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Fifteen years of Conitec: strengthening science to safeguard the SUS

Quinze anos da Conitec: consolidar a ciência para proteger o SUS

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ABSTRACT

In 2026, Brazil's National Committee for Health Technology Incorporation into the Unified Health System (Conitec) turns fifteen. This opinion article argues that the main challenge of the next decade is not expanding the number of incorporations, but consolidating the technical excellence of decisions, a distinction that matters to public health and to everyday pharmacy practice, since it shapes the population's access to medicines, clinical protocols, and care within the SUS. It contends that Conitec was born with the legal institutionalization brought by Law No. 12,401/2011 and Decree No. 7,646/2011, grew by consolidating a public and transparent process comparable to that of reference international agencies, and now must mature scientifically. Three critical axes are discussed: governance, still vulnerable to market, political, and media pressure, with social participation confined to the final and least influential stage of decision-making; the debate over adopting a single cost-effectiveness threshold, from which the author dissents for algebraic reasons and because of the difficulty of standardizing effectiveness for rare diseases and pediatric populations; and the need to modernize the methodology of Brazilian health technology assessment, incorporating multi-criteria decision analysis, real-world data, and causal methods. The article ultimately advocates transforming the Brazilian Health Technology Assessment Network (Rebrats) into permanent scientific infrastructure, rather than an occasional collaboration network. It concludes that the credibility of health technology assessment in Brazil should be measured by the technical soundness of each decision, favorable or not, rather than by the volume of technologies incorporated into the SUS.

Keywords: Health Technology Assessment; Unified Health System; Decision Making; Health Policy; Health Economics.

RESUMO

Em 2026, a Comissão Nacional de Incorporação de Tecnologias no Sistema Único de Saúde (Conitec) completa quinze anos. Este artigo de opinião defende que o principal desafio da próxima década não é ampliar o número de incorporações, mas consolidar a excelência técnica das decisões, uma distinção que interessa à saúde coletiva e à prática farmacêutica cotidiana, pois molda o acesso da população a medicamentos, protocolos clínicos e cuidado no SUS. Argumenta-se que a Conitec nasceu com a institucionalização legal trazida pela Lei nº 12.401/2011 e pelo Decreto nº 7.646/2011, cresceu ao consolidar um rito público e transparente comparável ao de agências internacionais de referência, e agora precisa amadurecer cientificamente. São discutidos três eixos críticos: a governança, ainda vulnerável a pressões de mercado, políticas e midiáticas, com participação social limitada à fase final e menos influente do processo decisório; o debate sobre a adoção de um limiar único de custo-efetividade, do qual o autor diverge por razões algébricas e pela dificuldade de padronizar a efetividade para doenças raras e populações pediátricas;

e a necessidade de modernização metodológica da avaliação de tecnologias em saúde brasileira, incorporando análise de decisão multicritério, dados do mundo real e métodos causais. O artigo defende, por fim, a transformação da Rede Brasileira de Avaliação de Tecnologias em Saúde (Rebrats) em infraestrutura científica permanente, e não apenas rede de colaboração pontual. Conclui-se que a credibilidade da avaliação de tecnologias em saúde no Brasil deve ser medida pela solidez técnica de cada decisão, favorável ou não, e não pelo volume de tecnologias incorporadas ao SUS.

Palavras-chave: Avaliação de Tecnologias em Saúde; Sistema Único de Saúde; Tomada de Decisões; Política de Saúde; Economia da Saúde.

INTRODUCTION

In 2026, Brazil's National Committee for Health Technology Incorporation into the Unified Health System (Conitec) turns fifteen. It is tempting to celebrate by counting how many medicines, products, and procedures it has incorporated into the SUS over that period. But that is not, in my view, the right question for this anniversary. The right question is another one: will the challenge of the next fifteen years be incorporating more technologies, or making better decisions?

As an advisory body to the Ministry of Health, Conitec's institutional mission is to issue recommendations on whether technologies should be added, altered, or removed from the SUS. To do so, it relies on Health Technology Assessment (HTA), a multidisciplinary field that combines the best scientific evidence regarding the clinical outcomes of therapeutic options with economic evaluations of its budget impact. HTA is the tool used to ensure that resource allocation is both equitable and sustainable.

That question regarding decision quality may seem distant from the daily routine of those working at the front line of care. It is not. Every time Conitec decides, favorably or unfavorably, it defines what will, or will not, be included in the national clinical guidelines, on the pharmacy shelf, and in the prescriptions written for millions of people served by the SUS. It is often the pharmacist who first translates that decision into patient care: dispensing what has been standardized, explaining why a widely publicized technology is not available through the SUS, or dealing with pressure, including legal action, for technologies that science has not yet endorsed. Understanding what lies behind that decision, then, is a matter of concern for the whole of public health, and for pharmacy in particular.

DISCUSSION

As a public health pharmacist, with a background in systematic reviews and economic evaluations of medicines and a career in SUS management, I will risk summing up these fifteen years in one sentence: Conitec was born, it grew, and now it must mature. It was born in 2011, when Law No. 12,401 and Decree No. 7,646 gave legal form to a process Brazil had already been maturing since 2006[1,2]. It grew by consolidating, in the day-to-day running of the SUS, a public process with statutory deadlines and mandatory consultation, structurally comparable to agencies such as Britain's National Institute for Health and Care Excellence (NICE), Canadian Agency for Drugs and Technologies in Health (CADTH) and Australia's Medical Services Advisory Committee (MSAC). It is a remarkable achievement for a universal public health system of continental proportions[3]. What is missing now is the hardest step: turning that mature structure into recognized technical excellence, rather than focusing on the mere volume of coverage decisions.

That first victory, institutionalization, should not be up for debate. The risk I see lies elsewhere: that Conitec itself, in its institutional communication, measures success by the volume of incorporations rather than by the soundness of each decision. A well-founded

negative recommendation is as much a part of protecting people's health as a favorable one. When that logic is inverted, the criteria of success quietly slides from the quality of the decision to the quantity of approvals. That is precisely where institutional maturity begins to regress.

This distinction matters beyond technical debate. Every coverage decision without solid evidence consumes a finite public budget, failing to fund another public health priority (from primary care to epidemiological surveillance) and may expose real patients to interventions of uncertain benefit or unassessed risk. A hasty decision, therefore, comes with a double cost: the resources it draws from the SUS budget, and the effective alternative that goes unfunded in its place.

The challenge of maturing shows up, above all, in governance. Conitec still relies almost entirely on demand-driven agenda from managers, industry, and medical societies to set its agenda. This arrangement has been identified as permeable to market pressure, and one that leaves out precisely the technologies with the least commercial appeal, such as those aimed at so-called diseases of poverty[4,5]. Recent episodes during politically sensitive periods suggest that the institutional insulation of technical assessment from acute political pressures remains fragile. This became particularly evident in the ministry directives endorsing the use of chloroquine without prior technical appraisal by the Committee[6,7] and in the reversal of the initial recommendation against nusinersen for spinal muscular atrophy amid intense political pressure[8]. The same holds for social participation: public consultations exist, and are already a real advance, but rarely change the final outcome of a recommendation, and when they do, it tends to be due to targeted mobilization rather than genuine plurality of voices[9]. For those working in municipal or state pharmaceutical services, these governance weaknesses are not a distant debate: they help explain why a medicine recommended today may become the subject of litigation tomorrow, or why a clinical guideline approved without local context arrives disconnected from frontline care.

I also part ways, incidentally, with part of the recent debate on adopting a single cost-effectiveness threshold in Brazilian decision-making. The cost-effectiveness threshold represents a cut-off point on the Incremental Cost-Effectiveness Ratio (ICER). The ICER is the definitive output of a cost-effectiveness economic evaluation. An ICER below the designated threshold is typically used to justify the adoption of the technology under analysis. Setting a rigid cut-off value, typically based strictly on Gross Domestic Product per capita multiples, offers a false sense of scientific objectivity that ultimately distorts the macroeconomic reality of the SUS. Identical incremental cost-effectiveness ratios (ICERs) often conceal radically different clinical and budgetary conditions: a technology may prove mathematically cost-effective yet present a prohibitive budget impact capable of destabilizing the funding of entire care networks.

Furthermore, the methodological standardization demanded by a fixed threshold disproportionately penalizes populations highly vulnerable to evidence gaps, such as rare disease patients or pediatric populations. In these scenarios, the scarcity of robust epidemiological data, ethical constraints on controlled clinical trials, and reliance on surrogate endpoints yield uncertainties that traditional cost-utility models fail to capture fairly, artificially pushing these interventions beyond the allowed 'ruler.'

Resource allocation in public healthcare is not a mere accounting exercise, but a tragic choice of an ethical and distributive nature. Consequently, a blind monetary barrier fails to weigh disease severity, the availability of therapeutic alternatives, and the societal cost of denying care. Rather than a single

ruler automatically applied, I advocate for governance rooted in explicit, multi-criteria decision analysis (MCDA), transparently recorded and justified case by case, where economic rationality dialogues with equity and the constitutional mandates of the right to health.

The most urgent maturation, however, is scientific. Over these fifteen years, we have trained a generation competent in systematic reviews and cost-effectiveness analyses in the classic mold consolidated since the 2000s. That was necessary. But international HTA has already moved on to methods that, in Brazil, remain the exception: more sophisticated decision modeling, multi-criteria decision analysis, the use of real-world data, causal methods from econometrics applied to health, and artificial intelligence applied to evidence synthesis[10]. Without that leap, we risk keeping an HTA enterprise technically competent for yesterday's problems, and ill-prepared for the costly, advanced therapies with uncertain evidence that already dominate today's agenda.

That is why I see the Brazilian Health Technology Assessment Network (Rebrats) as the most underused asset of these fifteen years. Created to be the link between research, policy, and management[11], it still operates, in practice, as an occasional collaboration network, when it should be treated as the country's permanent scientific infrastructure. That means continuing education and competency certification for those who assess technologies. It must include Clinical Protocols and Therapeutic Guidelines, today treated as an administrative byproduct when they should meet the same quality standards required of incorporation analyses[12]. It also means actively managing the Health Technology Assessment Centers, with technical support for institutions outside the South-Southeast axis, and a digital portal that truly connects this community, currently fragmented across universities, teaching hospitals, and state centers that rarely talk to one another. It is worth noting, in my own professional impression, that pharmacists already make up a significant share of the technical staff at Health Technology Assessment Centers across the country, a professional responsibility that pharmacy education still incorporates unevenly and insufficiently across teaching institutions.

FINAL CONSIDERATIONS

Over the next fifteen years, the defense of Conitec should not rest on the number of technologies it approves, but on how well each of its decisions is grounded, regardless of whether it recommends incorporation into the SUS. It was born institutionalized. It grew transparent. What is missing is scientific maturity. The credibility of HTA in Brazil will not be measured by the volume of incorporations, but by society's confidence that each recommendation was built with technical excellence and commitment to the public interest. That is the task facing Conitec and the HTA community over the next fifteen years. For practicing pharmacists and healthcare professionals, decoding these decisions is far from an academic exercise. It is a reminder that the quality of HTA in Brazil directly shapes what reaches the pharmacy shelf, defines the clinical protocol, and ultimately guides patient care.

CONFLICT OF INTEREST

The author declares that there is no conflict of interest

DECLARATION OF THE USE OF ARTIFICIAL INTELLIGENCE

The author declares that the Claude tool (Sonnet 5 version), developed by Anthropic (2026), was used to assess the comprehensiveness of the arguments, perform spelling and grammatical corrections, and organize citations and references. Following the use of the tool, all content was reviewed, checked, and validated by the author, who assumes full responsibility for the final version submitted to the BJHP.

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