services are necessary to maintain and prolong life and relieve suffering. In addition, health care systems accompany people throughout their lives, and they are generally born and die in the facilities of these systems, especially in hospitals. This is why different societies have the same objectives for their health care systems [2].

The Organic Health Law, Law 8080 of September 19, 1990, which regulates health actions and services throughout the national territory, states in Article 2 that "health is a fundamental right of the human being, and the State must provide the indispensable conditions for its full exercise". Thus, the state's relationship with the population is defined by the principles of universality (health as a right for all), equity (equality with attention to differences) and integrality (the multidimensionality of health). Integrality is related to the integral condition of the human being, considering that the health system must be prepared to listen to the user, understand them in their social context and, from there, meet their demands and needs. Many SUS users have linked comprehensive health action to respectful, dignified treatment, with quality and a welcoming atmosphere. In addition to these principles, there are the strategic principles, which refer to the political, organizational and operational guidelines that indicate "how" the "system" we want to shape should be built, such as Decentralization, Regionalization, Hierarchization and Social Participation [3].

With the implementation of the SUS, enormous social inclusion was achieved by ensuring the same coverage of health services for all Brazilians, overcoming the division that had existed until then between urban and rural workers and

between those who contributed to the social security system and those who did not. However, the implementation of the SUS was complicated by state support for the private sector, the concentration of health services in the most developed regions and chronic underfunding.

The organization of the Health Care Network in the SUS regulates levels of care and health assistance, namely: primary care, secondary care and tertiary care. Primary Health Care aims to offer universal access and comprehensive services, coordinate and expand coverage to more complex levels of care (e.g. specialized and hospital care), as well as implement intersectoral health promotion and disease prevention actions at the individual and collective levels. In Primary Care, professional teams are divided into: Family Health, Riverside Family Health, Prisons, Street Clinics, Primary Care, Oral Health, among other strategies. This level of health care has expanded its coverage in the country through the Family Health Strategy (ESF), which began to be implemented in the mid-1990s.

Specialized care is organized in a hierarchical and regionalized way, strategically integrating the Health Care Network, operational in conjunction and in harmony with Primary Care in order to foster continuity of care according to the population's health needs. It is divided into two elements (secondary and tertiary care), which are, respectively, medium and high complexity (outpatient and specialized hospital). The vast majority of primary care and emergency units are public, while hospitals, outpatient clinics and diagnostic and therapeutic support services (SADT) are mostly private. However, the provision of specialized services is hampered by poor integration between providers at municipal and state level, especially in the provision of diagnostic support tests [4].

SUS actions go beyond medical and hospital care. The system also carries out other important actions in cities, in the countryside, at borders, ports and airports, such as disease prevention, vaccination and control. It carries out permanent surveillance of sanitary conditions, sanitation, environments, occupational safety and the hygiene of establishments and services. It regulates the registration of medicines, supplies and equipment, controls the quality of food and its handling. It standardizes services and sets standards to ensure greater health protection. It also has important health information systems, such as the SUS Hospital Information System and the Family Health Program, which reaches almost 94% of the total Brazilian population [5].

Due to the principle of decentralization of management and health policies in the country, the municipality should be valued as a locus of possibility for the construction of health care, configuring itself as a potential space for high

capillarity social participation networks. The cooperative and supportive relationship between municipal management and state management, forming a regionalized model, represents the concrete possibility of building comprehensive health care. As the reality of the country's regions is very diverse, due to socio-political and cultural dynamics and geographical scope, the demands, needs and potential can vary, making the decentralization strategy fundamental. The SUS is financed by three levels of government (federal, state and municipal), general taxes, social contributions, direct disbursements and employer spending. Public sources are linked to the social security budget and private sources are complementary. Law 141/2012 establishes that municipalities and states invest, respectively, 15% and 12% of their revenues in the SUS, and the Union invests the amount from the previous year plus the variation in GDP [6].

Participatory management governs the day-to-day management processes of the SUS, a cross-cutting strategy that enables formulation and deliberation by a group of players in the social control process. To this end, it requires the adoption of practices and mechanisms that ensure the participation of health professionals and the community. This management model brings together approximately 100,000 councillors and integrates networks and social movements.

Despite being recognized by the World Health Organization in 2008 as a model health system, the SUS has faced problems since its creation, especially in the area of financing. The instability of health spending parameters jeopardizes one of the greatest achievements of Brazilian society. As a result, the SUS has less public resources to meet the health needs of the population than was foreseen when the system was created, with the aim of becoming a universal and equitable health system in Brazil, financed with public resources. This financing reality has an impact on the coverage and quality of the services offered.

The SUS is also faced with the need to respond to a complex health situation, influenced by social determinants with still adverse indicators, reflected in poverty, inequality, violence, education and sanitation, among others. Overcoming inequalities in living conditions between Brazilian regions and between the units of the Federation is a major challenge, as Brazil has a territorial extension of 8,514,876 km². And its area corresponds to approximately 20.8% of the area of the whole of the Americas and 48% of South America. The population of Brazil's Northeast region, for example, has a life expectancy at birth five years lower than that of the South.

In addition, Brazil is undergoing a demographic transition, as it has experienced a significant slowdown in population growth in recent years, a reduction in fertility

and early mortality rates, an increase in life expectancy at birth and the consequent ageing of the population. This trend represents a potential increase in demand for health services, particularly in relation to chronic diseases, the incidence of which is higher in older age groups. The SUS is also challenged by Brazil's epidemiological profile, in which chronic diseases and external causes are responsible for the majority of deaths, while infectious diseases still maintain an important weight on the morbidity burden, due to their epidemiological diversity and epidemic cycles. This multiple burden is mainly concentrated in the most socially and economically vulnerable groups, as a result of the deep inequalities that still persist in Brazil [7].

The availability of health professionals with relevant skills, in sufficient numbers, allocated where they are needed, motivated, involved and supported is essential for the management and delivery of health services in all countries. The imbalance in the workforce, such as geographical maldistribution and, in particular, the lack of qualified Human Resources for Health (HRH) in rural or underserved regions, is a social and political problem that affects almost all countries. Shortages and imbalances in the distribution of the health workforce are social and political problems that, together with socioeconomic inequality, reduce the population's access to health services [8].

In order to face these challenges, it is necessary to draw up an agenda that seeks appropriate technical and managerial solutions and, fundamentally, to renew the commitment to a universalist social policy for health, which has the capacity to respond to the complex reality that Brazil is experiencing.

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