Comparison Between the Healthcare System of the United States and the Brazilian Unified Healthcare System (SUS): A Narrative Bibliographical Review

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ABSTRACT

Access to healthcare is a basic and inalienable right, linked to the guarantee of life and the provision of the best available resources by healthcare systems. Brazil and the United States offer healthcare through different models: the North American system is primarily private, with public coverage limited to specific groups, while Brazil has a universal public system with guaranteed access to all through the Unified Health System (SUS). This study aims to compare the two healthcare systems, emphasizing their structural particularities, financing methods, organizational principles, and results regarding access, equity, and performance. The research was conducted through a narrative literature review, using electronic databases for the survey. The results suggest that Brazil has a healthcare system based on universality, comprehensiveness, and equity, despite the challenges faced due to underfunding. Conversely, the US system, despite offering high per capita investments, faces significant inequalities in access and presents varied health outcomes.

Keywords: Health system. Health Unic System. Health management. SUS. U.S. Brazil.

INTRODUCTION

Moiti et al. (2013) argue that health systems are organized according to the local understanding of the health-disease segment, with the common goal of promoting health to citizens of a given State.

For Pegoraro (2013), health systems play a fundamental role in increasing the life expectancy of the population and improving the quality of life and well-being of the entire world.

However, enormous difficulties remain and the difference in results between health systems is very high. Health systems have failed to offer services to everyone, and millions of people around the world are excluded from health services (World Health Report, 2000).

Pegoraro (2013) continues by saying that when it comes to health, it is crucial to realize that this factor is essential, an inalienable asset, which is similar to other forms of human needs such as education and personal skills. However, the great and distinctive feature of health is that it is an asset that cannot be accumulated, but can be improved through the services of health systems.

L'Esperance et al. (2017) reinforces that primary care in health services is a strong basis for public health. He states that the share of health financing must be greater for this sector. Thus, there is evidence that investment in primary care can reduce health expenditure costs.

In the United States, Brito (2016) clarifies that they do not have a universal health system. Their health system is heavily influenced by the involvement of the private sector. Government participation is minimal, restricted to assisting specific populations such as the elderly, the poor, and people with disabilities and certain types of illnesses, who are assisted by the Medicare and Medicaid programs.

In Brazil, Pessoto et al. (2015) states that the Constitution of the Federative Republic of Brazil of 1988 established the right to universal and comprehensive health care, to be guaranteed by the government. This constitution established the creation of the Unified Health System (SUS), as a public health system that is universal, comprehensive and equitable.

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Bodenheimer & Grumbach (2012) argue that in both the US and Brazil, health care reform can be considered an essential step towards balancing equity, effectiveness, efficiency and economy. These are essential pillars of public health management. The current scenario presents a certain imbalance in these pillars.

The same author explains that in the United States, the issue of equity in the provision of services has a long way to go, since a large percentage of the population does not have access to public health care. In Brazil, access is recognized as a constitutional right, granting access to all people in the country.

In this sense, this research carries out a bibliographic review and a comparative analysis of the Health Systems of the United States and the Unified Health System of Brazil (SUS). It also explores these systems in order to understand how they work and how their methods are offered to the population.

Therefore, this research contributes with information about the health sector in the USA and Brazil, and the results may eventually show the best health system offered by these countries.

The research was carried out between February and March 2025, and was researched with articles in the Scielo, Lilacs, Pubmed and Virtual Health Library databases.

METHODOLOGY

This research was conducted using a narrative bibliographic review, of a qualitative nature and with a descriptive purpose. According to Cavalcante and Oliveira (2020), this type of review focuses on offering a broad view of the evolution of a specific topic, bringing together different theoretical and methodological perspectives adopted by researchers over time. The objective of this scientific study is to carry out an analysis of the scientific literature to describe and discuss the difference between health plans in the United States and the Unified Health System in Brazil. The aim is to identify the main ideas, limitations and opportunities for improvement, with the aim of providing a comprehensive understanding of the topic in question.

The development of the search equation had the assistance of a librarian specialized in the health area, aiming at greater sensitivity and refinement in the results. The searches were conducted from April to June 2025. The time frame of the research covered the years 1990 to 2025, using the data archive of the Virtual Health Library (VHL), Latin American and Caribbean Literature in Health Sciences (LILACS) and U.S. National Library of Medicine (PUBMED). To complement the search, the Scientific Electronic Library Online (SciELO) and Google Scholar were also consulted. The following descriptors were used, combined with Boolean operators: ("health system" OR "unified health system") AND ("health management" OR "SUS") AND ("United States" OR "Brazil").

The inclusion criteria were: peer-reviewed scientific articles, dissertations, theses and relevant reports; publications in English and Portuguese; full texts and abstracts accessible in the cited databases. The following were excluded: duplicate articles; publications published before the defined period; studies without access to the full text; works not related to the research topic; publications that only presented an abstract.

The initial search identified 45 potentially relevant studies, of which 10 were eliminated due to duplication. The analysis of titles and abstracts of 35 publications resulted in the exclusion of 5 studies that did not meet the inclusion criteria. Thus, 30 articles were evaluated in full to verify eligibility. In the end, 25 articles were selected to comprise this work. Of these 25 articles, 13 were selected to comprise the results and discussion.

Below is the Prisma flowchart of the articles found:

IDENTIFICATION	Records identified throung database searching (**n = 45**)
SCREENING	Duplicates escluded (**n = 10)**
	Excluded after title and abstrat screening (**n=5**)
ELIGIBILITY	Full-text articles assessed for eligibility (**n=30**)
INCLUSION	Studies included in the review (**n = 25**)
	Studies for results and discussion (**n = 13**)

The selected materials were subjected to an initial exploratory reading, followed by an analytical and interpretative reading.

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THEORETICAL BASIS

United States Health System

According to Silva (2003), he highlights that the United States health system is predominantly in the private sector for access to health insurance services, which deviates from the universal health model, and there are few public health programs offered to the population. He highlights that this predominance is a result of US culture.

According to Schreck (2018), the United States has significant healthcare spending, representing approximately 17.3% of GDP in 2022. This indicates the highest per capita investment in healthcare globally. However, this high expenditure does not necessarily lead to better health outcomes for the population.

Liberato (2021) tells us that the United States health system is the process of policies implemented in 1965 by President Lyndon B. Johnson, followed by the ideas of John F. Kennedy. This is how the few public health programs in the USA were created, the main ones being Medicare – a specific health program for seniors aged 65 and over, and Medicaid – a health program that provides services to the low-income population.

Bodenheimer & Grumbach (2012) and Brito (2016) explain that the U.S. healthcare system is highly decentralized. Medicare and Medicaid programs are largely funded by the federal government, with contributions from state governments, which are responsible for administering and co-financing Medicaid. Municipalities, on the other hand, have little or no involvement in healthcare financing.

Buss & Labra (1995) state that Medicaid, under state responsibility, is funded by the government according to the poverty level of each state. It serves the low-income population and provides care in private hospitals contracted by state governments.

According to Schreck (2018), Medicare is one of the largest government health programs, funded by the government, which involves the management and payment of contracts with private companies that provide services to the state. Access is restricted to the elderly population over 65 years of age and people with disabilities.

Pegoraro (2013) states that the functions of the public and private sectors are different with respect to the provision of services to the health system. The public sector is responsible for health and epidemiological control and surveillance, as well as the management of the provision of services to the low-income population and the elderly. The private sector is responsible for a large part of the provision of services, directly or indirectly.

According to Pinto et al., (2020), a large part of the American population has health care through the private system, where it dominates the market, which is guaranteed by health insurance companies, known as Health Maintenance Organizations (HMO), maintained by direct expenses and donations. The system is extremely important and ensures health for thousands of people. Most health plans are paid for by employers, with employees being able to assume a small portion of this cost.

In the co-participation system, Barreto (2020) warns of a barrier to access to health services in the USA, where the user pays a percentage of the service used.

Sandoval (2020) also says that people who have a plan or insurance claim that many co-participations in payments, deductibles and others, represent a disastrous financial impact if hospitalization is necessary.

Triverde et al. (2018) states that cost sharing, deductibles, copayments and out-of-pocket expenses prevent preventive measures from becoming effective and may be underutilized. In this regard, the Affordable Care Act (ACA) requires that most private health plans and Medicare eliminate cost sharing for services based on scientific evidence.

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Costa (2013) states that the ACA allowed the creation of benefit exchanges, imposing an organized market for health insurance sales, called the National Health Insurance Exchange, where this package has services defined by the health authority, with regulation, affordable values, accessibility for small businesses and low-income individuals. It also prohibits the exclusion of citizens who have pre-existing health risks.

Koh & Sebelius (2010) report that it is impressive that only about half of Americans receive recommended preventive services. In this sense, the ACA refers to prevention through a wide range of initiatives and funding. The law offers the population improved access to prevention services.

For Fiscela (2011), aspects related to prevention include support for primary care, improved information technology, new payment models and monitoring of services. Health care means more than eliminating prejudices, but the creation of patient-focused care systems, clinical methods that interact with the team and the patient, improving adherence to treatment and prevention proposals.

According to Fiscella (2011), "A robust primary care health system is the basis for a more equitable health system."

Starfield (1998) explains that there are more doctors specializing in health treatments in the United States, where it is strongly recognized worldwide. In fact, the United States has more medical specialists than general practitioners, where only one-third of general practitioners offer health services.

Pinto et al. (2020) point out that it is important to emphasize that emergency care is provided for by law in all US hospitals, which protects people's health, regardless of their health insurance. If the patient treated in an emergency does not have the financial means to pay the costs, the expenses are assumed by the hospital and there is a socialization of losses.

For Guimarães (2020), the American health system is an example of fragility in terms of the health system model, with a system that is preferably private, which excludes a large part of the population.

Koh & Sebelius (2010) and Fiscella (2011) highlight that, despite high costs, the US's health performance is not without inequalities. In 2021, life expectancy was 76.1 years, lower than in other high-income countries. Furthermore, preventable and infant mortality rates are higher than in countries with universal public health systems. Even with the implementation of the Affordable Care Act, a large portion of the population still faces difficulties accessing preventive health services.

Furthermore, according to Sandoval (2020) and Trivedi et al. (2018), the financing model based on insurance and copayments creates significant economic obstacles to ongoing care, especially for chronic diseases.

Brazilian Unified Health System (SUS)

Paim (2009) explains that before the creation of the SUS, there was a health system that served only a part of the population that had access to the Assistance Institutes, which had been centralized in INAMPS - Social Security Assistance Institute. Those who did not have access to INAMPS were served by another parallel system, which were the municipal and state public services. In the SUS, access was unified for the entire population, and based on ethical principles of social inclusion, it became a health system model open to the entire population, without the need for corroboration of a link with any institution, becoming a universal system.

Paim (2009) continues by stating that the 1988 Federal Constitution recognized health as a right for all and a duty of the state. This recognition resulted in a debate, political battle, and theoretical clashes that led to the implementation of the Unified Health System (SUS). However, it was not until 1990 that the National Congress approved and considered the Organic Health Law, which clarified and standardized the functioning of the system. Following this, Brazilians gained the right to universal and free health care.

According to the Brazilian Ministry of Health (1998), the Unified Health System (SUS) is one of the largest and most complex public health systems in the world, covering everything from Primary Care to organ

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transplant surgery, ensuring full, universal and free access to the population. Thus, the SUS provided universal access, comprehensive care and became a right of all citizens, focusing on health with quality of life, aiming at precaution and health promotion.

Continuing, the Brazilian Ministry of Health (1988) clarifies by saying that the principles of the unified health system are: University – Where health is a right of citizenship and it is up to the state to ensure this right, regardless of sex, race, occupation and other social and personal characteristics; Equity – where the focus is on reducing inequalities; Comprehensiveness – where it considers people as a whole, meeting all needs, and articulates health with other public policies, to ensure action between the different areas in health, and quality of life for citizens.

According to Bodenheimer & Grumbach (2012) and Nascimento (2013), one of the most discussed aspects of the sustainability and effectiveness of the Unified Health System (SUS) is its financing. In Brazil, public health spending represents approximately 3.8% of Gross Domestic Product (GDP), a percentage considered low compared to the average in countries with universal systems, such as Canada and the United Kingdom, where spending exceeds 7% of GDP.

Paim (2009) and the Ministry of Health (1998) indicate that the SUS financing model is tripartite, with resources distributed among the federative entities: the Union, states, and municipalities. However, research indicates that, over time, financial responsibility has gradually been transferred to municipalities, which often lack the fiscal capacity necessary to cover costs. In 2022, according to Guimarães (2020), municipalities were responsible for approximately 31% of total public health spending, while the Union contributed approximately 43%, and states the remaining 26%.

Nascimento (2013) demonstrates that, even with budgetary constraints, the SUS exhibits positive performance indicators. Among the most significant results are: the reduction in infant mortality, which fell from 47.1 per thousand live births in 1990 to 11.9 in 2020; the expansion of vaccination coverage, which historically exceeds 90% in the main campaigns; and the strengthening of primary care, especially through the Family Health Program, which serves over 65% of the population.

Continuing, Nascimento (2013) states that Brazil has a health organization and structure focused on primary care. The SUS, through its programs, anticipates the decentralization and management of health care provision. The main program is the Family Health Program, responsible for providing medical care throughout the national territory. This program has been growing continuously.

For Starfield (1992), the focus on primary care is considered a positive milestone towards the health of the population, as it provides preventive measures, curative care, integrated services and necessary rehabilitation, which demonstrates the capacity to serve the population's needs.

Nascimento (2013) continues by saying that secondary health care is impacted by the fact that a large part of private hospitals and outpatient clinics provide services to the Brazilian government. Thus, the government depends on these structures to offer secondary services. The problem with this is that the service is divided between private and public services.

According to Solla & Chioro (2008), tertiary care also depends on the private sector for the provision of high-cost services, such as organ donation, transplants, and oncological and cardiac surgeries. These treatments are offered to specific groups and paid for by the government through agreements that benefit both parties.

Bodenheimer & Grumbach (2012) state that all three levels of care: primary; secondary and tertiary – are part of a coordinated process of actions, where each region of the country is mapped and evaluated according to its needs. This care model has been valued for its cost reduction methods, because primary care is predominantly employed, producing disease prevention and control.

The population that does not use the SUS, according to Fleury (2010), may be acquiring a private health service. Private health services have two categories: First, the category of independent providers, which consists of medical clinics, laboratories, and hospitals and doctors, who work with the provision of

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independent services; The other category is the health plan market, which is composed of medical cooperatives, private insurance companies that offer paid health services to the population.

Health characteristics between the United States and Brazil

For Nascimento (2013), the first characteristic between both countries is related to a mix of public and private initiatives. The second characteristic is the division of health care into three levels: primary, secondary and tertiary.

Gruber (2011) states that health financing in both Brazil and the United States comes from different sources, such as the government and the private market. Both have tax payments directed to health services, as well as social and welfare insurance where coverage depends on contributions through specific payments from workers.

RESULTS AND DISCUSSIONS

The final literature review sample, used for the results and discussions, consisted of 13 studies that, using various methodological approaches, examined the structure, challenges, and progress of the US and Brazilian health systems. These studies include historical analyses, public policy investigations, documentary reviews, and theoretical essays, providing a broad and diverse view of both models.

AUTHOR (YEAR)	METHODOLOGY	MAIN FINDINGS
Pegoraro (2013)	Comparative analytical review	Structural differences between systems; A more equitable Brazil
Paim (2009)	Historical-documentary study	Creation and consolidation of the SUS as a universal system
Bodenheimer & Grumbach (2012)	Political analysis of systems	Advocates reforms in both countries; focus on primary care
Brito (2016)	Descriptive study	Details the functioning of Medicare and Medicaid in the US
Pinto et al. (2020)	Theoretical-legal essay	Legal aspects of the American system; criticism of privatization
Nascimento (2013)	Comparative analysis	Identifies common and different characteristics in both systems
Koh & Sebelius (2010)	Government opinion piece	Assesses the impact of the ACA on prevention and access to healthcare in the US
Guimarães (2020)	Analytical essay	Defense of the Unified Health System (SUS) as an essential structure in emergencies
Starfield (1998)	Population study	Emphasizes the importance of primary care in the US
Trivedi et al. (2018)	Quantitative study	Effects of cost-cutting on prevention in Medicare
Sandoval (2020)	Analytical report	Criticism of the US healthcare system during the pandemic; highlights collapse and inequality
Fleury (2010)	Economic-fiscal analysis	Examines the tax exclusion in employer-sponsored insurance in the US
Gruber (2011)	Technical-economic study	Discusses the effects of the tax exclusion in private health plans

author's table 2025

Authors such as Pegoraro (2013) and Nascimento (2013) stand out among the studies examined, having conducted direct comparative analyses between the two countries. Pegoraro emphasizes that the Brazilian system has a clearer ideal of equity and universalization, while the North American system prioritizes efficiency and individual autonomy, even if this results in the exclusion of a significant portion of the population. Nascimento, on the other hand, emphasizes that both countries have a structure with three levels of care (primary, secondary, and tertiary), but there are significant differences regarding access and integration between these levels.

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Research such as that by Paim (2009) and Guimarães (2020) provides a historical and institutional overview of the Unified Health System (SUS), highlighting its origins in the context of Brazilian redemocratization and its establishment as a policy of social inclusion.

Regarding the United States, authors such as Brito (2016) and Pinto et al. (2020) address the restrictions of Medicare and Medicaid, highlighting the selectivity of these programs and the predominant role of the private sector as a regulator of health care access.

Bodenheimer & Grumbach (2012) and Starfield (1998) highlight the strategic importance of primary care in both Brazil and the United States, although its consolidation occurs differently in each country. In the United States, a strong emphasis on medical specialization and fragmentation of care persists. In contrast, in Brazil, despite structural challenges, initiatives such as the Family Health Program are frequently cited by various authors as examples of good primary care practices with a territorial and community focus.

The importance of preventive health care is another significant point discussed in studies such as Koh & Sebelius (2010) and Trivedi et al. (2018). The passage of the Affordable Care Act (ACA) in the United States was an attempt to expand access and strengthen preventive practices by imposing requirements on private plans to cover services based on scientific evidence. However, the financial burden of the U.S. system still poses a barrier, especially in cases of emergency or chronic illnesses.

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However, as Sandoval (2020) points out, the financial impact of the U.S. system still represents an obstacle, especially in cases of emergency or chronic illnesses.

Finally, authors such as Fleury (2010) and Gruber (2011) highlight the importance of fiscal policies and market logic in shaping the US healthcare system. This contrasts directly with the principle of universality of the Unified Health System (SUS), enshrined in the 1988 Constitution.

This variety of methods and analytical approaches enabled a critical and contextualized analysis of the two systems, allowing not only a formal comparison of their structures but also a debate on the principles that guide public health management in each country.

The Brazilian system is committed to equity, established in the Constitution, with the goal of reducing social and regional inequalities. The Unified Health System (SUS) is organized to serve everyone, regardless of income or social class. In contrast, the American system, based on the market, imposes significant financial obstacles that hinder fair access, especially for lower-income populations.

While the Unified Health System (SUS) ensures universal and free access to health services, in the United States, access is conditioned by factors such as employment status, insurance coverage, or eligibility for public programs like Medicare or Medicaid. The existence of co-payments and deductibles in private health plans in the United States makes regular access more difficult, especially for preventive care.

Both countries face challenges and progress in quality. Brazil faces structural challenges, such as a lack of financial resources and regional inequalities. In the United States, quality may be high in private settings, but it is not uniform, and high costs hinder continuity and comprehensive care. Primary care, supported in both countries, is considered a strategy to increase quality and reduce costs.

FINAL CONSIDERATIONS

A comparison of the healthcare systems of Brazil and the United States reveals not only significant differences in structure but also quite different results regarding equity, access, and performance. Although the Unified Health System (SUS) operates with limited resources—approximately 3.8% of GDP in public healthcare

spending—it has managed to ensure universal, free, and fair access. The SUS has also been responsible for significant advances, such as the reduction in infant mortality and the expansion of primary care. On the other hand, the US system, which consumes more than 17% of GDP, presents less favorable population health indicators, such as lower life expectancy and high rates of preventable mortality. This demonstrates that greater investment does not necessarily guarantee better collective performance.

Regarding equity, the SUS demonstrates a stronger constitutional commitment to universality and social justice, whereas the American model creates financial barriers to access, especially for uninsured or underfunded groups. The existence of co-payments, deductibles, and tax exclusions in the US demonstrates a market logic that values private efficiency but undermines equity in distribution.

Healthcare is fundamental to the well-being of the population. The availability of healthcare services, both public and private, is essential to ensure the population receives the necessary care, ranging from promotion and prevention initiatives to highly complex care. In this context, the quality and continuity of services offered are directly affected by the structure and financing of the systems analyzed.

However, as a narrative review, this study has significant limitations. This type of approach does not adhere to systematic criteria for searching, selecting, and evaluating the literature, which can result in selection bias and lack of reproducibility. Furthermore, the lack of a meta-analysis of the data limits the ability to quantify the results or make more robust generalizations.

Therefore, we suggest that future research use more organized approaches, such as systematic reviews or empirical studies with mixed methods (qualitative and quantitative), to further analyze health systems based on comparable and verifiable metrics. Longitudinal studies investigating the effect of public policies on indicators such as effective access, perceived quality, clinical outcomes, and financial sustainability would also be useful.

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