

The collective health movement and health policy in Brazil: from regime transition/democratization to democracy and neoliberalism (1970s to 2014)

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Abstract This paper analyses how the Brazilian Collective Health Movement (CHM) and its main representatives have influenced the policymaking process for health policy during distinct political periods: from regime transition/re-democratization to democracy (1970s to 2014). We develop a contextual descriptive analysis, involving a literature and documentary review, and interviews with key players. We take into account the political macro contexts (democracy and economic model), governmental coalitions, ideas and actions of the CHM, relationships of the CHM within society, institutionalization of participatory channels, and the interrelations between the Ministries of Economics, of Health and of Social Security. Three main periods were identified: 1) The transition to democracy and Constituent Assembly period, with the fight for and creation of the new national Unified Health Care System (SUS). 2) The first years of re-democratization, during the implementation of the institutional foundations of the SUS (1989- 2002). 3) The period of democracy with neoliberalism (from 2003-2014), when a managerial and participative approach coexisted and conflicted with attempts to subordinate health care policy to the developmental model. The results indicate that the influence of the CHM was less dominant in subsequent years, characterized by the institutionalization of civil participation in health councils, by the prominence of the economic model, and by a more institutionalized political action of movement leaders in the Health Secretaries and the Ministry of Health. In conclusion, we highlight the relevant political lessons regarding the CHM's possibilities of effective revival in the years to come.

Key words: health policy, health movement, participation, health councils, policymaking process

Resumen

Este trabajo explora las formas en que el Movimiento Brasileño de Salud Colectiva y sus principales representantes han influido en el proceso de formulación de políticas de salud durante el período de transición y consolidación de la democracia en Brasil (1970s-2013). Desarrollamos un análisis contextual descriptivo, con una revisión bibliográfica y documental. Se identificaron tres períodos claves: 1) Entre finales de los años setenta y 1988 vemos la formación del movimiento de salud y el desarrollo de una lucha política socialmente arraigada para la creación del nuevo Sistema Único de Salud (SUS). 2) Entre 1989 y 2002 se implementaron las principales bases institucionales del nuevo sistema de salud brasileño. 3)

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Entre 2003 y 2006 se formó una línea gerencial y participativa; y luego (después de 2007) se mantuvieron aliados a un esfuerzo por vincular la política de salud con el modelo de desarrollo. Los resultados indican que aunque las ideas del movimiento colectivo de salud han sido influyentes durante todo el período, fueron menos dominantes en los últimos años, caracterizadas por la institucionalización de la participación de la sociedad en los consejos de salud y por una acción política más institucionalizada de los líderes de el movimiento en las Secretarías locales / estatales y en el Ministerio de Salud Nacional. En la actualidad, y principalmente después de las protestas del movimiento de masas y salud en junio de 2013, se ha considerado esencial renovar el movimiento.

Palabras claves: reforma de salud, participación, movimiento de salud, consejos de salud, proceso de formulación de políticas.

Collective health movement and health policy in Brazil: From regime transition/democratization to democracy and neoliberalism (1970s to 2014)¹

Introduction

The Brazilian transition to democracy contributed to the emergence of a broad political consensus regarding the creation of a new universal health care system, which led to the decline of the former Social Security Health Care System (INAMPS) in the country. The idea of providing a universal, participative and decentralized health care system was so popular that it eventually became part of the 1988 Constitution. Through the Constitution's introduction of the Unified Health System (SUS), health care became an official government responsibility and human right, an issue on which liberal and conservative political players and representatives agreed at that time.

The new system was sustained with the help of the proactive Collective Health Movement (CHM), also known as *sanitaristas*, comprised of medical doctors, bureaucrats and politicians. As asserted by Nelson Rodrigues dos Santos, one of the main representatives of the Collective Health Movement, “what unifies these actors is the historical importan-

ce they give to the movement in the achievement of health care for citizens, through the organization of the Universal Health Care System” (Ministério da Saúde, 2006: 100).

Although in different ways, for almost 30 years since the creation of the SUS, the Brazilian Collective Health Movement continued to play an important role in the new participative type of policymaking process. Those years witnessed the drafting of legislation for the SUS, and its implementation in more than 5,000 Brazilian municipalities. Besides gaining a new shape and a huge number of representatives, the actions of the Collective Health Movement took place in a more diverse and contradictory political economic context, after the adoption of neoliberal economic policies. However, the Collective Health Movement continued to be characterized by one common goal, though in a more diverse and sometimes less prominent way: to guarantee full coverage for the right to health care for Brazilians, through the implementation of the constitutional principles of the SUS. According to Santos' perspective:

The Collective Health Movement showed a capacity to unite diverse sectors of society, from the lowest to the highest income levels, around the utopia of a new society, a new democratic state ... this trademark has mobilized hearts and minds in a way that has been strong and sufficient enough to resist neoliberalism for 15 years (Ministerio da Saúde, 2006: 100).

The aim of this paper is to explore the ways in which the Brazilian Collective Health Movement and its main representatives have realized their discourse and political initiatives during both the transition and consolidation periods of democracy in Brazil (1970s-2013) during the implementation of the SUS. We will answer two main questions: In what ways did the Brazilian collective health community/actors and their ideas influence the health care policymaking process in Brazil? Why and in what context can we understand the present call of the collective health care community for a renewal of the health care movement in Brazil?

In order to answer these main questions, we have mapped three key periods that include changes in the power coalitions of the federal government, as well as new limits and possibilities for the Public Health Movement in its advocacy for the right to health care in Brazil. This paper is divided according to these key periods. Firstly, we will explore the years of political transition (1970s - 1988), where we see the formation of the collective health movement, and the development of a socially rooted political struggle for the creation of the new Unified Health System (SUS), leading to its creation in the Constitutional process of 1988. Secondly, we will present the years of the construction and implementation of the main institutional foundations for

1 This paper was written in English and revised by a translator whose mother tongue is English. Personal communications carried out in 2015 were related to a research project entitled 'What is coefficient of legitimacy in public policy?', approved by UFG's Research Ethics Committee/ the National Research Ethics Committee (CONEP), registration number CAAE 26584514.3.0000.5083 of May 2014. Personal communications of 2003 were developed in the context of Dr. Saddi doctoral research at the University of Sao Paulo, in a period where researchers did not have to submit proposals to Research Ethics Committee.

the new universal health care system, after the emergence of neoliberalism in Brazil (1989 - 2002), during the first years of re-democratization. Thirdly, we will focus on the period of Lula's and Rousseff's Governments, during a period of democratic neoliberalism, when a managerial and participative approach was formed (2003-2006); and afterwards kept allied to an effort to tie health policy to the development model (Between 2007 onwards).

In conclusion, we will highlight some lessons regarding the limits of this long institutional road of the health movement, in light of the main problems regarding the SUS, and of the challenges presented by the mass and health movement protests during June 2013. This will enable us to pinpoint why the renewal of the movement has recently been considered essential not only to advocate for a complete realization of the right to health, but also to advocate for better quality public health services in the country.

Social and political mobilizations in health (mid 1970s-1980s)

In the 1970s and 80s, Brazil witnessed years of authoritarianism (Linz, 1977) and the beginning of the democratization of the country. Its economic development was at stake, however economics was no longer the principal driving force to foster the political cohesion of the civil-military group in power since 1964. Growing social pressures pointed toward a need to conciliate the economic state-led type of development with less authoritarian social policies. This was the view point of President Geisel, from the middle to the late 1970s, who planned and implemented a slow, gradual and safe transition toward democracy.

The socio-organizational roots of the movement

This context favored the development and consolidation of a critical social movement related to health care in Brazil. It included a collective health care movement, known as the sanitary party or *sanitaristas*. It was engaged in the spearheading of both social and political initiatives that would lead to changes in the Brazilian public health care system (Saddi, 2014). Most of them criticized the health care system maintained during the military years, and acted in left wing organizations during the period.

In the context of an authoritarian political regime, the movement managed to create a network of relationships in the country, due to the creation of new institutions such as Departments of Preventive Medicine in many universities, the Brazilian Center for Health Studies (CEBES) and the Brazilian Association of Collective Health (ABRASCO). The success of their social mobilizations can also be expressed in the fact that they also managed to interact closely with political representatives in the states.

They developed a critical perspective on the established social security health care system in the country, similar to the critiques developed during the populist democracy, before the authoritarian rule. This revival occurred firstly in the departments of preventive health and Public health, created in many universities in almost all Brazilian states since the early 1970s.

Therefore, the influence of the fields of preventive medicine and public health, contributed to the dissemination of a new and alternative body of ideas regarding collective health. According to the field of collective health, health and diseases cannot be explained exclusively according to biological dimensions, as they are also constituted by social and historical dimensions.

As a result, Brazil saw the emergence of young practitioners, who were committed to alternative ideas coming from collective health, who turned a theoretical critiques into communitarian practices. Many communitarian practices emerged in Brazil, like the social movement which occurred in Campinas, when students from the Department of Social Medicine of the University of Campinas started to develop community outreach in the poorest parts of the city (Lavras, personal communication, August, 2003; Saddi, 2014; Santos, personal communication, July, 2003; Silva, personal communication, September, 2003).

Another indicator was the creation of the Brazilian Center for Health Studies (CEBES) in 1976. CEBES was formed by *sanitaristas* like David Capistrano Filho and Ermerison Merhy with the aim of building a critical space for the dissemination of ideas attached to collective health. They were linked to labor unions, led movements against the torture of doctors, attracted feminist movements to their cause, and became deeply involved and linked to social and community health care movements in the *favelas* and on the outskirts of big cities. These communities undertook initiatives aiming to develop better living conditions for the poor in the *favelas* and on the outskirts of big cities in Brazil. They promoted a national mobilization with academics from the field in order to form the institution. In December 1976, there were already five thousand people associated with CEBES (Escorel, 1998; Escorel, personal communication, September, 2003; Mehy, personal communication, October, 2003; Saddi, 2014).

According to Nelson Rodrigues dos Santos, the CEBES managed to unify and lead a movement formed not only by "sanitaristas", but also by all those who studied health and medicine, even if they came from the private and social security sectors. CEBES encouraged knowledge transfer regarding the health care reforms that took place in many other countries.

Furthermore, the health movement also started engaging in political action. By means of establishing closer relationships with parties, they formed a strong political coalition to fight for the new health care system. This took place especially during the efforts that preceded the new Constitution (Escorel, personal communication, September, 2003; Escorel, 1998). Escorel reminds us that:

The health movement is not an institutionalized political party, as it has the characteristics of a social movement. It is not a bureaucracy, nor does it hold a constituent law. It gathers people identified by the same theoretical approach, discourse and struggle (Ministerio da Saude, 2006: 66).

The formation of ABRASCO also represented an important step for mobilization and consolidation of the field of Collective health care in Brazil. This organization was and still is the academic arm of the movement, together with CEBES. The main academics in the field were and still are gathered at ABRASCO, whose aim is to produce knowledge related to collective health. ABRASCO has organized seminars and conferences at the National Congress and at Universities as well, contributing to rapid discussions regarding the new system.

The politics of mobilizations in health

The context of political transition created opportunities for the movement to start forming coalitions and exercising pressure within the political sphere, and enabled the health care movement to conquer space for participation. The main events during this period were the mobilizations held during the 8th National Health Conference and at the 1988 National Constituent Assembly. These events are recognized as the apex of social mobilizations and participation in the field of health care in Brazil.

The 8th National Health Conference

The 8th National Health Conference took place in March 1986 and is considered one of the two highpoints of the health care reform movement, when discussions took place concerning the transference of the Social Security Medical Services (INAMPS) to the Health Minister. Arouca (2003) explains that:

the idea was to transfer the INAMPS to the Minister for Health, integrating both systems. Sarney authorized the move of INAMPS to the Minister for Health. Although the former Conferences used to be a bureaucratic space, the 8th Conference comprehended a social political event, in which 50% of the participants consisted of regular citizens and users of the health care system (Arouca, 2003: 4).

Pereira (1996), a political scientist, has recognized the role played by the 8th Conference:

It assumed the format of a social-political mobilization, legitimating the need to construct a new health care system in the country. More than 4 thousand people took part in the discussions held for 14 hours. Additionally, the main representatives from the private sector left the conference, saying unanimously that the main decisions had already been previously discussed (Pereira, 1996:13)

The negotiations at the Constituent Assembly

Two main polemical themes characterized the struggles surrounding health care in the Constituent Assembly, which were 1) the redefinition of the nature of public policy and the role of the private sector in it, and 2) the funding of public health care (Rodriguez Neto, 1988). The results were negotiated between the representatives of the social security system, the private sector and the Collective Health Care Movement (Arouca, 1988; Rodriguez Neto, 1988). Negotiations took place behind closed doors, with the private sector advocating for the possibility of continuing to have access to public funds and maintaining a secondary system alongside the new public system.

In the following years, the challenge for the health care movement would be the consolidation and implementation of the new paradigms formalized by the Constitution of 1988. This would happen in a political and economic context redefined by neoliberalism.

Institutionalization of participation in health care

The years of Collor, Itamar and Cardoso (1990-2002), as a whole, were the years of the introduction of neoliberalism and the consolidation of the new democracy (Teixeira & Pinto, 2012). During this period, tensions between the economic and social sectors of the government were constant. As far as the health care movement was concerned, it was no longer characterized by a broad process of social and political mobilization, but by the development of a long process of institutionalization. During process, forms of mobilization and participation were not only gradually framed by the new legislation and channels of participation, but also confronted the new coalitions of power committed to neoliberalism, during the Collor (1990-1992), Itamar (1992-1994) and Cardoso (1994-2002) governments (Saddi, 2014). The health care movement was slowly emptied or depoliticized, as described by some representatives of the movement (Pinheiro, personal communication, August, 2003). The main locus of the political fight during this period was in the government, with the Ministers for Economics and Health and the National Congress. As we will see, Political actions/coalitions tried

to halt or slow the process of realization of the right to health care through the implementation of the legal SUS, which means the implementation of policies aligned with the main principles of the new universal, comprehensive and decentralized health care system.

More restrictive participation in the policy-making process: the unstable beginning of neoliberalism in the new democracy

Health legislation vetoed by Collor

Collor's vetoes of the SUS complementary law were made due to pressure from the economic wing of the government, as publicly declared by the minister for health at that time. The three main vetoes made by Collor were related to funding and participation matters as approved by the Constitution. 1) He blocked the transfer of direct funding to states and municipalities, as negotiated in the Constitution, and maintained the transfer on a pay by procedure basis, already practiced under the INAMPS. 2) He also blocked the constitutional articles that forecast the deliberative participation of the population in the new system, in the conferences and health care councils. 3) The president refused to shut down the former INAMPS as advocated for in the Constituent process. As a result, there was a mobilization of civil society, which began to demand that the president act in accordance with the principles and guidelines approved by the Constitution.

1991 Basic Operational Norm (NOB-91) and the 9th National Health Conference

The elaboration of the Basic Operational Norm (NOB-91) consisted of another attempt by the federal government to centralize the health budget. This norm proposed the full centralization of the budget by the federal government. It received much criticism, especially from the cities movement, which was allied to the Collective Health Care Movement during this initial implementation phase of the SUS. These discussions contributed, in the following years, to the drafting of laws regarding the transfer of funds from the federal to state and municipal governments.

The reaction of the health care movement together with the city movement took place at the 9th National Health Care Conference. At this event, sanitarians and academics joined thousands of Brazilians in demonstrations against the Collor government.

1993 Basic Operational Norm (NOB-93)

In the midst of the political instability produced by Collor's impeachment, the new president Itamar Franco tried to reestablish a commitment with the implementation of the SUS, by means of elaborating the complementary legis-

lation for the SUS, known as the 1993 Basic Operational Law (NOB-93). The new health care reform legislation was in tandem with the demands made by both the Collective Health and city movements. The new legislation 1) established stages for the implementation of the SUS in the municipalities and 2) instituted the formation of management commissions as a locus of negotiations regarding health. As far as participation is concerned, the NOB-93 instituted the Commissions for health managers with the aim of generating debate between managers at the three levels of government of the health care system (federal, state and municipal), thereby contributing to the formulation of proposals regarding the implementation of the SUS.

Rolling back the previous Health Care Security System (INAMPS)

The closure of the former INAMPS was another occurrence influenced by pressure coming from the health care movement. Carlos Mosconi, one of the main representatives of the health care movement, took over the INAMPS and played a central role in the process of closure of the INAMPS in the years of President Itamar (Mosconi, personal communication, September, 2003).

Confiscating health funds

Concomitant with the closure of INAMPS, the minister of social security decided to confiscate the funding that should have been transferred from the Ministry of Social Security to the Ministry of Health. In reaction, Deputy Eduardo Jorge, another important representative of the Collective Health Care Movement in the National Congress, proposed a law that determined what percentage of the federal, state and municipal budgets should be allocated for health. This law reform resulted in the Constitutional Amendment 29/2000, passed in 2000.

Politics of health care in times of democratic neoliberalism (from the mid 90s)

In the new Brazilian democracy, it was only after a period of both economic and governability crises that neoliberalism finally started playing a more central role in Brazil. The promotion of economic stability was the main political goal of the new political coalition that took power in 1995. Brazil now had a new currency and started developing an even more controlled, stable fiscal policy, which was considered essential to maintaining political power and legitimacy (Saddi, 2014; Teixeira & Pinto, 2012).

The politics of policy-making

In the first two years of the Cardoso government, the participation and influence of the health care movement in the policy-making process was more significant. This can be seen 1) in the process of elaboration of the Basic Opera-

tional Norm of 1996, 2) in the fact that the executive did not manage to approve PEC-32 in the Congress, withdrawing the proposal, and 3) in the political alliances formed by the minister of health, Jatene, in favor of creating a compulsory specific tax to be directed to the health care sector, the so called CPMF, which is a tax on bank account transactions.

However, as a whole, the Cardoso years were characterized by a decline in the direct influence of the Collective Health Care Movement in the policymaking and decision making processes. This is highlighted 1) by the fact that other forms of budgetary transfer to health care had been blocked after the emergence of the CPMF, 2) by the consequent revival of the fight to increase health care funding, 3) in the adaptation of new bills and decrees from the federal government, which produced significant changes regarding the NOB-96 and 4) in the implementation of a modified version of NOB-96 when Serra took over the Ministry of Health. During this period, new policies were privileged, such as programs related to generic medicines and HIV/Aids. However, it was also the period of institutionalization of new channels of civil participation in health care.

Institutionalization of Health Plenaries during times of neoliberalism

The FHC period was also considered a period in which participation in the SUS was fostered. Some experts consider this a period of institutionalization of participation in health care that occurred firstly at the National Health Plenaries and secondly at the Health Council National Plenaries. Health plenaries were a space of pressure and debate, mainly bringing together representatives from civil society. The Health Council Plenary, on the other hand was formed by both social and state representatives.

The national health plenary was very active until 1997. In 1996, more than two hundred health councils participated in the plenary. The final report stated that “the need to promote a better organization and mobilization of the health movement was clear, as a means to unify all the sectors in favor of the health care reform and the SUS” (Ministério da Saúde, 2006: 178). In 1997, the plenary report asserts that the health care movement had been revived after the 10th Conference, promoting activities and debates in favor of the implementation of the SUS, such as those that occurred with representatives from the main Brazilian newspapers and television channels.

Those activities demonstrate that the health care movement not only continued to mobilize society, but also developed a more institutionalized form of participation in the plenaries. The end of the health plenaries occurred in parallel with the formation of health council meetings in the country that afterwards gained the name of Health Councils

Plenaries. Initial activities began in 1994, and was finally officially established in April 1995. Although presenting a different nature in comparison with the health plenaries, the agenda of both movements was committed to advocating for the SUS and its principles. The first health council plenary occurred in Brasilia in November 1996.

Although the health care movement had to face the government initiatives that tried to reshape the health care reforms or even block the development of the SUS according to its main constitutional principles, by means of procuring new and distinct infra-institutional legislations, representatives of the health care movement highlighted some achievements that occurred during the period, such as: 1) the development of participative forms of management in councils, throughout the country, 2) the articulation of a new modality of participation in the plenaries, with an intense agenda across the whole period, 3) and the approval of the constitutional Amendment n° 29/00. The election of the new President of Brazil, coming from the left wing party, which supported the health care movement on many occasions, was seen at the time as a new opportunity in which the health care movement would gain a more direct participation in policymaking.

Institutionalized participation in health care (2003-2013)

Although the election of the new President of Brazil coming from the left wing party that supported the health care movement on many occasions, was viewed at the time as a new opportunity for direct participation by health care movement representatives in policymaking, and as an opportunity to fulfill the principles of the SUS, in fact it did not lead to a period of broad social and political change in terms of mobilizations to realize constitutional health care reforms. Ideas and pressure coming from below were channeled and institutionalized principally in health care councils, revealing the fact that the health care movement's initiatives became more diverse, diffuse and depoliticized during this period. All the ministers for health from this period belonged to the sanitary movement.

dDuring Lula's government and in the first three years of the Rousseff government (from 2003 to 2013), the health care policymaking process was characterized both by the formation and prevalence of a managerial approach subsequently (in 2007) allied to an effort to tie health care policy to the developmental model. As far as the possibilities of participation were concerned, it became not only more complex, but also more institutionalized in the sense that discussions and negotiations focused more on technical or managerial demands mainly coming from the Ministry of Health, than on broader health care reform topics stemming from counter-hegemonic movements.

The institutionalized politics of policymaking

Research reveals that Lula's Government gave priority to four types of health care policies, and that they have remained the main structural problems related to the SUS (Machado, Baptista, & Nogueira, 2011). Priorities were given to the continuation of the Family Health Care Program, and adoption of new policies such as Smiling Brazil, Mobile Emergency Services and The Popular Pharmacy (Machado et al., 2011). The persistence of structural health problems is highlighted "in the fragmentation of policies, limitations on funding, distortions in public-private relations and health care inequalities (Machado et al., 2011).

The introduction of the Health Care Pact was directed by various forms of discussions that took place in the Health Councils in 2003 and 2004, and especially at the Three-parties Health Commission (CIT) and National Health Council (CNS). CIT's is made up of representatives of the state and municipal Health secretaries, and the Ministry of Health. Therefore, all three federal units are represented in the CIT. After discussions and negotiations in those councils, the new Health Pact of 2006 was approved, involving a strategy that reconfigures intergovernmental relations in the sector.

The government discourse and action included a change in priorities that moved from the gradual implementation of the SUS to themes related to health conditions and determinants. Those changes took place mainly after 2007 (Menicucci, 2011) with the formulation of the program entitled More Health.

This strategy gives priority to primary health care focusing on expanding the Family Health Care Strategy (FHS) throughout the whole country, qualifying professionals of superior levels working at FHS, Smiling Brazil, and community health care agents, who would also be active in schools (Menicucci, 2011; Paim, Travassos, Almeida, Bahia & Macinko, 2011).

As a whole, the period presented two key moments. The development of a managerial approach for health, in the first period of Lula's government, guided by democratic and managerial initiatives, characterized by an intense debate inside the Ministry of Health and with other actors (from the federal, state and municipal spheres of government). From Lula's second term in office (2007-2010), as well as during the Rousseff years (2011-2013) the managerial approach was maintained, allied to an effort to tie health care policy to a developmental model (Machado, Baptista, & Lima, 2010; Menicucci, 2011).

It is also necessary to mention that the governability crises that occurred during Lula's government and in the Natio-

nal Congress, as a result of the misuse of both public and private money to fund electoral campaigns, undermined the credibility of the political coalition in power and generally affected policy management.

Jandira Feghali, a political representative aligned with the health care movement, made clear that one of the difficulties of the Lula's government was that a great number of health care activists were allied to parties that form the political base of the government. As Feghali stated:

this led to a defensive posture by the health care movement, contributing to a paralyzation and immobilization of the movement, because people were afraid to compromise or damage even further the the government's credibility. Parties started to assume defensive positions hampering action by the health care movement ... and also generating a certain institutionalization. Although we have spearheaded a health plenary, the mobilizations had a much smaller scope (Ministerio da Saude, 2006: 275).

The institutionalized politics of prioritizing basic health care policies

During the Rousseff years, primary health care became the Ministry of Health's first priority, as clearly stated several times by former minister Alexandre Padilla. The government continued not only to implement the new National Policy of Primary Health Care (PNAB), elaborated in 2011, but also elaborated the National Program for Improving the Access and Quality of Primary Health Care (PMAQ). The objective of the PMAQ is to promote better services with better quality. To this end, it introduced a payment for performance system, that comprises the transfer of economic incentives to municipal health secretaries and/or front line actors involved in primary health care at thousands of health care units in 5,556 cities throughout Brazil. Both the commissioning (of units and health teams) and monitoring of the process was undertaken by municipal health secretaries, and required the provision and use of software systems and internet in all units.

The program was elaborated by the team that worked at the Department of Primary Care at the Ministry of Health and presented to CIT, to be discussed and validated. Although there was disagreement regarding many aspects of the policy, such as an adoption of flexible payments and choice of indicators, the general consensus moved in the direction of its approval. Besides great pressure coming from the federal government, the PMAQ was also considered a starting point to develop better quality services. Discussions occurred mainly at the CIT, first with the task force formed by assessors from the CONASS, CONASEMS and DAP, and then in discussions that took place in the CIT's plenary, involving state and municipi-

pal leaders/ health secretaries and the Minister of Health (Bretas, personal communication, May, 2015; Evangelista, personal communication, May, 2015; Sousa, personal communication, May, 2015).

There was a development of closer relationships between primary health care policy and social development programs. The elaboration and discussions surrounding the new health care strategies linking the FHS to the Family cash transference program and health education followed the path of PMAQ, being presented and approved by the CIT.

As emphasized by Santos, health counselors have not yet internalized the values of the SUS and are not ready to turn its principles into political negotiations.

This will depend on the continuation of social pressure from below and on the degree of politicization and political engagement. The politicization of Brazilian society that is reflected in the politicization of health counselors, has not yet achieved a sufficient enough degree to promote changes from one model to another. They all share the causes of universality, comprehensiveness and equality, but they are empty causes. The question is how they can be transformed into effective political projects (Ministerio da Saude, 2006: 275).

From the perspective of participation in policymaking, we see the continuation or even deepening of a pattern of action already emphasized by Cohn (2009), which is the emptying of the political sphere in favor of technical and managerial approaches. Additionally, this refers to the fact that representatives from the health care movement now have to deal with political conflicts and dilemmas involved in policymaking, as they have taken up roles in many health secretaries throughout the country, at both state and municipal levels.

Various and Dispersed forms of movement coming from below

During this period, we have seen the formation of new social mobilizations in health care, but they not only occur in isolation from the political sphere, but also exert a lesser degree of influence on the political sphere given the dominance of pressure coming from a neoliberal coalition of powers and the prevalence of both economic and social development issues as priorities. Moreover, they are narrower in their scope, as far as the comprehensive scope of health rights and the SUS are concerned. They represent a specific cause attached to a contextual problem and do not consider the main structural challenges faced by public health.

In this process, the massive, national protests of 2013 regarding health and wider issues are not only differentiated from the other mobilizations, but also make evident the limitations of persistent institutionalized forms of participation in health care. The national mobilization against privatization and the ‘+ 10 movement’ are probably the main broader movements recently supported by representatives of the Brazilian health movement, like CEBES and ABRASCO.

National Front against Privatization in Health Care

The Front against health privatization consists of various forums formed in the main Brazilian states, by public sector representatives, demanding that the SUS be 100% state owned. They mobilize public servants in conferences and seminars and through their internet page (1) and regular emails. They also take part in the national health conferences, like the 14th Conference of December 2012 that targeted privatization as the main theme of the meeting. Although Conferences had become a national mode of social participation in many fields of government policy, following the example given primarily by the health sector, it no longer had the same influence as the 8th Conference that preceded the Constitution.

The ‘Health +10’ movement

Another mobilization supported by the health care movement was the so-called ‘Health + 10’. This movement was created in March 2012 in a historical meeting with broad participation by diverse entities representative of Brazilian society, initiating what has been called a National Movement in Defense of Public Health (2). Although this movement collected 2 million, one thousand signatures, in favor of an increase in federal funding for the SUS, the National Congress did not approve it. As asserted by the representatives of the movement, popular pressure was not enough to block pressure coming from the economic arena.

Popular and health Protests of 2013

As broadly asserted by the collective health care movement, the protests of June 2013 returned health care to the public agenda, and contributed to strengthening debates in diverse health associations and mobilizations, within academia, and in the historical entities closely linked to health care reform. Bahia (2013) says that the streets demanded FIFA quality health care and questioned the government about health services, which was a turning point in how health care was viewed in Brazil, no longer as private asset, but as a public matter.

As a direct result of protests for better public health care in Brazil, Dilma Rousseff announced a new program (More Doctors for Brazil) that aimed to encourage national practitioners to work in remote regions of the country in primary health care units. More Doctors would also encourage immigration of foreign practitioners to Brazil to work in poor and remote areas of Brazil. For decades, there had been discussions in the health sector, in diverse associations and councils, about the lack of doctors working in rural, marginalized and poor regions of the country and parts of the cities. Given the conflict involved with medical associations principally due to doctors working mainly in the private sector and in specialized fields of medicine, a solution had never been found for this issue nor resulted in policy development. As recognized by the health care movement, More Doctors for Brazil was only a stopgap measure, with more definitive solutions requiring changes to the curriculum of schools of medicine to attract younger Brazilian doctors to the primary and family health care fields.

As a whole, this third broad phase of the long pathway toward institutionalization of participation of the CHM in health policy highlights that legitimacy and governability issues are closely related to public policy concerns in a democratic government. Democracy imposes certain political limits on the policymaking process, in the sense that it needs to be responsible to society. Those limits become clearer when we make a retrospective analysis of the processes of institutionalization of participation in health.

Conclusion

The reconstruction of the long institutional process of participation of the CHM in health care policy (from 1970s to 2013) indicates that although the ideas and actions of the movement have been influential during the whole period, they were less dominant in later years, more characterized by the institutionalization of social participation in health councils and by a more institutionalized political action of movement leaders in local/state Secretaries and in the national Ministry of Health.

Over the last decade, few individual voices had highlighted the need to promote either a revival or reformulation of the health care movement. Among these, as good examples, is the analytic, academic voice of a representative closer to the health care movement, Rodriguez Neto. In a book edited by CEBES (2003), Neto summarized well the process in which he closely participated. According to him:

the movement became more complex, with the involvement of new actors, resulting in an emptying out of some entities,

and a strengthening of others, generating confusion as to whether there might have been or not a retreat of the movement. In reality, the high point of the movement occurred at the 8th Conference, and afterwards in the Health Plenaries. Moreover, the movement had never before been so melded with the government, at the state, municipal and federal levels, nor had it been so limited by economic and technical pressures. This happened exactly at the moment when society started to demand concrete answers from institutions. (Rodriguez Neto, 2003:126).

Reflecting on the Brazilian National Health Reform after 25 years of experience with the Universal Health Care System, Amelia Cohn highlights a significant question that needs to be considered by the public health sector and those engaged with public health policy in Brazil. According to Cohn (2009), the significant question to be asked today, concerning reflections on new alternatives and on the rebirth of 1988's victories, should be whether those reflections would mean 'a reform of the reform' or a 'a counter-reform'.

The first alternative would include aiming at the current technicalization of the politics, while the second would entail the rebirth of both the political and social dimensions of health (Cohn, 2009: 1616).

The answer to this deep question might be that the field of public health has been unable to formulate a new project for health care that would be articulated with society. This might be the greatest challenge" (Cohn, 2009: 1618).

These isolated voices are now joined by many other voices from the field. At present, and mainly after the mass and health movement protests in June 2013, a renewal of the movement is now more widely considered essential to guarantee the full realization of the constitutional right to health care (public, universal, integrated/comprehensive, decentralized), but also as a means to demand better quality public health services in Brazil. However, the need for this revival has still not been unanimously recognized by all representatives of the movement, nor generated a unified and dominant position.

The contribution of the present paper lies in the fact that a reconstruction of the process underlines meaningful and relevant political lessons regarding the health movement's possibilities for effective revival in the years to come if it decides to take on or deepen the counter-hegemonic path asserted by Cohn (2009). It is worth noting that the SUS is now state policy and one of the great challenges concerns the construction of care models based on an expanded concept of health care and on the values that guide the SUS: universality, comprehensiveness and equality. The

undeniable progress of the SUS as a policy now requires the consolidation of care models to ensure the fulfillment of the Constitutional principles of the SUS.

According to Santos (Ministério da Saúde, 2006) this context includes the fulfillment of the high level of equality sought after by the health movement, for example, in the allocation of additional resources directed to ensure full accessibility at all levels of care for excluded and poorly included groups and individuals. This would contrast with the current low level of equality resulting from underfunding and the low level services on offer, with the adhesion of private health plans/firms.

As was observed, there are many health challenges for the health care movement during democratic periods to realize the principles of the SUS. Citizens expect that the SUS will respond to their health needs, or as Matus (2014) has asserted, democracy cannot defend itself if it is not successful in solving problems that affect people.

The efforts of recent governments towards inclusion and improvements in health care services through the structuring of community care based models guided by multidisciplinary teams is undeniable. This demonstrates that there is the political will to move forward. The present More Doctors for Brazil is a recent example of this. It is also undeniable, as emphasized by Nelson Rodrigues dos Santos (Santos, personal communication, July, 2003), that the SUS cannot be content to be an ineffective service for the poor. Advancing towards system recognized by citizens as truly universal, requires a great deal both from the spheres of policy and politics. The Brazilian policy environment is complex, and this complexity is reflected in the administrative machine and its management capacities at the three levels of government. The relationship between civil society and the State under the aegis of participation and popular mobilization, the presence of social movements, in the scenario encountered in the period of democratization, is insufficient if not combined with the managerial capacities of those who believe in the Constitutional SUS.

In democratic times, such a revival would require the health care movement to recognize the limitations of continuing this institutionalized participation, characterized by depoliticization and the isolation of the political health care debate, from society. Statements like 'the main problems involving the realization of health care rights and implementation of SUS are not financial, but political' should be accompanied by consistent action.

1. To reconstruct a cohesive health movement that would foster mobilizations strong enough to place pressure on

the political sphere, generating policies more in accordance with the principals of the SUS.

2. This united and cohesive movement would have to be in alliance with broader social demands as happened in 2013, or closely related to social or health experiences taking place on the ground, as took place in the early 80s.

3. A renewal of the political activism of the main representatives of the health care movement would also be essential. There would need to be a formation of a new generation of specialists in public health or practitioners interested in assuming roles within national, state and municipal assemblies, as well as in health secretaries and at the ministry of Health.

4. It would also entail the integration of Brazilian general practitioners and young doctors into the health movement, as occurred at the birth of the SUS. This rebirth would have to be accompanied by the establishment of closer relationships and actions between doctors and the public, like the favela movements which happened at the beginning of the SUS. Therefore, changes in the curriculum of medical schools would be essential.

5. Additionally, the movement should act as a united counter-hegemonic bloc allied to more progressive (or government opposition) blocs of power, monitoring the steps being taken at the legislative level and by the health minister. It should propose alternative programs for new policies drafted or voted in the main decision and policy-making arenas responsible for formulation and decision making about the SUS in Brazil.

As emphasized by Bahia (2014):

The health care reform project and the processes to achieve it have either been ignored or its relevance has been undermined due to an activism that seems incapable of reconciling health care needs with the rationality of political parties... the task ahead would imply rebuilding the foundations of the progressive alliance that approved the constitutional text, and an advocacy and promotion of the debate surrounding and implementation of the Brazilian Health Care Reforms (Bahia, 2014: 2)

Footnotes

1. They can be followed at <http://www.contraprivatizacao.com.br/>

2. The main actions and strategies used by this mobilizations can be seen at <http://www.saudemaisdez.org.br/>

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