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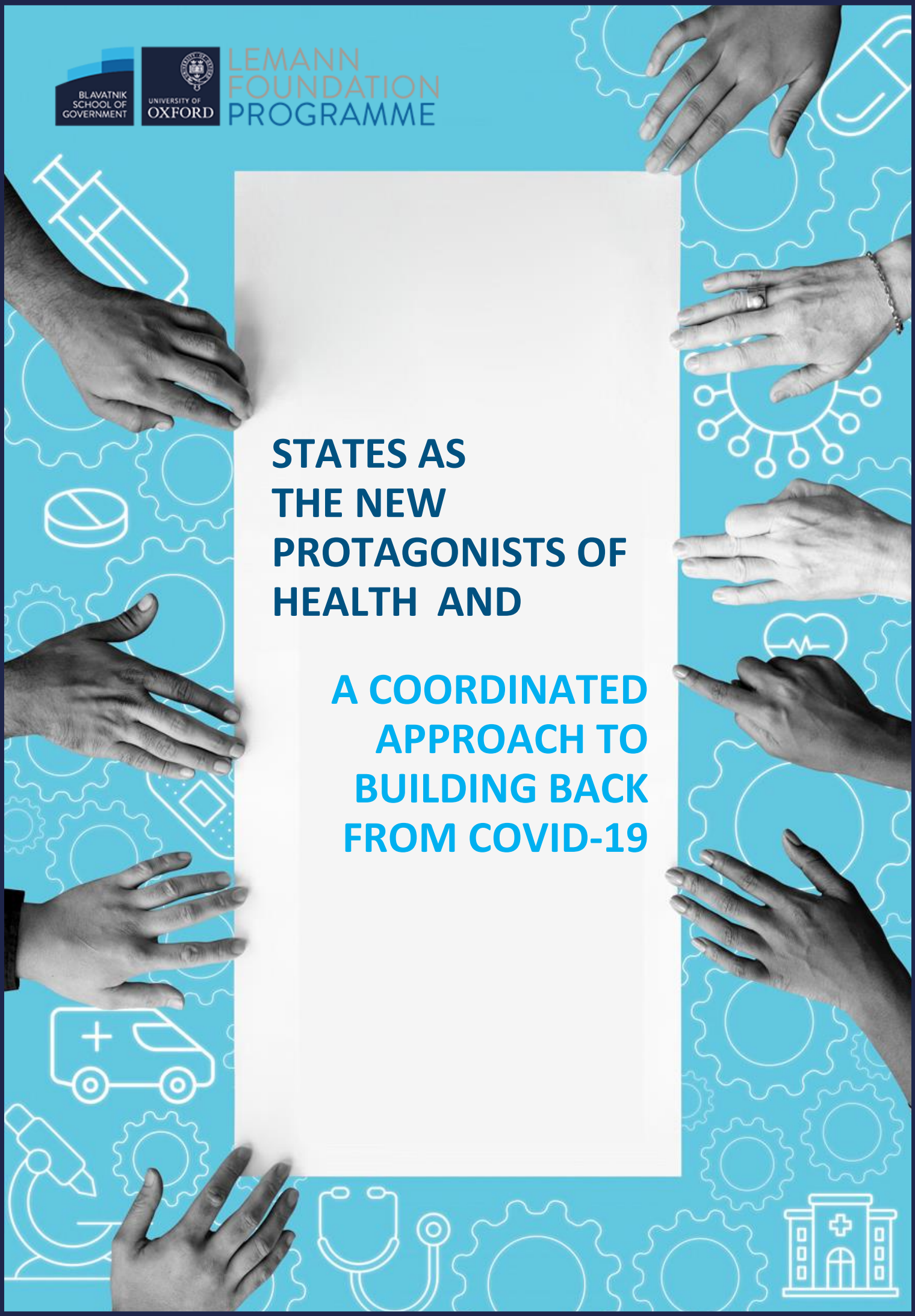

STATES AS THE NEW PROTAGONISTS OF HEALTH AND

A COORDINATED APPROACH TO BUILDING BACK FROM COVID-19

This report[I] is based on a series of interviews conducted in early 2022 with state health secretaries and other important stakeholders in Brazil's public health system and aims to inform and support state administrations in the country. It explores lessons on coordination arising from the pandemic period and outlines pathways for greater productive coordination moving forward in order to address the challenges of building back from COVID-19 and regionalisation of health.

After analysing the behaviour of state health secretaries during the pandemic, and recognising the immense challenges they had to overcome, this report recommends that state administrations when possible select health secretaries that are likely to remain for at least one entire term. This would allow for greater learning, trust-building, and for relationships among state health secretaries to develop over longer periods of time, facilitating coordination.

The experience of coordination during the pandemic also shows that despite great advancements, state administrations will need to maintain efforts to make health data more robust and integrated. It also advises that the structures which successfully managed coordination during the pandemic – and particularly CONASS – should continue to be strengthened in order to push forward new agendas.

This report also highlights the five areas within public health that Brazilian policymakers should pay greater attention to, in order to build back from the COVID-19 pandemic: the backlog of elective surgeries and missed diagnosis, changes in risk factors for chronic diseases, mental health, long-COVID, and immunisation.

CONTENTS

[I] This policy brief was developed by research assistant João Pedro Caleiro under the supervision of Anna Petherick , as part of the work of the Lemann Foundation Programme for the Public Sector at the Blavatnik School of Government, University of Oxford. Policy recommendations reflect discussions with interviewees as well as with members of the Lemann Foundation Programme team, Filipe Recch, Lia Pessoa, and Beatriz Kira.

BACKGROUND

Health consistently shows up near the top of the list of the biggest concerns of Brazilians since at least 2019[i]. Last June, it ranked just below unemployment and corruption[ii]. Brazil was also one of the most badly affected countries by COVID-19 by several absolute and relative measures: it has the second highest number of absolute deaths, the 16th highest number of deaths relative to population[iii], and is in the 31st position in excess deaths per capita[iv].

This tragic outcome has emerged despite the strengths of Brazil's free and universal public health system (SUS). SUS is the largest public health system in the world; no other country with over 100 million inhabitants provides universal free health care, and interestingly, those who use SUS have a better evaluation of its services than those who do not. And over the last thirty years, SUS had gained experience fighting previous epidemics, such as zika and chikungunya, and has established the largest preventative family health program in the world. Its multidisciplinary teams offer advice and follow-up checks to more than 60% of the population, reaching more than 80% in some statesv.

Historically, Brazil has pioneered several successful health initiatives - it was the first developing country to provide universal free access to antiretroviralsvi and is also regarded as a model in tobacco controlvii. In one of the most unequal countries in the world[viii], SUS is an equalising force, serving as the primary source of care for three out of four Brazilians. But this national average conceals vast inequalities in access and capabilities that were exposed, and sometimes deepened by, the COVID-19 challenge, particularly due to a lack of coordination.

During the pandemic, the Brazilian federal government did not seek national coordination on non-pharmaceutical interventions (NPIs), such as social distancing, and there were disputes since the start pertaining to even minor matters[ix]. Subnational actors, and particularly states, were left to lead the effort against the pandemic through institutional arrangements, old and new, including CONASS and Consórcio Nordeste, as well as dozens of new intra-state structures. This experience provides lessons on coordination between different state governments, inside these governments, and between states and other institutions, which could be of great value moving forward.

— The role of states in SUS

- Over time, states and municipalities have absorbed a larger share of SUS' responsibilities and financing due to increased decentralization combined with a retreat from the federal level
- Extreme levels of inequality in per capita health spending between states remain

States and municipalities had been taking a more prominent role in SUS since before the pandemic, particularly in funding. One reason for this shift is that due to decentralisation, municipalities are responsible for providing all levels of care – from primary to high complexity – and are held politically accountable for it, incentivizing mayors to fund health. Another factor is the structural problems of federal underfinancing, especially since 2014. Programs initially introduced with an adequate level of funding at the federal level, in areas such as primary care, could not be sustained over time, leaving municipalities to fill the gap.

Between 2004 and 2019, the share of total public health spending by the federal government fell seven percentage points, from 49.1% to 42.1%, fully compensated by an equivalent rise in municipal spending from 24.8% to 31.4%. The share of total public health spending by the states, meanwhile, was constant at 26%[x].

However, among Brazil's state governments, there is huge variation in public health spending. For example, on average, per capita Brazilians cost the public health system R$ 1,398 in 2019, and, on average, R$ 366 of this amount was paid by state government (with R$ 590 by the federal government, and R$ 441 by the municipalities)[xi]. Yet when state-by-state per capita spending for that year is compared, total per capita expenses range from R$ 787 in Pará to more than double — R$ 1,770 — in Roraima (see Table 1).

State	Federal expense	State expense	Municipal expense	Total per capita
Roraima	511.03	967.85	291.41	1,770.29
Tocantins	499.24	772.17	329.78	1,601.18
Mato Grosso do Sul	413.39	488.86	611.90	1,514.14
Acre	467.92	721.88	200.78	1,390.59
Mato Grosso	378.60	448.58	543.50	1,370.68
São Paulo	310.80	389.72	652.70	1,353.23
Santa Catarina	389.22	400.48	549.62	1,339.33
Rio Grande do Sul	482.90	372.84	466.39	1,322.13
Paraná	383.21	345.13	512.78	1,241.12
Espírito Santo	349.53	497.45	377.08	1,224.06
Rondônia	395.01	475.13	343.30	1,213.44
Rio de Janeiro	488.14	289.57	430.02	1,207.73
Amapá	330.49	688.06	166.31	1,184.86
Minas Gerais	373.20	317.34	469.37	1,159.91
Piauí	473.04	309.05	357.49	1,139.58
Sergipe	399.85	389.02	293.66	1,082.53
Rio Grande do Norte	373.62	323.76	369.16	1,066.54
Goiás	336.58	335.35	370.92	1,042.85
Alagoas	452.73	300.21	264.22	1,017.16
Pernambuco	393.21	347.02	274.00	1,014.23
Amazonas	265.91	453.61	281.50	1,001.02
Paraíba	411.53	296.90	289.57	998.00
Ceará	394.54	285.44	309.07	989.06
Bahia	360.32	272.04	291.97	924.33
Maranhão	345.00	263.87	223.95	823.81
Pará	272.23	278.75	236.08	787.07
Federal District	2,311.64	1,260.79	—	3,572.43
National	188,30	—	—	188,30
Gasto per capita	**R$ 590,43**	**R$ 366,22**	**R$ 441.88**	**R$ 1,398.53**

Expenses with Actions and Public Services in Health (2019)
Source: SIOP/SIOPS/MS
Elaboration: CFM

1. PATTERNS OF CONFLICT AND COOPERATION DURING THE PANDEMIC

- The federal government decided not to undertake national coordination of non-pharmaceutical measures during the pandemic and challenged decisions taken on the subnational level, particularly by states
- This conflictual relationship between the central government and states remained for the entire pandemic period
- State governments led the reaction to the pandemic with the assistance of new structures, including *scientific committees* and *crisis committees,* cited as a source of mutual learning between states, and as key to decision making inside states
- We recommend that state administrations identify and evaluate what worked well or not in these structures, and consider emulating or maintaining them in some format to tackle challenges ahead

There is no definitive take on federations being less successful against the pandemic in comparison to unitary systems, as countries in both systems have performed well or poorly. However, conflicts between the central government and sub-national actors have been common across federal countries, though the nature of these conflicts has varied. In some countries, it was provinces (or states) resisting attempts at coordination by the central government, claiming too much centralisation. Brazil is one of the few cases in which the pandemic response was almost exclusively led by subnational actors, most notably the states.

Federalisation is at the heart of the Brazilian 1988 Constitution, and SUS is sometimes pointed as the most successful example of its model of shared responsibilities. The articulation and negotiation of SUS guidelines are managed through the Tripartite Intermanagement Commission (CIT), with equal representation of the Union, the states, and municipalities[xii]. That balance, however, was not stably managed during the pandemic.

The Supreme Court ruled early on that governors and mayors had competence to determine their own restrictive measures[xiii], but stated that it did not preclude the federal government from establishing coordination. The lack of national coordination turned out to be problematic in many respects, such as managing the shortage of PPE (personal protective equipment), oxygen, medical kits for intubation, and testing.

Virtually all state health secretaries interviewed for this report described a strained and conflictual relationship with the federal health ministry, reporting lack of trust, delays, and failures in communication, which they attributed mainly to problems of personnel instability, lack of political will, technical capacity, and willingness for open dialogue among those in leadership positions.

However, it would be overstating the point to paint a picture of completely binary opposition between the federal government and the states. In the case of "precocious treatment" through the use of unproven drugs pushed by the federal government, for example, 14 states also advocated or allowed for their use through their local guidelines.

The federal government established an inter-ministerial committee to "supervise and monitor the impacts" of COVID-19[xiv] in March 2020 but would only establish a national crisis committee in March 2021[xv]. Both committees did not have representatives from states or municipalities. Local measures were challenged

by federal actors, placing additional burden on subnational structures: all states created at least one crisis committee before the end of March 2020, including nine before the pandemic was officially declared by the WHO.

In total, 69 new structures would be created at the state level for coordinating the response to the pandemic. Their responsibilities were often narrow, and their actual roles thus sometimes unclear and untransparent[xvi]. However, these structures were mentioned by most (if not all) state health secretaries as a source of mutual learning between states, and as key to the decision processes inside states.

These structures can be divided into 1. *scientific committees*, or *knowledge broker structures,* either interdisciplinary or focused on health professionals, which function was to produce and filter evidence to inform and guide policy decisions made under time pressure and uncertain circumstances; and 2. *crisis committees*, whose main goal was facilitating coordination between different government departments.

Many of these state committees also included members of the judiciary, such as members of the state prosecutor's office and the state attorney's office. State health secretaries lauded this move as a pre-emptive way to avoid later judicial challenges and blame-attribution, as the overreach of control bodies paralysing public policy is a topic of concern among public managers[xvii].

We recommend that state administrations identify and evaluate what worked well or not in the structures created to filter information and enhance cooperation inside their states, and consider emulating or maintaining them in some format to tackle challenges ahead.

— Cooperation on the ground

- There is no evidence of sustained horizontal coordination of measures against COVID-19 between states, and coincidental timelines seems to have been driven by common internal factors
- However, there is plenty of anecdotal evidence of mutual learning, solidarity, transfers of patients and exchanges of supplies
- There are reported incidents of political backlash to coordination, competitive dynamics between states and conflictual relationships between state and municipal governments
- Data gathering and management is central to coordination and should be an important focus for state governments going forward

The fact that states had virtually similar measures enacted at similar timelines in the 2020 period of the pandemic, as shown by Oxford Covid-19 Government Response Tracker (OxCGRT) data[xviii], does not by itself prove horizontal coordination, but rather expresses common features and concerns. According to one study[xix], policy stringency in Brazil was driven by internal factors of the reality in each state, such as healthcare capacity, population size, inequality, and human development.

However, interviews with the state health secretaries point to several episodes of cooperation, mutual learning and solidarity between the states, most notably in the transfer of sick patients from Amazonas and

informal exchanges of medical supplies. In interviews with them, the state health secretaries mentioned competitive dynamics between states as well, particularly in terms of which state would liberalise the use of masks first. Most instances described not coordination as such (i.e., co-created policies), but constant communication and sharing of experiences.

Initiatives of interstate cooperation were not immune to political backlash, however. One health secretary mentioned becoming a target of public criticism inside the state after the decision was made to receive patients from Amazonas, on the basis that it would reduce availability for local patients; although officials claim there was a comfortable level of idle capacity.

There were multiple mentions of the role played by OPAS (Pan American Health Organisation), and relationships with municipalities were reported by the state health secretaries as mostly harmonic, though sometimes they reproduced internally, within the states, the conflicted dynamic with the federal government. Another state health secretary highlighted that one of the most challenging aspects of handling the pandemic was the opposition to its measures by the municipal government of the state's capital city.

The interviews also point out to the important role of data management for handling the pandemic, which would recommend a renewed focus on more centralized information from themes ranging from strategic supplies to the emerging issues of the building back agenda. Mariel Deak, who was part of the committee for COVID-19 in São Paulo, emphasised the rationalisation and integration of fragmented data systems as both the largest challenge during the pandemic and the most important step moving forward: "There can be no coordinated management without a coordinated database".

— Spotlight on CONASS

- CONASS's credibility, technical team and modus operandi, unique among interstate thematic councils, were built historically and turned out to be well suited to address the pandemic challenge
- CONASS comes out of the pandemic period strengthened as a nexus of cooperation between states and with the potential to advance different agendas

Brazil has several interstate thematic councils. The finance council, Conselho Nacional de Política Fazendária (CONFAZ), was the first one, created in 1975. Similar councils exist in other areas like education (CONSED, from 1986), Justice, Citizenship, Human Rights and Penitentiary Administration (CONSEJ, from 1999), administration (CONSAD, from 2000), with slight variations of structure and objectives, and different levels of protagonism in public policy debates. Our focus will be on one entity that took an important role in coordinating between states in the pandemic: CONASS.

The National Council of Secretaries of Health (CONASS) is a private law entity that gathers the state health secretaries and their legal substitutes from the 26 states and the Federal District. CONASS predates SUS: it was created in 1982, and its role as the representative entity for the states in the aforementioned CITE would only be recognized in 2011[xx], bridging the gap between its deliberative and institutional roles.

CONASS is based in Brasilia and has an executive secretary, about 50 employees and an annual budget of 12 million reais[xxi]. Its board has five members, each a state health secretary from one of the five regions of Brazil, as well as a president and vice-president, chosen by CONASS' general assembly[xxii] through an

open vote and often by unanimity. More than one state health secretary interviewee independently mentioned that CONASS acts "towards the average", meaning that it aims for consensus in decision-making.

The pandemic first entered the CONASS agenda in early 2020, before there were any COVID-19 cases in Brazil. The state health secretaries mentioned that decisions were at first not strongly coordinated, but the rapidly changing context led to further exchanges and attempts at unity and coordination, much of it informally, through a WhatsApp group.

Some landmarks for the process of internal unity against external pressures were the exit of Brazil's health minister Luiz Henrique Mandetta in mid-April[xxiii] 2020 and the decision by the federal government to stop publicising COVID-19 data in early Junexxiv 2020, leading CONASS to publish its own online database of COVID-19 infections and deaths for public reference a couple of days later. During the pandemic, CONASS would release joint statements on a few occasions.

State health secretaries pointed out the role of the CONASS technical team in supporting states with the best available evidence, reinforced by an internal vision that it derived its political strength from its history, as well as credibility as a technical rather than political institution. Almost all state health secretaries interviewed agreed that the newfound protagonism by CONASS during the pandemic, combined with the higher salience of health and higher public support for SUS would lead to CONASS having a stronger societal standing regardless of changing political circumstances.

— The structure and environment of state health secretariats

- The high turnover of state health secretaries is highly disruptive to daily operations, policy continuity, learning curves, trust building, and cooperation between states, and should be a strong point of attention for state governments
- There is great variation on the way health secretariats are organized from state to state

Internally, state health secretariats did not reflect the same level of instability seen at the top of the federal level. About half the states had a single secretary for the entire pandemic acute period (between March 2020 and March 2022), with many going back to the beginning of the governor's term, since January 2019, at least.

In total, there were 58 changes (among 26 states plus Federal District) in those holding the title of state secretary of health since early 2019. About one quarter of the states had what could be considered normal changes, due to health reasons or secretaries being moved from one position to another within the same administration. Another quarter showed instability in their health secretariats, with some states having five health secretaries in two years, such as Rio de Janeiro, and another with ten (Roraima).

This discontinuity was mentioned by state health secretaries and other stakeholders as extremely disruptive both inside the state health departments, affecting the learning curve and the continuity of initiatives, and in the relationship between states and CONASS, as the process of establishing mutual trust had to be started anew.

Though there is no clear evidence, observers often speculate that state health departments are more prone to frequent changes than other departments, in part because of political factors. A third of the state health secretaries would eventually resign from their post in March 2022, corresponding to the the legal deadline for them to be able to run for office as state or federal deputies in the recent elections. Observers point out this is a common phenomenon in election years, due to the high ranking of health among citizens' main thematic concerns and given that health usually consumes the second-largest budget among state government departments. This seems to have intensified in 2022 due to the greater salience of health after the acute period of the pandemic, and increased media exposure of the state health secretaries.

We would stress the importance of carefully selecting a health secretary from the onset that is likely to stay over a prolonged period, ensuring continuity which would allow for policy development and for relationships and trust to build over time inside states and between states.

Another recommendation is to have a clear and rational structure to work in the health secretariats, and we encourage experience sharing on the best way to achieve this goal, as there is great variance from state to state. Out of the 26 states plus the Federal District, about two thirds have either one or two "undersecretaries", but nomenclature and structure vary greatly, is usually complex, and a lot is not easily accessible to the public.

2. THE FUTURE

— Regionalisation

- Health stakeholders mention underfinancing, an ageing population, a model of care unprepared for managing chronic diseases, and the judicialisation of health as structural challenges to SUS
- The reorganisation of health care on a regional basis (regionalisation) has been successfully undertaken by some states
- Regionalisation could serve as a counterforce to fragmentation and decentralization of the health system, with gains in efficiency and health outcomes

In interviews with health stakeholders, such as state health secretaries and experts, several chronic challenges that SUS had already been facing and that are likely to persist in the years ahead were mentioned, the most common being underfinancing, a rapidly ageing population, a model of care unprepared for managing chronic diseases, and the judicialisation of health.

One more prominent challenge is regionalisation, understood as the reorganisation and rationalisation in the flow of care through different stages of complexity based on regional needs and capabilities. It is one of the principles of SUS outlined in the 1988 Constitution, closely related to the separate principle of hierarchisation, which is the idea that health services should be organized on a scale from lower to higher levels of technological complexity[xxv].

However, the process is often at odds with political incentives (for locating hospitals and other high-complexity structures in their jurisdictions, for example) as well as with the federal financing structure (which does not prescribe transfers to regional actors, who are then unable to manage budgets and acquire supplies independently, for example).

Local experiences in states that have implemented regionalisation, such as Ceará and Espírito Santo, however, have shown strong gains in efficiency and health outcomes, which are projected for other states, too. Since regionalisation is precisely about organising the system based on needs and capabilities instead of political borders, it is also a possible point of focus for inter-federative cooperation and can be an opportunity for state leadership to serve as a counterforce to the increased fragmentation of the public health system.

— The building back agenda

- The reverberations of the pandemic are likely to remain stressing the Brazilian health system in different ways over time. The efforts to tackle these issues, catch up with those most affected by COVID-19, recover losses and avoid increasing inequalities is commonly grouped as the "building back agenda"
- Policymakers will be required to navigate with incomplete and uncertain data, and filling those data gaps is a promising area for action and cooperation
- The extent and treatment of long-COVID is a developing issue which will require constant monitoring and adaptation by policymakers
- The decline in vaccination numbers is a concern prior to the pandemic which has been exacerbated by it. Policymakers should consider policies based on the "3Cs" model proposed by the WHO, tackling confidence (dealing with hesitancy), complacency (raising awareness), and convenience (facilitating access)

The post-pandemic period brought a sense of stronger understanding and increased support[xxvi] of SUS among the population; an acceleration in some regulation processes, such as telemedicine; and a broader consensus around the idea that government could move faster and in a more coordinated way.

Many state health secretaries mentioned in their interviews leaving a positive "legacy" in terms of the greater salience and support for health, as well as greater availability of healthcare equipment and physical installations. For example, pre-pandemic, the available stock of intensive care units (ICUs) in Brazil was 22,600. During the pandemic, there was a concerted effort by states, municipalities, and the federal government to rapidly expand that number, reaching a peak of 49,000 in July 2021. And, out of the 26,000 new ICU beds, 7,300 will remain active, leading to an increase of 32% over the pre-pandemic period[xxvii].

As previously mentioned, COVID-19 also exposed and deepened inequalities in the health system that will have to be addressed, while also bringing new issues and pressures that will reverberate for the years to come. The philosopher Jonathan Wolff, Alfred Landecker Professor of Values and Public Policy at the Blavatnik School of Government at Oxford University, separates the pandemic response into three waves[xxviii]: "emergency response" (when urgent questions such as who should be prioritised for medical care, or the legitimacy of restricting freedoms of movement, were at the forefront), "crisis management" (focused on less pressing – but still hard – questions, such as balancing health and economic concerns over a longer period) and a new set of issues under the umbrella of "building back" (which involves catching up with those most affected to avoid the longer term consequences of the pandemic and reinforcing inequalities).

One of the difficulties in building back is that policymakers will often have to navigate without timely and reliable data about what needs to be done, as well as under resource constraints due to a need for fiscal tightening following a period of fiscal expansion. Below we suggest 5 key topics identified as priorities for the building back agenda:

- Backlog of elective surgeries and missed diagnosis

The need to flatten the curve of infections during the pandemic (and therefore hospital admissions) to prevent overwhelming the capacity of health systems led to advice for people to avoid health services except in case of emergency. This has had some profound consequences: an increase in deaths at home from non-COVID causes, missed diagnoses and appointments for follow-up of chronic diseases, delayed treatment, and an increase in the backlog of elective surgeries. More vulnerable states experienced a larger decline in all procedures[xxix]. Centralized, reliable, and timely state-level data about the backlog was not readily available in any of the states surveyed.

Many state health secretaries spelled plans to tackle this backlog problem but expressed frustration at a lack of readjustments in the SUS pay-out table, which determines values for procedures. States are free to complement the values, and many do. Poorer states and municipalities, however, have difficulty doing so – once again exacerbating inequalities.

- Changes in risk factors for chronic diseases

The most effective (and cost-effective) form of health care is preventative, and health policy has a role in encouraging habits and lifestyle choices, such as eating well and exercising, which are associated with better health outcomes. Those habits and choices have also been upended by the various disruptions brought about by the pandemic.

According to the latest Covitel report[xxx], a survey of risk factors for non-transmissible chronic diseases among Brazilians, the share of those who consider themselves in good health has declined from 76.6% of the population in the immediate pre-pandemic period to 63% in March 2022 and the regular consumption of vegetables and greens has fallen, as has the proportion of individuals who practise the WHO-recommended level[xxxi] of exercise. Obesity is projected to increase from 22% to 30% of the Brazilian population by 2030[xxxii]. Nonetheless, in between the pre-pandemic moment and March 2022 there has been a slight drop in tobacco use, stable levels of alcohol consumption and declines in the consumption of sugary drinks. It is unclear as to what extent these shifting trends will continue.

- Mental health

COVID-19 and the restrictions associated with it had multidimensional impacts on psychological well-being. Stay at home orders, as well as the fear of infection itself, led to a drastic drop in the frequency of social connections which are positively associated with greater mental health. A study on 15 countries (not including Brazil) found that the stronger the policy stringency, the greater were the mental health costs [xxxiii], measured in psychological distress scores and life evaluations. But the effect is not unidirectional: a higher level of COVID-19 deaths was also linked to worse mental health outcomes in general, so stringency, insofar as it plays a role in reducing deaths, is also important in managing population mental health overall.

Notably, some of the worst predictions about mental health made at the beginning of the pandemic did not materialise. There was no verified increase in the number of suicides in the first year of the pandemic in Brazil [xxxiv]. Depression has increased in prevalence from 9.6% to 13.5% among the population between the pre-pandemic period in 2019 and the first quarter of 2022. The South is the most affected region, and women are 2.5 times more likely to report it than men. While depression was more common among the elderly in 2019, now all age brackets have similar prevalence, and there could still be underreporting. The mental health of health professionals in particular was also cited a major ongoing concern by state health secretaries.

Interviewees from both inside and outside government point mental health as a particularly tricky area to act on in the last few years, due to national policy uncertainty as the federal government moved away from the guidelines of a community model of mental health. Expenditure on the area on the federal level has remained constant at R$ 2,6 billion since 2009 (corrected by inflation) but has fallen in relative terms, from 2.7% of health expenses in 2001 to 2.1% in 2019[xxxv].

- Long-COVID

Since the early days of the pandemic, there have been numerous reports of lingering symptoms from COVID-19 for months after the initial infection subsided. There is not always a clear relationship between graveness of infection and post-infection health impacts, and there a clear medical understanding of long-COVID has yet to emerge.

A lack of consensus on the time window and symptoms that should be classified as long-COVID has led to a lack of standardisation, and an unclear scale of the problem. There is emerging evidence[xxxvi], however, that long-COVID is more common in women than men, and that fully vaccinated people have a substantially lessened chance of developing it than those who remain unvaccinated[xxxvii], with no clear difference for types of vaccine. Clinics for treating effects of long-COVID have been opened in several Brazilian states.

The Brazilian Health Ministry recently estimated that 8,5 million people in the country may be affected by it, and earmarked R$ 160 million for treatment[xxxviii]. However, this is an area where high uncertainty is likely to remain, with a lack of reliable data on both local and national levels, and where ongoing monitoring would be highly recommended.

- Immunisation

Brazil has historically been a leader in immunisation. However, 2021 had the lowest rates of children's vaccinations in the last 30 year[xxxix]. Dangerous and nearly eradicated diseases are having a resurgence, with the potential to create new pressures on the health system. A more specific reason for the decline in non-COVID19 immunisation is the pandemic disruption and the lack of access to services during the period, leading to a discontinuity. But the trend predates the pandemic.

There are multiple reasons for this. First, the Brazilian immunisation program is widely understood to be a victim of its own triumphxl. As old diseases fade from memory due to the success of vaccines, new generations are less knowledgeable about them, and so perceive them to be less dangerous than is truly the case. Second, there has been a decline in the spending on mass campaigns in Brazil. Third, there is the impact of vaccine hesitancy, listed by the WHO in 2019 as one of the top 10 global health

threats[xli]. In 2011, the WHO proposed the "3Cs" model for immunisation, tackling confidence (dealing with hesitancy), complacency (raising awareness), and convenience (facilitating access)[xlii].

Confidence strategies should be multifaceted and consider that the spectrum of vaccine hesitancy goes from people who may have legitimate concerns and a lack of information to a highly organised and coordinated vaccine denialism movement. The convenience element may include policies to expand the opening hours of clinics to evenings and weekends to facilitate access to those working commercial hours, as well as drives in educational settings to help reach the teenage population, one of the most difficult groups to reach. To tackle complacency, raising awareness amongst policymakers and health professionals is an important first step. The challenge is in dialogue with the threat of disinformation in health in general, a target of health programs in the areas of training [xliii] and communication[xliv]. It is also part of a broader shift from a model of pointed care for acute conditions to a model of permanent accompaniment of patients, with active search of the unvaccinated.

CONCLUSION

We want to thank the state health secretaries, stakeholders and experts who have taken their time to contribute to this report so that others could learn about how SUS has responded to one of the greatest challenges it has ever faced, and how it can be better prepared to both provide regular quality care and be more resilient against future crisis.

The pandemic stressed the health system in Brazil, both from a resource and a political perspective, but it also encouraged coordination and solidarity to a degree once thought unimaginable. The role of trust and experience from individual actors in fostering coordination was vivid from the interviews and reiterates the importance of avoiding turnover and making sure prepared state health secretaries are placed from the onset and prepared to work on a longer time horizon on well-structured secretariats.

Addressing the health needs of Brazilians in the immediate future will also require new integrated systems of data and a clear understanding of the constraints in which political actors are operating, of low social trust and increased political polarisation. However, as the largest public health system in the world and with structures like CONASS firmly established and empowered, SUS has enormous potential to make sure this challenge is addressed.

For those interested in following up on this discussion within their own teams, we recommend three discussion points:

1. How can we foster more continuity in health departments, and use that as a tool to incentivise and routinise coordination in health, within and outside CONASS?

2. How can the new forms and institutions of cooperation, created for integration and dialogue between different states during the pandemic, be used to accelerate regionalisation?

3. What are the gaps in data and items on the building back agenda that are more pressing in your state and what should be prioritised?

APPENDIX: List of people interviewed

Adriano Massuda, Professor at FGV-EAESP, Medical Doctor and former health secretary for Curitiba and deputy secretary at the Ministry of Health

Pedro de Paula, Country Director for Vital Strategies in Brazil

Alethele de Oliveira Santos, Senior Legal Adviser at CONASS

Gonzalo Vecina, Sanitary Doctor and former president of ANVISA

Lucas Correia, director of the Centre of Studies and Health Policy Promotion (CEPPS) at Hospital Israelita Albert Einstein

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Mariel Deak, Former Advisor in the São Paulo State Committee for COVID-19

Juan Mendes, secretary of Health for Amapá (2020-current)

Claudio Alexandre Ayres, former secretary of Health for Alagoas (2019-2022)

Cipriano Maia, secretary of Health for Rio Grande do Norte (2019-current)

Fabio Beccheretti, secretary of Health for Minas Gerais (since 2021)

Juliano Mello, adjunct secretary of Health Attention and Vigilance for Mato Grosso

Christinne Maymone, adjunct secretary of Health for Mato Grosso do Sul

Nésio Fernandes, secretary of Health for Espírito Santo (since 2019) and president of CONASS

Carlos Lula, former secretary of Health for Maranhão (2016-2022) and former president of CONASS

Alberto Beltrame, former Secretary of Health for Pará (2019-2020) and former president of CONASS

Geraldo Medeiros, Secretary of Health for Paraíba (2019-2022)

Alexandre Chieppe, Secretary of Health for Rio de Janeiro (since 2021)

Mariana Varella, editor-in-chief of Site Drauzio Varella

Cláudia Colucci, health correspondent for Folha de São Paulo

Paulo Mazzancini de Azevedo Marques, Associate Professor of Medical Physics and Biomedical Informatics at the University of Sao Paulo (USP)

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