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OPINION ARTICLE

Analysis of the new specialized care policy: A change in the federative role of the Ministry of Health?

Análise da nova política de atenção especializada: mudança no papel federativo do Ministério da Saúde?

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DOI: 10.1590/2358-28982026E311079I

ABSTRACT This article analyzes the Ministry of Health's recent policy on specialized care in the Unified Health System (SUS), highlighting its impact on Brazil's federative pact. The discussion begins with the international and national trajectory of health reforms, emphasizing the need for integration, coordination, and strengthening of federal governance. In the Brazilian case, following a period of weakening federal institutional capacity, the Ministry of Health has regained its leading role with the creation of the National Specialized Care Policy, the More Access to Specialists Program, and later the Now There Are Specialists Program. These initiatives introduce innovations in financing arrangements, regulation instruments, professional training, the use of digital technologies, the organization of care networks, and the expansion of service provision, including new prerogatives for direct federal action. The analysis concludes that these strategies represent a gradual effort to restore the Ministry of Health's capacity for federative coordination, which had been eroded over the past decade. Through incremental expansion of policy- and program-inducing mechanisms, developed in partnership with the National Council of Health Secretariats and the National Council of Municipal Health Secretariats, the Ministry progressively reconstitutes its role as the national coordinator of the SUS.

KEYWORDS Specialized care. Federalism. Ministry of Health. Health governance. Unified Health System.

RESUMO *O artigo analisa a recente política do Ministério da Saúde para a atenção especializada no Sistema Único de Saúde (SUS), destacando seus impactos sobre o pacto federativo. A discussão parte da trajetória internacional e nacional de reformas em saúde, enfatizando a necessidade de integração, coordenação e fortalecimento da governança federal. No caso brasileiro, após um período de enfraquecimento das estruturas federais, observa-se a retomada do protagonismo do Ministério da Saúde com a criação da Política Nacional de Atenção Especializada, do Programa Mais Acesso a Especialistas e, posteriormente, do Programa Agora Tem Especialistas. Essas iniciativas introduzem inovações no financiamento, na regulação, na formação de profissionais, no uso de tecnologias digitais, na organização das redes de atenção e na ampliação da oferta de serviços, inclusive por meio de novas prerrogativas de atuação direta da União. Conclui-se que tais estratégias representam ações de retomada paulatina das capacidades de coordenação federativa do Ministério da Saúde, esvaziadas na última década. Assim, aos poucos, o Ministério da Saúde amplia suas estratégias de indução de políticas e programas setoriais, em parceria com o Conselho Nacional de Secretários de Saúde e o Conselho Nacional de Secretarias Municipais de Saúde, recompondo seu papel de coordenador nacional do SUS.*

PALAVRAS-CHAVE *Atenção especializada. Federalismo. Ministério da Saúde. Governança em saúde. Sistema Único de Saúde.*

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The current context of health system reforms: National governance as a priority agenda

Health systems have undergone major transformations over the past three decades, challenging long-established organizational patterns. Internationally, the health system reforms of the 1980s and 1990s—driven by macroeconomic adjustment policies—promoted market-oriented mechanisms and led to new institutional arrangements marked by the separation of stewardship, financing, and service delivery functions. These reforms introduced provider competition through internal markets, alongside decentralization and delegation, expanded consumer choice, the use of copayments to rationalize spending, reductions in hospital bed supply, and higher utilization rates, among other measures[1,2].

Despite the extensive use of various regulatory mechanisms, after two decades of implementation, this process has intensified several undesirable features observed across different countries, such as fragmentation of provider networks, insufficient continuity of care, inability to contain rising costs, weakened planning capacity, targeted and selective policies and programs, the growth of individual insurance coverage, and reduced investment in network expansion.

In response, from the 2000s onward, the idea of health system integration became central in guiding new institutional reform strategies in the health sector[3-5]. Within this framework, restoring the unified nature of health systems became essential, with efforts focused on strengthening regionalized health care networks capable of coordinating a broad and articulated range of health actions and services across different levels of technological complexity. Primary Health Care (PHC) was placed at the center of this model, acting as the entry point and coordinator of care across other levels, to ensure care continuity over time[6].

Within this agenda, care integration requires that service delivery structures be minimally articulated in logistical, financial, and institutional terms. This perspective reinforces the importance of unifying functions within public health systems, based on joint decision-making, centralized or regional coordination mechanisms, shared planning processes, global per capita resource allocation, and other similar strategies.

The 2008 economic crisis and the resulting fiscal and budgetary pressures reinforced the value of public and unified health systems. At the same time, however, they reintroduced concerns regarding the financial sustainability of health systems and the need to identify new sustainable funding sources, contain costs, improve service quality, generate efficiency gains in resource use, and streamline administrative structures, among other priorities[7].

Since then, countries with more consolidated health systems—particularly in specialized care—have increasingly pursued micro-institutional reforms of various types to ensure a minimum level of financial stability and address major structural challenges, without compromising the ability to provide a comprehensive set of health actions and services that uphold the principles of universality, comprehensiveness, and equity[8].

Among these major challenges are both long-standing issues—such as epidemiological transition, chronic diseases, rising costs, fragmentation of specialized care networks, and workforce training—as well as emerging ones, including the industry 4.0 technological revolution and digital health, environmental impacts, and new global health emergencies, remote work and mental health, to name a few.

Ultimately, the COVID-19 pandemic demonstrated, with evidence from several countries, that aligning these complex objectives—which require a medium- and long-term agenda—demands the reconfiguration of national governance prerogatives and instruments within health systems, as well as cooperation with actors and institutions

committed to a project of social inclusion and well-being. Addressing new health emergencies alongside longstanding system challenges requires strengthening federal governance capacity to define and implement a micro-institutional reform agenda focused on effectiveness and efficiency[9-11].

In the most recent agenda of health systems, strengthening the federal governance capacity of health systems[9,12] necessarily involves four key dimensions:

1. Building a national agenda of priority institutional reforms based on consensus among key stakeholders, particularly state and municipal governments;

2. Establishing institutional practices, arrangements, and coordination mechanisms within the federal structure to ensure joint action across regional and local levels;

3. Strengthening federal policy instruments to promote the regional integration of health care service networks, aligning regulatory frameworks, financial incentives/investments, and managerial innovation;

4. Developing strategies and mechanisms to monitor and evaluate key health system performance indicators.

Each country, according to its health system model, has sought in the post-pandemic period to advance these strategies while simultaneously taking into account the political opportunity structure for introducing innovations, fiscal capacity to sustain reforms, and the dynamics of actors and institutions within the health sector.

In this article, we present and analyze the main strategies introduced by the Ministry of Health (MS), from January 2023 to August 2025, within the scope of specialized care, outlining their foundations, mechanisms, and especially their potential impacts on the role of the federal level within the federative arrangement of the Unified Health System (SUS). The central question is the extent to which these strategies reposition the role of the MS within the sectoral federative pact.

Thus, in addition to this section, the article also includes three further sections. The second section discusses the main challenges facing specialized care within the SUS, while the third presents the three main new strategies of the MS to address these challenges. Finally, the fourth section concludes by analyzing the initial federative impacts of these policies and programs.

Governance of specialized care in the SUS: A fundamental agenda of challenges for the federal government

In the case of Brazil, there is broad recognition among the expert community that, following a significant process of dismantling federal policy and program coordination structures since 2015, restoring the governance capacity of the MS and its relationship with state and municipal governments is essential to trigger a reform agenda aimed at improving the SUS[13,14].

Thus, governance in the field of specialized health care represents a particularly central component in reestablishing the federal government's coordinating role within the SUS. Specialized care encompasses a broad and diverse set of policies designed to ensure access to outpatient and hospital services with higher technological intensity, corresponding to the secondary and tertiary levels of health care. Its organization covers strategic areas such as hospital care, home care, emergency services, the national transplant policy, regulation, and the evaluation and control of care systems and service flows, among others. Its implementation mobilizes substantial budgetary resources and a large network of health facilities, professionals, equipment, and supplies, whose proper functioning is essential to ensuring comprehensive care within the SUS[15].

In the current phase of SUS consolidation, after more than three decades of operation, it has become imperative to develop and implement new strategies and policy instruments in this field that enhance federal governance capacity to drive political-institutional, managerial, financing, and service delivery changes. The aim is to address a set of challenges that at present define Brazil's strategic health policy agenda.

Among these challenges, regional inequalities in service supply are a priority on the policy agenda, since the profile of specialized care provision shows marked territorial asymmetries and poor alignment with demand, whether due to excess capacity or service shortages. Brazil's extremely rapid and concentrated urbanization process has resulted in an uneven geographic distribution of resources and service delivery infrastructure, particularly those with higher technological density. Therefore, access to specialized and hospital services is constrained not only by insufficient and unevenly distributed supply, but also by weak integration with primary health care. This process has produced suppressed demand, discontinuity of care, and service provision that is poorly aligned with population health needs[16].

Within health regions, barriers and conflicts related to access to services by residents of different municipalities remain common, as do disputes over resources and investments. Despite the emphasis on solidarity-based and cooperative regionalization, and the creation of a specific forum for negotiation and consensus-building—the regional intergovernmental committee—the dismantling of governance mechanisms in recent years has discouraged the development of interdependence, complementarity, shared decision-making, and the pooling of technical and financial resources, as well as the definition of shared macro-level health commitments at the regional level[17].

In addition to the insufficient funding base for health policy, the current model of intergovernmental financial transfers for specialized care—largely based on installed capacity—creates institutional incentives that are poorly aligned with the development of care models grounded in continuity of care, integrated and functional service delivery arrangements, and efficient management with accountability for socially relevant goals, objectives, and outcomes. Despite advances such as reduced fragmentation through the funding blocks established under the Health Pact, service supply patterns and historical expenditure trends still carry significant weight as criteria for financial planning and the allocation of operating resources within health regions[18].

Similarly, the use of parameters and standards of effectiveness and efficiency in health actions, service monitoring and evaluation instruments, concrete mechanisms for defining negotiated targets (management contracts—public or private), as well as quality certification practices, remain at an early stage of dissemination. The adoption of results-based management models incorporating cost systems, internal controls, performance targets, clinical audits, workforce qualification systems, and performance-based remuneration, among others, remains limited and uneven across health organizations, hindering the development of a managerial efficiency culture within the system[19].

Managerial coordination in health regions is also a central challenge to ensuring comprehensive care in the SUS. Efforts to consolidate policies aimed at controlling financial and care-related flows are still underway and require further reforms to overcome the low functionality and limited rationality of the processes used to organize and manage health systems at the regional level.

The consolidation of regulation, control, and evaluation policies, including the universal adoption of regulatory complexes, and the updating of the Agreed and Integrated Programs (PPI), represent major challenges for regional management. Likewise, there is limited dissemination of managerial coordination instruments and logistical support

systems aimed at building functional regionalized arrangements, such as patient transport, communication, and supply systems[20].

Such coordination is essential for responding to new public health emergencies, particularly in integrating specialized services, primary care, and surveillance systems. This integration is key to enhancing the capacity to generate rapid and coordinated responses, provide accurate information to the population, prevent hospital system overload, and protect the health workforce, among other strategies.

Finally, due to multiple barriers to access, the constitutional right to universal health care—a landmark in the country's social protection system—has increasingly become a mechanism for individualized claims on public resources through judicial action. Beyond promoting unequal use of the health system, given the socioeconomic profile of those who resort to the judiciary, this practice disrupts and fragments health care planning and financial management across federative entities, particularly at the municipal level[21].

In light of these challenges and aligned with the international agenda, which, as discussed in the second section, emphasizes the need to strengthen the federal governance capacity of health systems, two lines of action are fundamental for the current administration.

The first is the reactivation of the federative pact, materialized in the cooperation processes between the MS, the National Council of Health Secretariats (CONASS), and the National Council of Municipal Health Secretariats (CONASEMS), as well as in the extent to which tripartite discussions reflect SUS priorities, the technical depth of the debates, the breadth of perspectives and interests involved, and the scope of the concrete future developments of each agreed tripartite agenda[14].

Along the same lines, it is essential to rebuild the federal organizational structure and its capacity for policy and program formulation, implementation, and evaluation, which requires the reconstitution of technical staff, work processes and dynamics, and information systems, among other elements. Special attention must be given to the design of strategies and policy instruments aimed at policy induction, so as to overcome barriers to state and municipal adherence and to build new fronts for intergovernmental collaboration[22].

Thus, recent initiatives led by the MS to reformulate national federative governance in specialized care—such as the new National Policy for Specialized Care (PNAES), the More Access to Specialists (Mais Acesso a Especialistas) Program (PMAE), and the Now There Are Specialists (Agora Tem Especialistas) Program—are important strategies to address the challenges outlined above.

These policies and programs seek to expand and diversify the mechanisms through which the federal level acts to increase service supply and improve the efficiency of resource allocation within health regions. Nevertheless, what are their main components, how do they operate within SUS service provision, and how might they reshape federative relations within the SUS? Below, the three MS initiatives are presented as designed up to the time of writing of this article. The fourth section analyzes their possible federative impacts.

The Ministry of Health's new strategies: Expanding the scope of federal action in specialized care

This section presents the main features of the PNAES, the PMAE, and the Now There Are Specialists initiative. The three initiatives are interconnected and form a continuum of policy formulation, discussion, and negotiation with CONASS and CONASEMs over the past two and a half years. This analysis focuses on the provisions set out in the three main normative instruments that define the foundations and mechanisms of action of these initiatives: GM/MS Ordinance No. 1.604/23, Provisional Measure No. 1.301/25, and GM/

MS Ordinance No. 7.266/25. Throughout the section, additional sources are incorporated when necessary, including ordinances, government reports, official presentations by MS officials, MS information from the data system, and other relevant materials.

The National Policy for Specialized Care: Reaffirming comprehensiveness as a core principle of the SUS

Specialized care within the SUS has, until recently, been marked by substantial fragmentation across services, with dispersed rules and regulatory frameworks. This fragmentation underscored the urgent need for stronger integration with PHC to ensure comprehensiveness of care[23].

The development of the PNAES was preceded by a series of initiatives within the Secretariat for Specialized Health Care (SAES) of the MS. Among these, the National Open Conference on Specialized Care in the SUS: Challenges and Perspectives, held virtually in May 2023, stands out. The conference sought to foster debate on a more integrated, accessible, and resolutive model of specialized care within the SUS.

In June 2023, the International Seminar on Specialized Care in the SUS further advanced these discussions by bringing together national and international experiences and helping to define the core axes of the new policy. The debates addressed key themes such as workforce training, technological innovation, federative governance, financing reform, and the regulation of access to specialized care.

Another important milestone was the research project Cartography of Specialized Care in Brazil, conducted by the Federal University of São Paulo (UNIFESP), with 36 researchers across all 27 states. The study had two main objectives: (1) to produce a situational diagnosis of specialized care in the country, identifying barriers to access and factors contributing to waiting lists for surgeries, consultations, and diagnostic tests; and (2) to inform the formulation of the PNAES with data and evidence.

PNAES was created through Ministerial Decree GM/MS No. 1.604, of October 18, 2023, shortly after approval by the National Health Council through Resolution No. 721/2023, on October 6, 2023. Its main objective is to organize and strengthen specialized care within the SUS, ensuring access to high-quality health services, focusing on comprehensive care and equity in service provision. The policy was designed in response to a set of structural and operational challenges that it seeks to address.

The policy establishes guidelines for organizing specialized care, with an emphasis on expanding timely and territorially based access, reducing waiting lists for surgeries, consultations, and diagnostic procedures, improving the quality of care, and promoting equity, comprehensiveness, and more efficient use of resources. Regionalization is a central pillar of the policy, encompassing care pathways, patient transport arrangements, and integrated regulatory mechanisms based on clear clinical criteria. These arrangements aim to reduce waiting times, missed appointments, and unnecessary procedures, while strengthening continuity of care and shared responsibility between health professionals and users.

The policy also prioritizes the use of technologies and digital health solutions, strengthens specialized care through increased federal participation in financing, improves funding arrangements, supports the training and retention of health professionals in priority areas, and promotes technological modernization, while ensuring social participation and oversight throughout all stages of implementation.

Thus, the structuring of specialized care within the SUS through the PNAES seeks to respond more effectively and in an integrated manner to population health needs. It introduces governance innovations aimed at improving the management and coordination of health services through the creation of structures that facilitate coordination across different levels of care. This includes a clear definition of roles and responsibilities among managers to achieve a more integrated and efficient management.

Moreover, the policy emphasizes the need for coordination across different sectors, not only in health care but also in areas such as education, social assistance, and urban development. This cross-sector approach is essential for addressing the social determinants of health and promoting more comprehensive care.

These innovations proposed by PNAES regarding SUS governance aim to strengthen the management and coordination of health care services, fostering a more efficient, transparent system centered on the population's needs. The effective implementation of these guidelines will be crucial to the policy's success and the improvement of specialized care services in Brazil.

The More Access to Specialists Program

To fully implement the new structure of specialized care, the MS launched the National Program for the Expansion and Qualification of Specialized Outpatient Care (AAE), also known as PMAE.

Established by Ordinance GM/MS No. 3.492 on April 8, 2024, the PMAE was designed as a strategy to expand access to specialized consultations, exams, and outpatient therapeutic procedures, while improving the quality of care based on PNAES pillars and guidelines.

As shown in *table 1*, PMAE aims to integrate specialized care with PHC, focusing on patients and t heir journey through the health care system. It achieves this through innovations targeted at continuity and comprehensiveness of care, as well as financing and governance models. Therefore, the program strengthens the governance of Health Care Networks by establishing Tripartite and Bipartite Steering Groups. These groups are responsible for jointly tracking, monitoring, supporting, and evaluating actions across federal, state, and local governments to improve the management of care.

Table 1. Summary of the More Access to Specialists Program

Axis	Summary
Purpose of the PMAE	To promote the integration of services with Primary Health Care (PHC), with an emphasis on individuals and their journey through the health system, ensuring continuity and comprehensive care.
Program innovations	Introduction of new arrangements for specialized care, with changes to the care model, financing, and governance of specialized outpatient services.
Problem addressed	Overcoming fragmented care, marked by unpredictable response times and the lack of coordination in the user's clinical and diagnostic care journey.
Integrated Care Offerings (OCI)	An integrated set of procedures, technologies, and care practices designed to complete stages of the care pathway or treat specific health conditions with quality and timeliness, ensuring effective resolution and comprehensive care.
Protocols and workflows	Definition of protocols and regulatory workflows to ensure effective communication between Primary Health Care (PHC) and Specialized Outpatient Care (SOC).
Information systems and regulatory frameworks	Adaptation of systems for recording, collecting, and assessing information, with an emphasis on monitoring response times in care delivery.
Telehealth	Use of telehealth in the regulatory and healthcare delivery as a strategy to expand access and strengthen continuing professional education.
Financing Model	Federal funds transfers through OCI, with more appropriate reimbursement for public and private providers that adopt integrated, user-centered practices.
Provider approach	Care delivery grounded in humanization, care coordination, problem-solving capacity, and integration with primary care throughout the patient journey.
The PNRF within the PMAE	Integration of the National Waitlist Reduction Program (PNRF), established by Ordinance GM/MS No. 5,820/2024, with positive results in expanding elective surgeries.

Source: Authors' elaboration.

In this sense, the PMAE, by proposing an innovative model of health care management grounded in articulated regulation between PHC and AAE, the sharing of information across services, the organization of waiting lists, and the monitoring of the delivery of Consultation and Intervention Offerings (OCI), is part of a broader movement to restructure the national policy for specialized care. It is in this context that Provisional Measure No. 1.301/25[25] was enacted, establishing the Now There Are Specialists Program. Its creation reinforces a growing trend toward expanding the role of the MS in the promotion, coordination, and, more recently, also the direct execution of actions within the field of specialized care.

Provisional Measure No. 1.301/25 and the federative foundations of the 'Now There Are Specialists' Program

Provisional Measure No. 1.301/2025, issued on May 30, 2025, establishes the Now There Are Specialists Program, launched on the same date by the Minister of Health, Alexandre Padilha, during a national event attended by the President of the Republic and other authorities25. As shown in *table 2*, the initiative aims to expand the prerogatives, resources, and institutional capacity of the MS in specialized care, to support states and municipalities in expanding service provision and reducing waiting times for consultations, procedures, and exams, particularly in territories with gaps in health care coverage.

From a federative standpoint, the main innovation lies in the amendment of Article 16 of Law No. 8.080/90[26], which authorizes the federal government to directly provide health actions and services in local territories, either through its own provision or through contracted services, in situations characterized by high demand, long waiting times, and the need for specialized care. The Provisional Measure also authorizes the creation of a national public data system on waiting times, under the management of the MS, with mandatory data reporting by states and municipalities.

Table 2. Summary of the expansion of federal powers and changes in the Ministry of Health's role in specialized care in Brazil's Unified Health System (SUS)

Analytical Axis	Description
Role of the Ministry of Health	The Ministry of Health is beginning to combine its traditional roles of policy coordination and policy induction with the possibility of directly providing or contracting for specialized services.
Legal and regulatory framework	Introduction of new legal instruments that increase flexibility in the regulatory framework of the Organic Health Laws and subordinate regulations, while formally preserving the decentralized model.
Financing mechanisms	Creation of new federal financing sources through the offsetting of financial credits against tax debts from the private hospital sector and the supplementary health sector.
Contracting of the private hospital sector	Authorization to contract private, for-profit, and philanthropic hospital services through the use of financial credits primarily allocated to the settlement of tax debts with PGFN and the Federal Revenue Service.
Integration with the supplementary health sector	Possibility for health insurance operators to convert tax debts arising from reimbursements owed to the SUS into services delivered to the population, through participation in calls for proposals issued by the Ministry of Health.
Economic Rationale of the Strategy	Anticipation of future revenues arising from the negotiation of tax liabilities, converting them into immediate capacity to purchase services under federal management.
Federative Relations with States and Municipalities	Provision of contracted services as a complementary offering to subnational entities, subject to regional programming agreed upon with intergovernmental management bodies.
Institutional Reorganization	Regulatory reforms to strengthen the Ministry of Health's institutional capacity and broaden national policy scope, including the consolidation of Grupo Hospitalar Conceição S.A. as a federal public enterprise with enhanced legal certainty, administrative autonomy, and expanded teaching and research activities.

Source: Authors' elaboration

Similarly, the Provisional Measure expands the scope of action of the Oswaldo Cruz Foundation (FIOCRUZ), authorizing its support for national policies and projects in the field of specialized care through agreements and contracts, including the hiring of personnel and service to operate in decentralized territories of the SUS[27].

It also broadens the powers of the Brazilian Agency for Support to SUS Management (AGSUS), created by Law No. 14.621/23[28], enabling it to operate in specialized care through the recruitment of physicians and specialized services, the incorporation of health care and management technologies, the development of continuous professional training programs, and the complementary provision of services to states and municipalities. These functions were previously restricted to PHC and Indigenous health.

In the field of policies and programs, a notable development is the expansion of the Mais Médicos Program[29] with the creation of the More Specialized Doctors (Mais Médicos Especialistas) Project, aimed at deploying professionals to specialized care services in priority regions, selected through specific public calls and entitled to the program's benefits. A similar expansion is foreseen under the Doctors for Brazil (Médicos pelo Brasil) Program[30]. The Provisional Measure also includes actions to expand access to radiotherapy under the National Policy for Cancer Prevention and Control, ensuring medical transportation and covering lodging expenses for patients undergoing treatment away from home[31].

In sum, the Provisional Measure strengthens the role of the MS as the national coordinator of the SUS in specialized care, expanding its actions to include the direct provision of services in local territories. It should be noted that these measures remain subject to approval by the National Congress. As of the date of preparation of this article (August 18, 2025), the joint committee had already been established (August 5, 2025) and had held its first hearing with the Minister of Health (August 6, 2025), with a deadline of September 26, 2025, for completion of its work[32].

GM/MS Ordinance No. 7.266/25 and the details of the 'There Are Specialists' Program

Ordinance GM/MS No. 7.266, dated June 18, 2025[3], establishes the Now There Are Specialists Program within the SUS, intending to expand access to specialized consultations, diagnostic tests, and surgical procedures, thereby reducing waiting times for the population. The program includes outpatient and surgical components, regulated respectively by Ordinances GM/MS No. 3.492/2024 and No. 5.820/2024 (PMAE), expanding access through lines of action33.

The ordinance establishes six strategies for the program operationalization in joint actions with state and municipal health managers, as shown in *table 3* below:

Table 3. Strategies for operationalizing joint actions

1	Expanded use of existing public capacity, as well as complementary and supplementary networks;
2	Organization of task-force initiatives and provision of specialized mobile services;
3	Direct communication with citizens, managers, and health workers through SUS Digital platforms;
4	Provision of interregional and interstate access strategies to optimize oncology care;
5	Structuring of Health Regulatory Complexes;
6	Implementation of initiatives to ensure supply training for medical specialists.

Source: Authors' elaboration.

These strategies will be implemented through actions structured around eight components (lines of action), including outpatient and surgical care, access to radiotherapy, the use of financial credits, reimbursement to the SUS, workforce provision, improvement, and on-the-job training, retention and management of the specialized workforce, SUS Digital, and also the provision of specialized health services on a complementary basis.

Some lines of action stand out for their innovative character. The first two are based on the exchange of private-sector debts for the provision of care to SUS patients. To implement this mechanism, the ordinance establishes two components: financial credits and reimbursement to SUS.

- Financial credits: these refer to the offsetting of federal tax debts in exchange for the provision of specialized services to SUS patients. This mechanism may be used by private health establishments, whether for-profit or non-profit, provided that they formally join the program.

- Reimbursement to SUS: this applies to private health insurance operators, which may convert outstanding reimbursement obligations owed to SUS into the provision of specialized health services.

Another line of action corresponds to the 'Complementary Provision of Specialized Health Services' component, implemented through direct federal government action in states, the Federal District, and municipalities. This component provides care by contracting health services based on locally identified needs, integrating this supply into the existing mechanisms for regulating access in these territories.

It also allows for the accreditation of companies providing health services through mobile units. The aim is to bring specialized care to Indigenous and Quilombola communities, as well as to patients living in hard-to-reach areas or in regions with insufficient service capacity and long waiting times.

In sum, Ordinance GM/MS No. 7.266/2025 represents a milestone in strengthening specialized care within the SUS by coordinating multiple strategies and lines of action that combine innovative financing, expansion of installed capacity, and the direct provision of services in territories with care gaps. By integrating federal, state, and municipal resources and by establishing mechanisms of cooperation with the private and supplemental health care networks, the program seeks not only to reduce waitlists and waiting times but also to promote greater equity in access, reaffirming the commitment to universal and comprehensive health care.

Finally, it is worth noting that, as of July 2025, 32 legal instruments had already been issued to support the implementation of the Now There Are Specialists Program, including one Provisional Measure, three decrees, nineteen ordinances, and nine public calls, with only the radiotherapy ordinance still pending to complete the regulatory framework that underpins the program.

Conclusions: Changing the role of the Ministry of Health in the federative pact?

In these concluding remarks, the central question posed in the introduction of this article is revisited, namely, the extent to which the main strategies developed by the MS to date in the field of specialized care are repositioning the role of the MS within the sectoral federative pact.

The answer to this question depends on which period of the last 35 years of federative relations is taken as a reference for comparison with the present moment. In broad terms, three periods can be identified, characterized by clearly distinct patterns of

intergovernmental relations, each corresponding to a specific modus operandi of the MS in coordinating the SUS.

The first phase, which took place throughout the 1990s, was marked by the construction of the institutional framework for decentralization, with the transfer of management responsibilities, particularly to municipalities. At that time, the MS was responsible for more than two-thirds of SUS funding and held the technical expertise inherited from the former National Institute of Medical Care of Social Security (INAMPS), assuming a central role in the process. During the Collor administration, a highly centralized model prevailed, formalized in the Basic Operational Norm (NOB) 91, which reduced subnational entities to mere service providers. During the Itamar Franco administration, significant advances were achieved, such as NOB 93, the dissolution of INAMPS, the establishment of Bipartite and Tripartite Intermanagerial Commissions, the fund-to-fund transfer of resources, and the consolidation of health councils. This period consolidated the role of municipalities as SUS managers, making the decentralization process irreversible. By the end of the decade, with the implementation of NOB 96, a rebalancing movement took place, with the MS regaining greater regulatory capacity by conditioning financial transfers on adherence to national policies. Nevertheless, the widespread adherence of states and municipalities to the NOB 96's rules helped consolidate a cooperative sectoral federalism, albeit with polarized relations between the federal government and municipalities and a weakening of the role of the states.

The second phase began in the early 2000s, particularly during the two terms of President Luiz Inácio Lula da Silva. During this period, efforts were made to restore the cooperative character of federalism envisaged in the 1988 Constitution, strengthening the role of states and fostering a results-oriented management culture. The MS implemented a series of internal organizational reforms and established mechanisms for greater coordination with the CONASS and CONASEMS. These initiatives culminated in the launch of the Health Pact in 2006, which proposed a new model of intergovernmental relations. In parallel, the MS took the leadership as the national public policy driver, with the creation of strategic programs such as the Mais Médicos (More Doctors) Program, the Farmácia Popular (Popular Farmacy) Program, and the Rede Cegonha (Stork Network) Strategy. This leading role was accompanied by the technical and political strengthening of CONASS and CONASEMS, which became central not only in policy formulation but also in implementation, monitoring, and evaluation, building articulation networks with other institutional and technical stakeholders throughout the country.

Finally, the third phase began with the political and economic crisis that culminated in the impeachment of President Dilma Rousseff. From the Michel Temer administration onward, a strategy to dismantle social policies took shape, marked by budget cuts, legislative changes, and administrative restructurings that weakened the Ministry of Health's presence and its capacity to coordinate national health policy. The spending cap established under the new fiscal regime, combined with the weakening of coalition presidentialism and the emergence of new forms of regional coordination—such as interstate consortia—further reduced the federal government's central role in steering the SUS. The outcome was a dispersion of resources and a fragmentation of policy-inducing capacity, undermining the cooperative and integrated logic built over previous decades and ultimately leading to the deliberate withdrawal of the MS under the Bolsonaro administration during the COVID-19 pandemic.

The current period, however, reflects a dynamic closer to that of the second phase, as the MS gradually resumes its role as the national coordinator of the SUS—functions that had been hollowed out over the past decade. Three features of the Ministry's current

actions illustrate the similarity between these two moments.

The first is the expansionary activity of Ministry departments in the formulation of policies and programs, coupled with the use of multiple inducement instruments to encourage states and municipalities to expand the supply of health actions and services. These include policy ordinances, new financial transfers, new payment mechanisms (such as OCIs), training programs, technical support activities, workshops on policy accreditation, and related initiatives.

The second feature involves the expansion of internal departments and regulatory mechanisms for monitoring the implementation of policies and programs. Institutional changes within Grupo Hospitalar Conceição S.A., AGSUS, and the scope of partnerships with Fiocruz exemplify this dynamic, as do improvements in information systems and rules requiring states, municipalities, and service providers to keep up-to-date data on quality, demand profiles, and the supply of specialized services.

Finally, the third dynamic concerns the evolving relationship with CONASS and CONASEMS. The entire process of designing these new initiatives has been carried out jointly with both entities, which have participated from the initial formulation stage through post-presentation revisions and approval by the Tripartite Intergovernmental Commission[34,35].

What emerges, therefore, is a reassertion of the Ministry of Health's capacity for federative coordination—severely weakened over the past decade—while preserving the tripartite dynamics characteristic of sectoral federalism. Clearly, changes such as the amendment to Law No. 8,080/1990, which allows the Ministry to provide services directly throughout the country, create new possibilities. However, the additional funding allocated remains far smaller than the annual ceilings for medium- and high-complexity care, which form the backbone of specialized care financing nationwide. Moreover, the program's implementation will be subject to agreements with states and municipalities. Ongoing monitoring of its implementation will therefore be essential for future analysis.

Authorship contributions

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Received on 08/29/2025
Approved on 04/11/2026
Conflict of interest: Non-existent
Data availability: The research data are contained within the manuscript itself
Financial support: FIOCRUZ/ENSP/Estudos Estratégicos em Atenção Primária à Saúde

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