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Expert communities and interest-formation in the Brazilian AIDS program

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Abstract *This paper examines the role of the Technical Advisory Committee for antiretroviral therapy of the Brazilian AIDS program in mediating the decision-making process of including new antiretroviral (ARV) drugs in the Unified Health System services by the end of the 2000s. We conducted documental analysis and interviews with key informants from the governmental sphere and professionals. The work features the Technical Advisory Committee as an "expert community", defined as a network of individuals with expertise and competence in a particular sphere and whose knowledge is relevant in critical public policy decision areas. It also indicates that the decision -making process for inclusion of antiretroviral drugs in the Brazilian program was incremental, considering the expectations of the innovative leader companies of pharmaceutical market. The work describes thus the results of the interaction of government interests, pharmaceutical industry and experts in the implementation of a relevant international policy. It provides arguments and evidence for understanding the role of expert communities on a sectorial public policy so far analyzed predominantly from the perspective of social movements.*

Key words *Health policy, Antiretroviral therapy, Conflict of interest, Pharmaceutical industry*

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Introduction

Brazil was the first middle-income country to offer universal and free access to antiretroviral drugs (ARVs). Studies[1,2] indicate that this initiative has brought important results, such as the reduction of mortality and morbidity. The provision of ARVs is the responsibility of the federal government, which is also the exclusive buyer of these drugs in the country. In this monopsonic exercise of power, understanding the role of the technical committees that advised governments in the early years of implementation and development of the policy of provision for the procurement of extremely important medicines.

Brazilian response to the AIDS epidemic has been successful due to its broad spectrum, which encompassed prevention, treatment and respect for human rights. The mobilization of civil society is a crucial element in shaping this response and has decisively influenced the development of all spheres of action[3]. However, a small group of professionals conducted one of the least visible components of the epidemic.

This paper examines the role of the Technical Advisory Committee for antiretroviral therapy of the Brazilian AIDS program in mediating the decision-making process of including new ARVs in the Unified Health System services by the end of the 2000s and shows that the decision-making process for inclusion of ARVs in the Brazilian program was strongly incremental, considering the expectations of the innovative leader companies of pharmaceutical market. This work features the Technical Advisory Committee as an "expert community", as will be seen below.

The paper thus describes the results of the interaction of interests in the implementation of a policy of great international relevance. It offers arguments and evidence for the understanding of the role of communities of experts in a sectorial public policy hitherto analyzed predominantly from the standpoint of social movements.

The community of experts

In recent decades, government decision-making has been increasingly drawing on scientific knowledge, including the health. The modern Western state has assimilated the notion of evidence-based policy, although scientific knowledge is only one of the elements that influences decisions, competing with other sectors and interests of society[4].

In Brazil, recent studies underscore the importance of improving qualification and professionalization for the modernization of bureaucracy and, consequently, for increased state capacity[5]. When analyzing innovations in governance within the federal administration, Ribeiro and Inglez-Dias[6] point out the weight of specialists in producing ideas for the establishment of a political agenda and decision-making.

In the analysis of public policies, the subject of relations between government, pharmaceutical industry and community of experts is of great relevance for the risk of induction to the incorporation of new products by means of symbolic, material or financial incentives to experts. Thus, the central debate on the action of public policy experts is related to their influence on government decisions.

The community of experts is a network of professionals who are experienced and competent in a particular field, whose knowledge is relevant in critical areas of public policy decision-making. Brint[7] and Haas[8] regard intellectual authority over a particular policy field as the main brand of this group.

These authors claim that periods of uncertainty and crisis are the most favorable for political authorities to delegate decision-making power to expert communities. The implementation of an important public policy such as the universal supply of ARVs can be characterized as one of these moments. Haas[8] emphasizes the participation of expert communities in the production of consensus for decision-making or policy coordination. Brint[7] and Haas[8] highlight the ability of these communities to influence governments through the introduction of technical representatives in regulatory or consultative organizations. In this study, we argue that the Technical Advisory Committee for ARV therapy (ART) of the Brazilian AIDS program shows classic features of expert communities, especially infectious disease experts, and that, by the end of the first decade of the 2000s, the process was heavily centralized in this community.

Relations between pharmaceutical companies and medical professionals

In 1982, Paul Starr[9] published a groundbreaking paper examining the establishment of a medical industry in the United States, which sparked debate that continues to this day.

According to a national survey[10] conducted in the U.S. in 2007, of 3,167 physicians in six spe-

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cialties, 94% of professionals reported some form of relationship with the pharmaceutical industry. The most frequent were the receipt of food at the workplace (83%) or free samples (78%), reimbursement for costs associated with professional events, congresses or medical education (35%) and payment for consulting, lectures or recruitment of patients in therapeutic tests (28%).

Results from the study indicated that the industry was channeling its efforts to physicians who could influence prescription patterns of other physicians and that payments to doctors who are opinion leaders were more frequent, such as those who had developed clinical guidelines. Initially more directed to physicians in liberal practice, marketing strategies extended to public, private, academic and other hospital institutions[11-15] over the last 20 years.

In Brazil, in 1985, Cordeiro[16] suggested the shaping of a medical-industrial complex, which would involve industries, the provision of medical services and professional training. Subsequently, other authors addressed the issue in the Brazilian context[17,18].

In 2010, a study[19] promoted by the Regional Council of Medicine of the State of São Paulo and conducted by an opinion research institute analyzed the relationship of São Paulo physicians with the drugs, orthoses, prostheses and medical-hospital equipment industry. Among the findings, 93% of the respondents stated that they received products, benefits or payments from the industry of less than R$ 500 in the 12 months preceding the survey. Eighty percent of São Paulo doctors were visited by representatives of pharmaceutical companies, on an average of eight visits per month. Of these 80%, 38% stated that they prescribed according to the recommendation of the representative.

Surveys[20] indicate that aggressive marketing encourages inappropriate drug use. The development of mechanisms of influence by the pharmaceutical companies has led public agents to update their regulations, as demonstrated in Resolution Nº 96 issued in 2008 by ANVISA, which establishes more explicit and restrictive parameters on drug advertising.

While it is possible to assume that the penetration of the pharmaceutical industry in Brazil is smaller than in the U.S., for example, its promotion and influence strategies are similar throughout the world. What makes them more or less aggressive in a given country are, on the one hand, its relevance as a market and, on the other hand, its permeability to business ventures.

Brazil is an attractive market. It ranks seventh in the world drug market overall. Regarding ARVs, from 2009 to 2015, the number of people receiving these drugs in the SUS increased by 97%, from 231,000 to 455,000 people[21]. The national basket is not restricted. In 2010, 19 drugs were being distributed in various forms. As a comparison, guidelines for the use of WHO ARVs[22] in that year recommended the supply of 17 drugs. In 2016, 22 ARVs are distributed, compared to 16 recommended by the WHO[23]. The annual cost of acquiring these products exceeds 1 billion Reals.

The Technical Recommendations Committee is one of the main adaptations of the Brazilian AIDS program because it is an intermediary structure between producers and professionals at the services level, with functions to evaluate the incorporation of supplies into the program. In the case of the Brazilian Committee, this intermediation refers to a concrete arena for effective decision-making, with clear repercussions on national public expenditures.

Methods and sources

We performed documental analysis and interviews with key informants. The period covered was from 1996, year of the establishment of combined antiretroviral therapy, to 2010. The Adult Committee was chosen because this population group comprises the vast majority of ARV users.

We analyzed 13 documents: 1996, 1997, 1999, 2000, 2001, 2002/2003, 2004, 2005/2006, 2008, 2008-Supplement I, 2008-Supplement II, 2008-Supplement III and 2008-Supplement IV[24]. As the preparation of these supplements required individual specific meetings at different dates and with different participants, for the purposes of this study, supplements were analyzed individually. The lists of participants surveyed were those contained in each document.

The first document analyzed included children, adolescents and adults. Since 1997, children and pregnant women have become the subject of specific documents. From 1997 to 2005/2006, adults and adolescents were grouped under the same document. As of 2008, recommendations for adults have become unique to this group. However, even when the recommendations were shared with other groups, the adult class was always comparably much larger, enabling the analysis of documents that addressed adults, regardless of whether they included other segments.

We also conducted a survey on the current regulations regarding the Committee, all these ordinances of the Ministry of Health, through the website Saúde Legis – Health Legislation System. We performed semi-structured interviews of about 60 minutes with eight key informants, government managers and professionals who have participated in adult committee meetings and have a good knowledge of it. The agenda covered the following topics: committee composition, membership inclusion criteria, discussion process at meetings, decision-making, final document production, conflict management tools and strategies.

The Research Ethics Committee, ENSP/Fiocruz approved the project that gave rise to this paper, which complies with the ethical principles contained in the Declaration of Helsinki, as well as the relevant Brazilian legislation.

Results

Origin, mission and character of the Committee

Law 9.313[25] of November 13, 1996, which established universal and free access to drugs for HIV patients and AIDS patients, states that "therapy standardization should be reviewed and republished annually, or whenever necessary, to *adapt to updated scientific knowledge and to the availability of new drugs on the market* (emphasis added). Three weeks later, the Ordinance of the Ministry of Health Nº 2.334 established a technical committee to "study and propose technical-scientific solutions" to comply with said law.

The Committee may only consider drugs that have already been approved for use in the country. When Law 9.313/96 was enacted, the National Health Surveillance Secretariat (SNVS) performed the approval of drugs. In 1999, the National Health Surveillance Agency (ANVISA) was established and assumed this regulatory function ever since.

During the period under study, 12 ordinances made provisions on the Technical Committee. In 2010, only two ordinances were in force, resulting from a process in which the current ordinances revoked the previous ones. The first of these was MS Ordinance Nº 91, dated 08/10/08, which created the Committee and defined that it should contribute to the establishment of recommendations for the use of antiretroviral drugs and for the formulation of public policies associated with them. The ordinance also determined that members should declare the lack of conflicts of interest between their activities and the functions of the Committee. The second ordinance in force was Nº 93, dated 10/10/08, which appointed the members of the Committee. It should be noted that the Department is entitled to replace members annually.

Observing the set of ordinances in the period, we note that the character of support for the formulation of public policies has always been maintained, as well as the nominal publication of experts, which gives them institutional legitimacy.

Composing members

In the period observed, the Committee was always composed of external experts and representatives of the Department of STD, HIV, AIDS and viral hepatitis (at the time called the National STD/AIDS Program). The number of government representatives increased over time, but experts have always remained, which ensured the preservation of the technical character of the group. The 2001 document mentions that representatives of civil society had been invited, but their names are not part of the credits. In the following years, up to two representatives of civil society participated in the meetings, identifiable in the list of participants. As of the 2002/2003 document, members of ANVISA and representatives of other MS sectors began to join in Committee meetings, notably the Tuberculosis and Viral Hepatitis programs. The last two to collaborate in the discussions on cases of HIV co-infection and these pathologies. In addition, there were occasional members of other Secretariats, such as the Executive Secretariat and the Secretariat of Science, Technology and Strategic Supplies.

Table 1 shows the participants to each meeting. External specialists were categorized as coming from academic institutions and specialized clinical services or managers. Each year, the vast majority is composed by infectologists. As of 2003, we can observe the participation of some pulmonologists whose presence is justified by HIV/tuberculosis co-infection. It is important to emphasize that infectologists' hegemony did not occur in the inaugural phase of the epidemic. It was gradually built and consolidated in the mid-1990s. Until then, the participation of dermatologists and pulmonologists, mainly in the medical monitoring of people with HIV/AIDS was frequent. With the developing epidemic, spe-

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Table 1. Participants in Committee meetings by year and institutional affiliation.

Year	External Experts			Civil Society	Government Representatives	Total
	Academic/Clinical	Managers	Subtotal			
1996	7	0	7	0	4	11
1997	12	1	13	0	4	17
1999	17	4	21	0	4	25
2000	18	4	22	0	4	26
2001	18	4	22	0	5	27
2002/2003	19	4	23	2	8	33
2004	21	5	26	1	7	34
2005/2006	30	7	37	2	11	50
2007/2008	18	5	23	2	17*	42

* Includes 6 technicians from the federal government and 11 external collaborators to the Committee, invited by the then National STD and AIDS Program and not identified as being from other MS sectors.
Note: Institutional affiliation information is not available in supplements subsequent to 2007/2008.
Source: Own elaboration based on the technical recommendations documents and interview information.

cialties that initially entered the market have lost ground to infectologists. In 2004, 2005/2006 and 2007/2008, the minimum numbers of specialists that can be considered infectologists because they have some postgraduate degrees in this field were 23 in 26, 17 in 23 and 25 in 37, respectively.

We noted that there were overlapping skills such as, for example, members of academic institutions who have clinical practice or, also, managers who are also clinical doctors. In the data analysis, we considered only one institutional affiliation, as shown in the list of participants in each document. In any case, through the analysis of the lists of members and interview information, we can conclude that the experts are individuals with training and/or technical-scientific experience in infectology that qualifies them as experts.

The total number of participants increased by the year, with the exception of 2007/2008. Specifically, the number of experts also declined in 2007, after escalating increase since 1996. Also in 2007, the meeting counted on six technicians of the federal government and 11 employees external to the Committee, invited by the Department and not identified as of other sectors of the MS. One could not clarify their functions or institutional affiliation. Table 2 below compares the participation rates of civil society, external experts and the government. It is noted that participation of civil society did not exceed 6% throughout period analyzed. Experts' participation decreased from 81% to 70% in 2002/2003, rising slightly to 74% in 2005/2006, despite some oscillation. The participation of government representatives increased in 2002/2003 and declined in 2004, and then remained stable at just over 20%. Therefore, between 2002/2003 and 2005/2006, a slight variation in the participation of experts and members of the government, with a decline in the proportion of the former and a hike in the latter.

In 2007/2008, this change became more marked due to greater decrease in the participation of experts (55%) and increase of government representatives (40%). The decreased presence of experts and the concomitant increase of regulatory agents, such as ANVISA and others may have occurred due to the maturation of the policy and the risks to its financial sustainability. The changing circumstances may have caused the government's motivation to grow.

From 1996 until the last recorded meeting, 104 individuals had already participated in the Committee, whether as external experts, government technicians, members of civil society or others. Table 3 shows the distribution of participants by number of meetings. There is a significant variation in the number of meetings in which individuals participated. More than half of the people (72) participated only in up to two meetings. The analysis of the components showed that this group is composed mainly of government representatives.

Nineteen individuals participated in 5 to 9 meetings. Data review showed that this segment is composed of external experts. This finding indicates that there is a reduced and assiduous core over the years, which suggests that the Committee's 'memory' has been preserved and that there has been continuous technical discussions. It also suggests that the Committee remained under the

Table 2. Proportion of participation by category.

Year	External experts (%)	Civil society (%)	Government Representatives (%)
1996	64	0	36
1997	76	0	24
1999	84	0	16
2000	85	0	15
2001	81	0	19
2002/2003	70	6	24
2004	76	3	21
2005/2006	74	4	22
2007/2008	55	5	40

Source: Own elaboration based on the information of technical recommendations documents.

Table 3. Number of individuals and number of meetings they attended.

Number of individuals	Number of meetings
3	9
2	8
9	7
3	6
2	5
6	4
7	3
14	2
58	1

Source: Own elaboration based on the information of technical recommendations documents.

'control' of experts. These statements were corroborated by interviews.

Recommendations documents

Regarding the technical decisions of the Committee, there were countless modifications regarding ART in the period 1996-2010. Chart 1 summarizes some of the main events in the course of the use of these drugs.

The first consensus established the use of eight ARVs, some of which had already been distributed before Law 9.313/96 was enacted. Over time, recommended medications were replaced in the face of more satisfactory therapeutic options.

Table 4 shows the ARVs recommended by the Committee, its original date of approval by the FDA, the original date of approval by SNVS or ANVISA, and the date of the Committee meeting that recommended inclusion in the basket offered by SUS. With the exception of five drugs, the remainder were adopted within two years after FDA approval. Considering that Brazil is not a high-income country, it is possible to assume that the SUS was permeable to the entry of ARVs into its basket. The speed of incorporation and the permanence of the decision-making power of the Committee between 1996 and 2010 are evident.

Organizational standard and decision-making

Up to the 2005 meeting, the Committee was organized as follows: experts, government technicians and representatives of civil society met for 1 or 2 days to evaluate the scientific evidence. According to the information of the documents themselves and those interviewed, they consisted of results from methodologically valid clinical studies published in scientific journals or presented at congresses. Based on this evidence, the new recommendations were defined by consensus. Next, a small rapporteurship committee was organized, which refined the content through e-mail reviews. In general, one of the members of the Department or one of the Committee's experts led the writing stage, whose product was submitted to all for final approval. The process was characterized by some informality and flexibility.

The 2008 recommendations document was the product of significant changes to the Committee, which started about a year earlier. In

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Chart 1. Main recommendations in the use of ART in adults and adolescents (1996-2010).

Year	Date of publication	Recommendation
1996	17/04/1997	▪ Establishment of antiretroviral therapy combined with nucleoside analog reverse transcriptase inhibitor (NRTI) and protease inhibitor (PI) ▪ Use of therapy in reducing vertical transmission
1997	29/03/1998	▪ Use of ART in chemoprophylaxis after occupational exposure to HIV ▪ Introduction of recommendations on drug interactions
1999	09/07/2000	Introduction of new-class ARV, that of non-nucleoside reverse transcriptase inhibitors (NNRTIs)
2001	25/05/2002	▪ Re-evaluations of the recommendation to start treatment ▪ Implementation of the National Genotyping Network (RENAGENO) to perform genotyping tests
2005/2006	20/06/2006	▪ Introduction of new-class ARV, that of fusion inhibitors ▪ Inclusion of an annex with cost of drugs
2008	23/10/2007	▪ Reassessment for treatment of asymptomatic individuals ▪ Inclusion of the cost factor in the therapeutic definition ▪ Use of evidence-based medicine for the use of recommendations ▪ Introduction of conflict management strategy of interest among Committee members
2008 (Suppl. I	2009	▪ Introduction of new class ARV, integrase inhibitors
2008 (Suppl. II)	February/2010	▪ Re-evaluations of the recommendation to start treatment
2008 (Suppl. III)	October/2010	▪ Use of ART to reduce HIV transmissibility ▪ Inclusion of recommendations on exposure to HIV in casual sex
2008 (Suppl. IV)	October/2010	▪ Updating recommendations for the management of therapeutic failure

Source: Own elaboration based on the information of technical recommendations documents.

November 2006, the Committee met to discuss the restructuring of drafted recommendations, which involved three themes: a change in the pattern of organization, a new method of analyzing scientific evidence and the definition of a policy to manage conflicts of interest.

The new organizational dynamics were as follows: first, the Committee chose the most important topics related to treatment – initial therapy, resistance management, toxicity and comorbidities. The Committee was then divided into four subcommittees, each responsible for one theme. The new analysis method included the establishment of criteria for the review of the literature and the definition that the clinical studies considered would be exclusively randomized clinical trials published in scientific journals of international circulation based on peer-review or in annals of scientific meetings. The Oxford Center for Evidence-Based Medicine Classification[26] was used to evaluate these trials, which classifies results according to levels of evidence and degrees of recommendation. Similar methods are used by the WHO[23] and the British HIV Association[27] (BHIVA), a non-profit, scientific civil association that routinely publishes technical guidelines for the use of ARVs in Great Britain.

Decisions not addressed by the methods of evidence-based medicine were taken by consensus. Subsequent updates, as already mentioned, occurred in the form of supplements, whose elaboration obeyed the same dynamics. Changes in the ethical management will be addressed next.

Conflict of interest policy

Until the Committee's reformulation, there was no defined "conflict of interest" policy, although one of the ordinances on the Committee had already addressed the issue in 2004. For the elaboration of the 2008 document, criteria were stipulated for evaluating the existence of these conflicts, which, if not met, excluded the member from participating in the Committee, and they were: (a) not having a job linked with phar-

Table 4. ARVs distributed in Brazil by dates of approval by the FDA, by the Brazilian regulatory agency and recommendation of provision by the SUS (1991-2008).

Drug	Original approval by the FDA	Original approval by SNVS or ANVISA	Recommendation of provision by the SUS	Approximate time between FDA approval and approval for provision by the SUS (in years)
Zidovudine	Mar/1987	Mar/1988	1991	4
Didanosine *	Oct/1991	Jun/1992	1994	3
Zalcitabine *	Jun/1992	Jun/1993	1994	2
Stavudine	Jun/1994	Apr/1995	Apr/1997	3
Lamivudine	Nov/1995	May/1996	Dec/1996	1
Saquinavir	Dec/1995	Feb/1996	Dec/1996	1
Ritonavir	Mar/1996	Apr/1996	Dec/1996	Less than 1
Indinavir	Mar/1996	Apr/1996	Dec/1996	Less than 1
Nevirapine	Jun/1996	Jan/1998	Mar/1998	2
Nelfinavir	Mar/1997	Jan/1998	Mar/1998	1
Delavirdine *	Apr/1997	Feb/1998	Mar/1998	1
Efavirenz	Sep/1998	Nov/1998	May/1999	Less than 1
Abacavir	Dec/1998	Mar/1999	Jun/2000	2
Amprenavir *	Apr/1999	Aug/1999	Jun/2000	1
Lopinavir / r	Sep/2000	Oct/2000	Oct/2001	1
Tenofovir	Oct/2001	Jun/2003	Oct/2003	2
Atazanavir	Jun/2003	Sep/2003	Oct/2003	Less than 1
Fosamprenavir	Oct/2003	Dec/2005	Oct/2007	4
Didanosine EC	2000	Dec/2001	Oct/2005	5
Enfuvirtide	Mar/2003	May/2004	Oct/2005	2
Darunavir	Jun/2006	Jul/2007	Oct/2007	1
Raltegravir	Oct/2007	Jan/2008	2º half/2008	1
Etravirine	Jan/2008	Feb/2009	2009	1

Source: Own elaboration based on technical recommendations documents.

* No longer in use in 2008.

maceutical laboratory (ies) and/or other private institutions manufacturing drugs; (b) not providing technical advice to private pharmaceutical laboratory (ies) manufacturing antiretroviral drug (s); (c) not being a member of an advisory board of pharmaceutical laboratory (ies) and/or other private institutions that manufacture drugs and (d) having no employment relationship, not being a shareholder of organization (s) that, somehow, may have benefits or harms with the participation of the individual in the Committee. A statement of conflict of interest was filled out and signed by each of the members and only those who met the conditions established could participate in the meetings for the preparation of the 2008 recommendations.

According to information from the interviews, the four situations above were considered the most relevant. Others were so widely disseminated that they could not be a selective criterion, such as ticket financing, per diems, congress registration, teaching activities, lectures and research funding. According to one informant, the need to control conflicts of interest was consensual among members, but the model adopted was controversial. Still according to interview data, at the time, six participants had conflicts of interests. Of these, three chose to give up the situations generating the conflicts and remain in the Committee, while the others left the group.

In the opinion of one respondent, participation in advisory boards with declaration can be less conflicting than the financing of tickets, per diems and registrations in international congresses, whose sum per trip can reach several thousand Reals, and these trips may occur several times a year. In addition, a professional can be financed by the same industry in different opportunities, which could increase the possibility of favoring this company by this professional.

Thus, the theme of conflict of interest became important in the mid-2000s, requiring agents in

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the process to change their behavior patterns. However, these changes, in practice, appear to be only partially achieving the desired outcome of formal measures.

Discussion

This paper describes the organizational dynamics, decision-making and conflict of interest management of the ARV Technical Recommendations Committee and characterizes it as a community of experts. It also intends to demonstrate that, from its inception to the late 2000s, one of the most important public policies of the country had its pathway validated by this community of specialists. Regardless of the comprehensive aspect of the Brazilian response and the leading role of social movements to address the epidemic, including support for the provision of a broad basket of ARVs by the SUS, government choices were strongly medical decision-based. The results also show that, in the observed period, the country was permeable to the incorporation of innovative ARVs into the basket, whose drug replacement process followed the pace of new products launch.

Findings also indicate that, in recent years, there may have been a tension between the government and the experts. Increasing the number of government representatives at meetings and adhering to new evaluative and organizational standards may have been an initiative to inhibit the discretion of experts. Even if the results indicate that policymakers retained control over decisions, threats to the financial sustainability of the policy that emerged in the mid-2000s may have motivated the government to increase its leadership power.

Regarding ethical aspects, the implementation of a government conflict of interest management policy at the end of the period studied meant an attempt to limit business lobbying that, disseminated under various forms of relationship with professionals, could influence the establishment of interests within the Brazilian program.

Recent study[28] confirms that treating people with HIV not only contributes to their health, but can also reduce their likelihood of transmitting the virus by up to 96%. This finding indicates that ARVs may also have an expressive effect on HIV prevention, which reinforces their centrality in controlling the epidemic and signals that the demand for these drugs is on the rise and will require new subsidies for decision-making from the government.

Finally, in 2011, the creation of the National Commission for the Incorporation of Technologies into the Unified Health System – CONITEC, in order to advise the Ministry of Health on the incorporation, exclusion or change of health technologies by the SUS could also reduce the prevailing medical decision between government and experts.

Collaborations

RF Lago and NR Costa were responsible for all the stages leading to the production of this paper.

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