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EDITORIAL

More Specialists Program: Contexts and expectations

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THE LEGAL FRAMEWORK OF THE UNIFIED HEALTH SYSTEM (SUS) establishes the prominence and interdependence of ethical and social values articulated with strategic guidelines aimed at guaranteeing universal access to health as a social right. Over the course of its implementation, the SUS has accumulated regulations that seek not only to carry out techno-assistance procedures, provide and consume biomedical services, but above all to provide comprehensive care with the promotion, protection and recovery (assistance, rehabilitation, reintegration) of health, with universality and equity. Likewise, the SUS has regulations to implement the guideline of social and community participation, which has been consolidated in social control and in the defense of health as a constitutional right.

Any government policy initiatives that establish social rights achievements with redistributive equity of resources and universal access to comprehensive health goods and services require innovative, viable, and progressively sustainable institutional strategies. Furthermore, such institutional innovations also require correlated social strategies, aiming to be recognized and legitimized by the population, both in terms of their usefulness and effectiveness, as well as their added ethical and social values.

Certainly, there is a set of institutional strategies that are essential for the viability and consistency of the SUS in essential terms and with a view to historical permanence, such as financing, professional work, comprehensive care, regional organization, technological sufficiency and appropriation and social control, among others. From the same perspective, specific and incremental programmatic strategies were created, aimed at integrating and operationalizing the set of institutional strategies anchored in the determined priorities.

In order to maximize proactive strategic synergies, specific programmatic innovations must be consistent with the principles and guidelines of the SUS and must be concatenated with each other, constituting a cohesive architecture capable of growth and consolidation in terms of social utility. Otherwise, programmatic innovations that are devoid of constitutional meaning and disjointed from each other can lead to shapeless and fragmented arrangements, often even counterproductive to the original scope of the public policy.

For this reason, whenever specific strategic innovations are implemented, especially those of a programmatic and incremental nature, it is important to analyze, in addition to the announced purposes and the respective normative measures, their coherence and synergistic and proactive potential in the sense of the constitutional architecture and guidelines of the SUS

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Of course, it is also important to analyze the broader political context surrounding the sectoral environment from which the programmatic innovations in question emerge, as well as the current circumstances and their prospects, at least in the short and medium term. This is because, obviously, there are multi-determined scenarios of a political, dialectical, and complex nature that pose difficulties, but also strategic opportunities.

Particularly when it comes to programmatic innovations to guarantee comprehensive health care, such as specialized assistance, this scrutiny becomes even more substantial because the historical debt of inequities and lack of care persists. Furthermore, this is an arena in which the omission of the public sector has allowed the private sector to become predominant, requiring interdependence between the public and private sectors. The strategic design for providing comprehensive care with specialties, in the short term, must necessarily be based on relationships that can be cooperative and complementary or competitive, but tend to replace the private sector.

Since the period prior to the SUS, when the National Institute of Medical Assistance of Social Security (INAMPS) was in force, significant segments of the private sector, both for-profit and non-profit, were fed with subsidies and grants and maintained with public resources, establishing relationships of financial dependence and technical assistance that persist to this day[1]. There was an unequivocal densification and concentration of the activities of these private segments, complementary to the SUS, in certain types of specialized technical assistance procedures, constituting niches and quasi-market dynamics, with their own mechanisms of access, regulation and even financing.

Furthermore, in view of the constitutional text, in its articles 197 and 199[2], the regulatory framework for the public-private relationship in the health field has been weak and insufficient, both to establish the appropriate sense of complementarity in terms of the public interest and to curb biases and inequities in access to and use of specialized services.

Although there is legislation regulating the normative requirements for the formation, organization and operation of Health Regions defined by Decree No. 7.508/2011[3], there are still notorious organizational and logistical shortcomings to increase and make this regional arrangement effective. There are currently 439 Health Regions in the country; however, most of them do not meet the established legal requirements and, therefore, have not formalized their respective Organizational Contracts for Public Health Actions (COAPS), an essential tool for organizing protocols and demand flows for Specialized Care, as well as for offering lines of care to be operated in networks—that is, coordinated and integrated by Primary and Specialized Care teams and services.

Without strategically targeted public investment to redistribute professional work, appropriate technologies and comprehensive services in Health Regions with notorious shortcomings, there is a persistent concentration of resources, techno-healthcare densification and specialized services in metropolitan regions, especially in the capital cities, which has led to overloaded demands, long waiting lines and inequities in access. In addition, as a large part of the specialized private services, complementary to the SUS, are located in the Southeast, South and metropolitan regions, government strategies for the regional redistribution of public investments and costs in Specialized Care would imply gradual shifts in resources, disfiguring techno-assistance oligopolies established since the 1970s[4].

Another aspect to be added to the picture is the difficulty of the SUS in effectively organizing the training and distribution of the professional workforce as established in Article 200 of the Federal Constitution of 1988[2], based on identified social and epidemiological needs and selected priority demands. When it comes to specialized assistance, the distribution of health professionals requires

regional offerings compatible with these needs and demands, as well as institutional strategies for retaining and retaining workers in these regions.

The institutional strategies and logistics established for the regulation of specialized assistance, as well as the complex regulatory mechanisms already in place, have been insufficient to manage and overcome the numerous shortcomings and difficulties. In short, the SUS has seen the perpetuation of bottlenecks and inequities in guaranteeing access, care and rehabilitation in Specialized Care, whether for outpatient and inpatient care in the Medium and High Complexity (MAC), or for Diagnostic and Therapeutic Support Services (SADT). It can be said that inequities have persisted for a long time, as a chronic situation with periods of aggravation, as observed in the post-COVID-19 pandemic, causing enormous suffering in the population, duly publicized by the media as 'crises', which are repeated.

It is also important to contextualize the issue of Specialized Care within the context of public financing, systemic reorganization, and the social effectiveness of Specialized Care, considering the biases, setbacks, and contingencies imposed during the implementation of the SUS due to the continuation of government policies dominated by neoliberal orientation. These are genostructural trends, such as the 'financialization' of public budgets, generating contingencies in social spending; the migration of state institutions from the aegis of Public Law to Private Law, with the internalization of rationality restricted to terms of business cost-effectiveness; the assignment to third parties of government regulatory prerogatives, health authority, and public management; the collateral presence of precarious regimes for the exploitation of public services; among other situations that hinder and limit the fullness and consolidation of the constitutional SUS.

Over the past few decades, there has been a succession of government initiatives and measures aimed at so-called fiscal adjustments, including the Fiscal Stabilization Fund, the Unbundling of Federal Revenues, the Spending Cap, and, more recently, the Fiscal Framework Regime. All of these adjustments not only hindered progressive investments and structural reforms essential for the consolidation of the SUS—financing, public work regimes and processes, comprehensive care modeling, regionalization, technological self-sufficiency etc.—but also reinforced its dependence on the private sector for specialized services, which, according to the Constitution, should have a complementary role.

Having summarized some contextual aspects of the highlighted issue, it is worth reiterating that, although institutional and programmatic innovations may include services, increase access by mitigating inequities and lack of assistance, improve processes and functionalities, and add utility values to public health goods and services, governmental and social strategies aimed at subverting and overcoming the degrading trends highlighted in this analysis cannot be restricted to the sectoral and programmatic scopes of health policies. The viability and consolidation of universal, equitable, comprehensive, and participatory public policies, as advocated by the Federal Constitution[2], require new provisions and commitments for economic and social policies of public interest[5].

The recent government initiative to implement the programmatic strategy generically titled 'More Specialists' (with derivatives such as 'Now There Are Specialists', 'More Access to Specialists' etc.) proposes a coordinated set of interventions to mitigate and address the problem of specialized assistance. The aims announced are to guarantee access to consultations, exams and specialized procedures as quickly as possible and with less bureaucracy, for more than 160 million people who could potentially benefit from them[6].

The institutional strategies concatenated in the 'More Access to Specialists' program began under Minister Nísia Trindade and were finalized and presented under the current ministerial administration of Alexandre Padilha.

According to a report from the Ministry of Health, by mid-July 2025, all states and 99.2% of Brazilian municipalities had signed up to the proposal[7]. It is a coordinated set of generic and specific proposals that provide for: accreditation of private clinics and hospitals with the SUS; expansion of public health facilities, logistical resources, and services; exchange of debts from the private sector, both complementary and supplementary to the SUS (pending reimbursements to the SUS), for specialized assistance required by the project; expansion of telehealth services; training of specialist physicians; increased care provided via mobile devices (trucks etc.) and joint efforts for specialized procedures; improvement of clinical protocols and therapeutic guidelines; among others. For the initial implementation of these measures, the Ministry of Health established six priority specialties: oncology, gynecology, cardiology, orthopedics, ophthalmology and otorhinolaryngology[6].

It can be seen that, in the case of an incremental programmatic strategy at sector level, with a short-term perspective, the aim was to articulate interdependent and synergistic initiatives, such as fostering and increasing the systemic participation of the private sector, which provides and owns the largest volume of establishments, equipment and specialized services that will be used to refer SUS patients.

In the short and medium term, it is possible that this programmatic strategy, with its derivations and concatenated measures, could effectively address the bottleneck, increase access, re-establish referral flows, organize priority lines of care and improve the criteria and terms of regulation for specialized assistance. Certainly, if there is such an increase and improvement, the tendency would be to mitigate resource shortages and even pre-existing systemic problems, producing an expansion of services and positive impacts on the health demands of individuals and populations, which justifies this initiative and the new incremental arrangement.

It is essential to warn, however, that in the medium and long term, as well as in an expanded perspective for the scope and scale of the public health sector, this programmatic strategy is not accompanied by interventions, even incremental ones, that would be essential to guarantee changes and sustain the related proposals, such as: redistribution of resources and deconcentration of public services aimed at making feasible and consolidating the architecture of networks and the process of regionalization or Health Regions; reorganization of work regimes and processes for health teams in the SUS; gradual and sustainable reduction of technical assistance dependence on the private sector; reinforcement of the regulatory capacity of the public sector in relation to the private sector; reinforcement of the attribute of coordination of comprehensive care based on strengthening the attributions of Primary Health Care (PHC) and qualification and strengthening of PHC to organize the comprehensive care network based on the needs and demands of the population.

Additionally, the viability and consolidation of Health Regions is essential to re-establish flows and guarantee access to Specialized Care in proximity itineraries, in terms of recursive scale and more equitable scope and comprehensive care. In the same vein, Health Regions are essential for ensuring support for PHC network, health surveillance and other changes in the model of care. However, this depends on the redistribution of public resources for investments and costs, which are now concentrated in a few regions (mostly metropolitan areas) where the private network predominates.

There is also a concentration of specialized professional occupations in just a few regions of the country. For the most part, these are workforces hired out to third parties and operated in a precarious way, particularly in the case of certain professional occupations. The training of specialists remains under corporate control, and its distribution and establishment are subordinated to market logic. Changing

this situation requires the implementation of a work system and careers compatible with the SUS, based on social needs and health priorities.

In this context, as the public sector has the smallest proportion of specialized establishments, technologies and services, and has no control over the training, distribution and retention of specialists, its regulatory capacity is compromised. Corporations from specialized segments compete for public resources, notably procedural values in the SUS Table, while establishing market intervention, translated, for example, into 'double and triple doors' that discriminate against SUS patients. In addition, the logistics adopted for regulating access to specialized services has not prioritized situational analyses and georeferencing for demand flows and care itineraries, maintaining the rigidity of care schedules inherited from the old INAMPS. There is an urgent need to redefine institutional strategies and initiatives that make it possible to establish criteria, logistics and terms for public regulation, based on social needs and care priorities, with a view to comprehensive health care and not just the consumption of biomedical procedures regulated by market corporations.

Moreover, it is not enough to improve the records, means and terms of referral from the PHC network to specialized assistance. PHC must be equipped with training to expand their resources, as well as logistical prerogatives to effectively coordinate the care of individuals, families and communities. It is also essential to redefine institutional strategies that reinforce the counter-referral of specialized assistance to PHC, returning those leaving this care to PHC monitoring.

As explained, the aforementioned program presents incremental strategic alternatives to address the problems of healthcare gaps, inequities, and a lack of specialized assistance. However, its objectives must be short-, medium-, and long-term, which requires defining structural strategies for expanding the public sector and progressively weaning it from dependence on the private sector, reducing its relative size. Given the current opportunity, it is important to combine the more specific, short-term initiatives contained in 'More specialists' with other synergistic structural measures aligned with the constitutional design of the SUS.

Collaborators

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