

The Brazilian health reform: A victory over the neoliberal model

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Abstract

This paper sketches the panorama of changes resulting from the Health System Reforms initiated in Brazil since the mid-seventies, exploring the political and structural limitations of the process, the social and political strategies used, and current proposals for reorganizing Brazil's "Unified Health System" (known as the SUS). The SUS is one of the world's largest public health systems. The central theme of this analysis and presentation is that the Brazilian Health System Reform is a Latin American example of an alternative health project, democratic and universal, based on the premises of Social Security, that its implementation was feasible, and, once implemented, resistant to obstruction by conservative neoliberal forces.

Introduction

Today Brazil has one of the world's largest public health systems—the SUS—an achievement of the Health Care System Reform. It was promulgated in the new Federal Constitution in October 1988¹ and regulated by Laws 8,080² in September 1990 and 8,142 in December 1990.³ However, before it was instituted and regulated a long trail of mobilizations and struggles had to be brought about by Brazilian progressive forces. Even after its formal inception, the Laws' implementation required a lot of effort against the consolidated interests within the health sector and the conservative political elite. The elite supported the proposals for conservative health

sector reforms, as these conservative reforms were in their economic interest and were defended (when not imposed) by the ideological leadership of the multinational agencies.

Thus, in the dawn of its 20th anniversary, the Brazilian Health Care Reform experience stands not only as successful but also as well consolidated and irreversible. This shows that the "minimal packages model" along with privatization is not the unavoidable destiny for developing countries. On the contrary, there are alternatives and they are historically attainable. However, this does not mean that there are no further challenges in carrying forward those constitutional precepts based on the model of Social Security established in 1988.

In this paper we will examine the process of the Brazilian Health Care Reform beginning with the main features of the social reality at the beginning of the movement. Next, the main proposals of the health movement as well as the first stages of implementation will be systematically analyzed. Lastly, the current challenges faced by the fine tuning of this program will be addressed. These involve the geographical dimensions of the country, the diversity and complexity of Brazilian society, and the Health Care System itself, which faces management and financial issues, as well as the ongoing challenge of guaranteeing universal access to health services for the population.

At the Beginning

Until very recently, i.e. the early 1980s, Brazilian health policy was characterized by its close link with the politics of Social Prevention in at least two main ways: funding and individual medical attention. This gave rise to two phenomena specific to Brazil in relation to health: the early onset of a privatization

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process of health care services, with the expected consequences. Privatization began with the certification of private medical services by the Social Prevention System as far back as the 1920s, with access to health care restricted to those workers in the formal labor market, and then only those within the urban areas of the country. This population segment represented a dynamic part of the agricultural sector initially and later of the industrial sector.

It is, as you will see, important to highlight these facts because they constitute the fundamental framework for understanding the dynamic and the processes that must, even today, be confronted so that the precepts and proposals of the Brazilian Health Reform, as it was conceived in the 1970's and 80's, can advance. Until the 1970's, Brazilian health care was characterized by the health care of social prevention, so that state public services included only those actions classically within the discipline of public health. From this fact arose the three historical frameworks which characterized the history of our social protection system. These frameworks were products of events in the decade of the 1920s.

Three Frameworks for Understanding the Brazilian Social Prevention System

From the point of view of economic policy: The tax-based Social Prevention System was, from its inception, a mechanism for collecting private funds from wage workers which would be invested in strategic sectors of the national economy. This occurred when the national economy was being consolidated, when the government was promoting economic development, and up through the current phase of economic structural adjustment.

From the health economy point of view: The early constitution of a private health system in the country is a product of the Social Prevention policies which, as early as the 1920s, began to purchase health care services for their contributors and their families. This took place initially through the certification of health professionals and services and later through contracts and agreements. As a result Brazil had one of the most consolidated and sophisticated health industry complexes among the

countries of Latin America by the 1960s and 1970's, as was noted in the classical study by Hesio Cordeiro.⁴ This private health care system grew and consolidated itself under the auspices of the State, which provided it with captive clients, i.e. those insured through Social Prevention. At the same time, the State failed to exercise its prerogative as the main buyer of such services, in terms of dictating pricing norms and quality control, much less in regulating this market. These have only happened recently, as we shall see. With the incentive provided by a captive clientele and State funding—either through the direct acquisition of services or through low interest funding mechanisms for the building of hospital infrastructure—a rather sophisticated private clinical and hospital infrastructure complex was developed. Most of this health infrastructure was concentrated in urban centers because it was here that the demand for health service was preferentially concentrated, i.e. among wage-earning workers in the formal sectors of the economy within the most active industries. This highly privatized system was characterized by unequal access and was very distant from the real health needs of most Brazilians. In short it was a system that, instead of responding to the widespread inequity of the social and health realities in Brazilian society, reinforced these disparities.

From the social dimension perspective itself: Because of its close ties with social prevention and its exclusive coverage of formal sector workers, most of the salaried classes developed an image and an ethos regarding social protection, and in particular the right to health (seen nearly always as curative health care) as a right which depends on paid contributions by individual workers and not, therefore, as a universal right. From this historical perspective and logic only persons who are part of the formal work market have a right to curative medical assistance.

Given this mentality, the conquests of the Brazilian Health Reform, “health is a right for everyone and a duty of the state,” as dictated by the Constitution in Article 196, demand even to this day a process of societal incorporation as to the real meaning of the right to health. This process is still more important because in the actual experience of

society, especially the poorer segments of society, access to medical services is available only under two circumstances: through social prevention in which they are affiliated as contributors, or through philanthropy. At the same time, persons who are better off in the society will opt for the health care free market.¹ State-provided public health services, until the mid seventies, included prevention measures such as vaccination, harm-reduction strategies, educational programs, health promotion, and measures to combat infectious diseases, but not individualized medical care. Health care, outside of the private market, was restricted to charity and to social prevention programs.

The Main Area of Confrontation

As stated above, in the mid-1970's when the Brazilian Health Reform movement, conditions in the health care system were very unfavorable. The Health System was highly privatized, already established as a medico-industrial complex, pre-eminently curative, concentrated in urban nuclei and only in high-income neighborhoods. Consequently, it reflected the antidemocratic characteristics of our society. Access was unequal, as were the services offered. Services were not available in all regions nor were they prioritized. The existing system did not follow any of the classic requirements proposed since the 1940's by international organisms, such as WHO or PAHO, regarding the features of health systems which meet the needs of populations in developing countries. As for the public health system, it was focused on the traditional programs of the time, i.e. programs which were vertical, centralized, and targeted prevention; these programs did not provide curative services.

As if the distortions noted above were not enough, the health care system was in reality composed of two subsystems which did not work well together. Acting in parallel, these systems left a

large portion of the population without any form of medical attention (except for that of a philanthropic character, and for a very few public state hospitals). There was a great schism between medical care and public health, both from the point of view of their funding and of their administration.

Funding

Preventive individual health care was funded through the social prevention system. The funds came from the contributions of affiliated workers, employers, and the state, supplemented by other sources, such as specific taxes on roulette games and fuels. It is noteworthy, in this case, that the state, by creating new taxes to pay its part of social prevention costs, did not assume the costs as its responsibility. Rather it linked the social prevention system and the national project of capitalist accumulation. On the other hand, employers would transmit their contribution on to the final price of their product under the label of "social charges." As for public health actions, these were funded by the public budget. In this manner a double link was established, duplicating management in the social prevention and health sectors. This duplication became one of the main points of contention for the health reform movement.

In fact, from the institutional perspective, preventive medical assistance was, until the 1980s, under the direction of social prevention, which in 1974—due to its large budget—became a full Ministry; previously it had been part of the Ministry of Industry and Commerce (later called the Ministry of Labor).

From this institutional arrangement one can see the close affiliation of social care with the capitalist accumulation project. Public Health, initially part of the Ministry of Education, would become a proper Ministry only in 1953, and would not incorporate the health care element of Social Prevention until 1990, two years after the institution of the SUS under the Federal Constitution of 1988.

At that point the intent was for health care to be directed by a single entity, no longer a victim of the duality between individual and collective medical actions, each with its own logic for funding (the one having been funded through contributions by

1 The health sector "free market" is heavily subsidized by the State, either through the tax exemption mechanism (income tax discounts based on direct spending in health care, insurance or personal healthcare plans), or even because in case of expensive treatments those sectors who could afford private treatments do recur to the SUS.

affiliates, thus with available resources; the other funded by scarce federal resources) and action.

Management

From the managerial perspective the system was both centralized and vertical. Policies originated at the national level. The local states and municipalities were expected to execute them without any room for autonomous action. The double command structure—social prevention and public health—was replicated at the sub-national level, making impossible the implementation of policies that might overcome the inequality and imbalance between the health requirements of different regions and social groups. On the other hand, this centralized and vertical health policy, especially in public health, made it possible for preventive actions, such as national vaccination campaigns, to acquire a high degree of coverage. This remains true up to the present day, even after the decentralization process that began after 1988.

The main feature of health care management was the non-existence of any public control over health policy. Technical criteria prevailed over any form of social demand. Often, under the guise of technical criteria, in a political order with a strong state apparatus and elements of self-interest, the meager resources assigned to the Ministry of Health were distributed according to private political agendas, to the detriment of public need and order.

National and International Context

Lastly, we must address the national and international context. Nationally, Brazil adhered to the policies of economic structural adjustment within the new global order, following the precepts put forth by multilateral funding agencies for developing economies. These precepts consist of neoliberal reforms in social spending, in particular for health care and social prevention sectors. These reforms are defended on the grounds that they are necessary to diminish public debt and fiscal expenses. Consequently, health services are reduced to a basic package, and social prevention is privatized under the model of individual contributions administered by private funds whose resources would generate a profit in order to

increase investment in the economy. At the international level Brazil has tried defend principles and proposals for health care reform that are in opposition to those dictated by international agencies, which cite the Chilean reform^{6,7} (and others in progress in the region) as a successful example.

In brief, the health care reform goes against the dominant national and international ideology, dominated by neoliberal principles in the context of a very unfavorable economic structure, and confronting a highly privatized health care system, with established private interests which had already been transformed into a sector dedicated to the accumulation of capital. As to factors that might support health care reform, there was something very precious: a political association with the country's fight to regain democracy. Association with this struggle caused the health movement to become much stronger.

Main Proposals and Stages of the Brazilian Health Movement

The Brazilian health movement originated through the association of social forces and intellectuals that came together in the 1970's with political forces mobilizing for democratization. It had its origin in academic circles (social medicine departments, also called departments of preventive medicine or community medicine, and in medical and public health schools), including medical residents, public health professionals, health workers and other productive sector unions, progressive sectors of the Catholic church, NGOs and other organizations, some of which would were the nuclei of political parties that were formed at the end of the decade.

The mobilization proceeded along two broad fronts. One of them was the production of knowledge, dedicated to promoting the political struggle, to the elaboration of case studies about the inequities of access to health care in Brazilian society and the inequities of the country's health system. This process incorporated a new element, common to Latin American thought of the time: a Marxist perspective in health studies, in opposition to the functionalist perspective until had until then

been unopposed. Here lies the importance of Latin American Social Medicine to the Brazilian intellectual production during this period. The association was felicitous, allowing for studies that expressed our realities, our social policies, and their place in the Brazilian history of capital accumulation and domination.

The second front consisted of the mobilization of those organized sections of society for the democratization of health care. This proceeded along various lines of action, ranging from those professional areas linked to health care and education, to unions, religious social groups, social movements, and popular organizations, etc. It is important to point out that a lot of the leadership was established in the mid-1970s, many of them participants in clandestine political parties. Later they would become parliamentary leaders, public participants in the health care struggle. Some of them remain active until this day.

What is interesting to note is that, even though the production of knowledge and the struggle for democratization of health care took place against the *status quo* represented by conservative proposals for sector reform, its critical nature did not prevent it from proposing a highly innovative, progressive reform. So much was this the case that when the Constitution of 1988 was written, the health sector served as a model for a principled system of service delivery that was more complete than any of the other social areas.

What Health Care Model was adopted?

The proposed health care system was the SUS – Unified Health Care System – a decentralized, regionalized, prioritized, and integrated organization. Its principles and philosophy are universality, equality, integration of services, and democratic management, under what was designated “social control.”

As pointed out by Viana and Dal Poz,⁸ the Brazilian experience can be characterized as a Big Bang Health Care System Reform because of the extent to which it brought significant changes in the mode of operation of the health care system after 1988. After the Big Bang, the requirement of universality for health care actions, decentralization

with local autonomy for the management of local health care organizations, and a new format for the organization of health services operating under a new logic, configured an altogether new model for health care. In order to implement this model the SUS was created with a single managerial structure at each governmental level. New forms of administration were adopted with empowered Health Councils at each of the national, state and municipal levels. The Councils were composed of participants from the government and users.

The first community diagnosis and field studies of what is today known as Collective Health were responsible for the inception of the institutional scheme for the new system that had been outlined in the Brazilian Constitution of 1988. Different institutions, gathering with other, non-academic, social forces, such as the Brazilian Center for Health Studies, joined efforts in this enterprise. The result was a large scale mobilization involving health care professionals from the public service and the Brazilian Association of Collective Health Graduates (ABRASCO). It had been during the VIII National Conference for Health in 1986⁹ that most of the proposals and precepts that would be integrated two years later into the Constitution had been worked out. Presided by the brilliant academic and politician, Sergio Arouca, the event congregated thousands of militants of the most varied origin along with representatives of the legislature; it generated the key document which would later guide the Constitutional Assembly.

Political Strategy of the Health Care Movement

The Brazilian Health Care Reform was led, essentially, by two political forces from the democratic front of that period (late 1970s and early 1980s) the clandestine PCB (Brazilian Communist Party) and the recently formed PT (Workers’ Party), with close ties to the worker unions of key sectors of the metropolitan region of Sao Paulo, progressive sectors of the Catholic Church and grassroots movements. The hegemony of the movement rested on the Communists, a party of cadres, who imposed their strategy of occupying positions within the State apparatus at all governmental levels; meanwhile the PT, itself a party of the masses, opted for external

popular mobilizations. At the time, this strategic difference generated tension. However, the two strategies ended up complementing each other. While the PT conquered popular support, the communists worked on implementing institutional measures favouring the adoption of the SUS from within the State. Another factor favourable to the future continuation of the SUS is that a good proportion of those former communist activists involved in the health care reforms continue to work in governmental posts. While this brings some problems, it also may have the positive effect of guaranteeing a minimum of continuity in maintaining the original precepts of the reform proposals.

It can be argued that the political movement behind the Health Care Reform fought along three main fronts: progressive innovations in the health care system from within the State apparatus, lobbying within the legislature during the negotiations for the new constitution, and lastly, alongside the civil society, with the mobilization of health care professionals and popular forces. This threefold process implied a certain distribution of labor: within the institutions, the main role rested on the communist leadership and militancy; the social mobilization was promoted by PT (Worker's Party) militants. Despite disagreements of political strategy and the convictions upon which the precepts and guidelines of the Reform were based, both tendencies flowed together towards the successful institution of the SUS, modeled on the conceptual frame of Social Security.

This is, in fact, this qualitative leap that marks the Brazilian Health Care Reform, the fact that Health, starting in 1988, became part of the Social Security System. The plan was modeled along the lines of European social democracy. It is ironic that at the end of the 1980's the neoliberal upsurge attacked even these established European systems, seeking their dissolution. Thus, as the title of this article suggests, the Brazilian Health Care Reform does represent, in our case, a defeat of the neoliberal model.

The SUS: A Unified Health Care System

The SUS is a universal, integral, equalitarian,

free system of health care. As a service model, it is regionalized, prioritized, and decentralized. Even though its formal creation dates to 1988, its construction began way back in the period of democratization and was made possible by an effective political strategy. The holding of key strategic posts within the State by the "reformists" made possible a series of measures adopted prior to 1988 in the context of public health; these antecedents were paramount in preparing the adoption of the SUS and its subsequent realization. Most of these preliminary measures dealt with the process of strengthening public sector participation in providing health care services. This was made possible by the purchase of Social Prevention by its users, a measure unheard of at the time. Another measure dealt with decentralizing the operation of the system, not so vertical anymore after the creation of the SUDS (Unified and Decentralized Health Care System) before the Constitution of 1988. Even under the direction of the Social Prevention Ministry this initiative was effective in decentralizing and universalizing services. Another reform introduced new ways of paying for medical services for the beneficiaries of Social Prevention, creating a more rational payment structure.

Nevertheless, once the SUS was created and regulated by the laws adopted in 1990, the question became how to put it in practice. The challenges then, as now, were not minor. However, with the elimination of a dual system of management between the Health and Social Prevention Ministries, the SUS began as a stronger institution and chose to operate through ministerial laws, later called Basic Operational Norms (NOB-SUS). In 2000 these were renamed Health Care Operational Norms (NOAS). The first norms dealt with decentralization, regulating this process and assigning roles and functions to different entities of the federation. They also set up criteria for transferring resources from the federal to the sub-federal spheres while creating structure for institutional negotiation. The second set of measures was oriented towards the regionalization of health care, seeking to balance regional inequities.

A specific measure deserves special mention is related to the mechanisms for transferring funds

from the federal to state and municipal levels. Until then, such transfers were based on calculation – either of the existing infrastructure or of service capacity and provision – with occasional smaller contributions for other considerations. Starting in 1998 the transferring of funds became automatic and based on a fixed *per capita* value for basic health services — either individual or collective. The Ministry of Health guaranteed monthly transfers to municipalities, regular and automatic, thus diminishing inequality and politically derived contingencies that could affect the amounts and spending of such resources. This measure directly strengthened the role of local authorities in the administration of their health care systems. Starting off from this PAB (Basic Assistance Floor) the system grew and developed. With the creation of the PSF (Family Health Care Program) it evolved two components, a fixed one (based on a set *per capita* calculation), and a variable component which allowed the transfer of federal funds to priority programs. These include the PSF, the Pharmaceutical Assistance Program and the Program for Controlling Nutritional Deficiencies. The introduction of this new variable mechanism for transferring fund, which coexists with the previous one, deepens the decentralization process of health care. It strengthens the programmatic lines of the SUS, specifically the universality of services and the equality and integral nature of their availability. It also promoted local management of health care resources> Each of the 5,604 Brazilian municipalities receives direct transfers from the federal system.

PSF as a Strategy for Changing the Model of Health Service Delivery

The introduction of the Community Health Care Agents Program in 1991 and the PSF in 1994, took place in the poorest regions of the country. These localities subsequently registered a significant reduction of infant mortality as well as a major increase in basic health care service coverage. This set the correct stage for health care services standards at a more complex level. Starting in 1994 the PSF expanded rapidly throughout the national territory, including the large cities. Today it has

presence in all the municipalities and has become one of the prioritized programs at the federal level.

Two things are of note. The PSF was a strategy for changing the health care delivery model in terms of policy, it is not itself a health care program. The objective of PSF was to change the model operant in the SUS. It was, according to official documents, “a strategy for reorienting the welfare model through the implementation of interdisciplinary teams in basic Health Care Units.” These Units provide follow-up to a certain number of families residing in a specific geographic delimitation. These teams engage in promotion, prevention, treatment, and rehabilitation of the more common diseases and health problems. They seek to preserve a healthy community through sound health care practices.

This introduces another innovation, along with balancing available financial resources by the PAB: the effort to expand coverage beyond their spatial confines of the healthy system’s installations. The objective is not only to expand coverage - the universality of the SUS - but to make it more effective and rational in the sense of truly making the basic health care services the entry portal into a larger Health Care System that could accommodate the needs of the community. The priority given to the PSF, from its inception (thus involving governments run by different political parties), has been so high that an extremely fast growth in the number of teams has been observed throughout all areas and regions. While this strategy was initially targeted to poorer areas, today the PSF is distributed throughout the national territory, including areas of varied income levels. This is due to the fact that, especially in metropolitan areas, spatial economic segregation is not always so rigid.

The second PSF innovation is probably the most important and illustrative of the new system. The extent and importance given to the Community Health Care Agents Program and particularly to the Family Health Care Program, shows that they are nothing like the classic “basic health care package” promoted by multilateral agencies like BIRD.¹⁰ What is surprising about the Brazilian case is the fact that social policy as a whole (as with the Family Support Program) is not structured after such model. Social Services are modeled on Social Security

principles since 1988, in spite of the unfavorable historic heritage of tightly regulated membership mentioned at the beginning of this article. This prevents the PSF proposal from becoming a strategy for public cost reduction by providing basic health care to the poor while leaving to the markets and the individual and families the responsibility of covering most health problems. Given the complexity of Brazilian social reality, assuring health care equity and comprehensiveness is still a challenge faced on a daily basis. These issues require investment in infrastructure and equipment of great sophistication. Nevertheless, this is exactly what is being done, in spite of budget restrictions. This leads us to the subject of funding.

The SUS and Health Care Funding

Health care funding in Brazil is drawn from various sources; two thirds are public and one third private. This estimation of public funding leaves out indirect transfers from the public sector into the private market through tax exemptions, an indirect form of subsidizing the private health care sector. Its implementation rests on allowing tax deductions for certain health expenses, such as providing medical service and private health insurance plans. This mechanism is also used in the education. Nonetheless, these figures show how significant public funding is in financing health care, in accordance to the Brazilian constitutional article 198.¹ This article contains one paragraph stating: “the Unified Health Care System will be funded ... with resources from the budget assigned to Social Security by the Union, the States, the Federal District and the municipalities, among other sources.” As such, these resources for the financing of health care are constitutionally tied to the Social Security budget draw from Social Welfare, Health and Social Prevention.

The resources ascribed to Social Security have tax revenues as their principle financing source. These are generally gathered in the form of “contributions” so that they do not legally figure as new taxes. New taxes would require legal, institutional and Constitutional changes which could only be authorized by an absolute majority of the legislature. As examples, the creation of a

Provisional Tax on Financial Transactions (IPMF) in 1994 was replaced in 1997 by the Provisional Contribution on Financial Transactions (CPMF). The Contribution was put in place as an emergency measure in face of fixed tax funds for health care expense at a time of high inflation. Instituted by Constitutional Amendments (a prerogative of the Executive and later needing approval by the legislative) the CPMF was successively rewritten. The new resources were eventually destined to other social areas, no longer exclusively to health care. Recently, in December 2007, the contribution was revoked by Congress.

It is worth mentioning that the CPMF was a taxation that rested on very fair grounds. It was progressive and only applied to those who had access to the financial market. It is exactly because of this that it was vetoed by the opposition in the National Congress; this occurred during the second term of a progressive government. Under this government, economic stability was finally attained; the economy began to grow again (even though modestly), formal employment increased, and there was a huge expansion of social policies of a redistributive nature.

Health Care Funding

In 2007, the budget of the Ministry of Health¹¹ was R\$40 billion (around US\$ 23.4 billion). This financed a system that potentially covered 183 million Brazilians. Around 40 million of them have some type of private health insurance, leaving 143 million as potential beneficiaries of public health care. During 2007, R\$60 billion (US\$35.1 billion) were spent by the 40 million affiliated to the private health care system. It is therefore a myth that privatization reduces costs, or that the free market allocates its resources more efficiently than the State.

In order to explain this disparity in health care costs thoroughly it is necessary to develop wider understanding of the Brazilian Health Care System. This is why we have left this topic until now. The system has two parts: the SUS, a public institution, and the supplementary (private) medical care. It is to this subsystem that private resources are destined, most of its elements subsidized by the State through

the tax exemption mechanism. In this manner, public policy enables a private health care market, regulated by the government as will be seen. At the same time, the political forces mobilized around the health care project seek to guarantee resources for the funding of this sector.

It is in this context that the initiative of the CPMF should be evaluated. Even if these resources did not mean the expansion of the system in the same degree as the amount collected. What it meant was more of a substitution of funding sources than a net growth of them. The context was that of an unfavorable economic moment in the midst of structural adjustment economic policy. The Constitutional Amendment Project no.29, approved in 2000, rescued the sector by introducing significant changes in the mechanisms for the global funding of the health care system. This amendment defined norms for the participation of the three spheres of government in relation to financing the sector. At the federal sphere, health care spending is to be readjusted according to the nominal variation of the GDP. At the state and municipal levels, at least 7% of public spending must be channeled towards health care and it should reach 12% and 15% respectively by 2004, reducing the gap by a fifth each year. Having reached this level not only signified a significant increase in the resources for the sector but it also made them stable. Until then, they were subject to reductions - as the rest of social spending - due to the contingencies created by the structural adjustment and economic stabilization policies that were being adopted. At the same time Brazil was going through a period of transition towards a less orthodox economic model.

Although the health sector had guaranteed this minimum level of (much) increased funding, it was still not sufficient to meet health needs that had been historically unmet. So the private health market remained as a challenge to the reform.

Regulation of the Health Care Sector

Neoliberal governments at the beginning of the 1990s adopted (along with the privatization of state owned productive infrastructure and the dismantling of the state itself) the transference of market regulation capacities to specialized agencies. This

was seen as a means to “discipline” key economic markets. Under the previous development-oriented policy, regulation had been a state prerogative.

The health care sector was no exception. Independent agencies linked to the Ministry of Health were created. The Agency for Health Surveillance (ANVISA) was created in 1999 with the mission of regulating sanitary control over the production and commercialization of products and services in the health sector. Its function was to regulate the operations of the private health care sector to protect the public interest. Much debate occurred about the actual capacity of these agencies to effectively regulate, especially in the case of free markets that were imperfect. However, in the specific case of Brazil, the role of these agencies became that of provoking a public discussion and debate over the private and public interests at play in the health care sector. This made it possible to implement significant achievements such as the extension of medical assistance coverage to the treatments of diseases previously not contemplated by such contracts.

These agencies would become all the more important given the diversity and complexity of the private health care subsystem, which encompasses several forms of organization: group plans, medical cooperatives, self governing entities, health insurance and health plans. The tension lies between the plan operators and the service providers (private medical care companies and providers of diagnosis and therapeutic services).

New Frameworks for Management and Public Governance

As a consequence of SUS, results of the Constitution of 1988, health care finally acquired forums for public participation for its management. These are the National, State and Municipal Health Care Councils. They are composed of representatives of society and government, and they act as deliberative bodies. The existence of such Councils is a precondition for states and municipalities receiving federal resources. Service Units can create management councils, although this is not a requirement. Initially, the Presidency of this council system was given to the Health Minister>

More recently other representatives have been served as President, not uncommonly by members of the community.

Beyond these Councils there are the National Council of State Health Ministries and the National Council of Municipal Health Ministries. These are not part of the formal organization chart of the SUS but stand beside the Ministry of Health. They serve as intermediary negotiating instances between federal units and levels, mainly in issues dealing with the distribution of resources but also in more general aspects of health care policy. These instances are becoming, more and more, valued facilitators of democratic decision making exclusively among those responsible for health care practice, without social participation. However, because of the diversity of size and wealth amongst municipalities in Brazil, these managerial consensus spaces are extremely important for the exchange of experiences and the formulation of effective negotiation patterns with instances at a higher level in the federation.

The prevision for public control mechanisms in the Brazilian Constitution as part of the SUS made possible the emergence of numerous new political actors and social subjects mobilized around health care issues. In fact, starting in 1988, the country saw an accelerated increase in social participation which surpassed the cadres of those organized segments of the population, including even beneficiaries of the health services. These actors began to act along with social movements, turning Brazil into a big laboratory of social participation of the most varied kind.

In a similar manner, the participation of health care professionals in the Councils also introduced a new culture within the management of health services. This tended to make the job of those professionals less bureaucratic, even though it is common knowledge that it is precisely health care professionals who most vehemently oppose any type of modification of their behaviour and methods.

The increasing local autonomy in the management of health care systems, resulting from the process of decentralization, and its democratization, due to the introduction of social control, provide two perspectives for drawing up a

balance sheet of these experiences. While both initiatives made significant advances, a fair balance must also admit there is still a long path yet to be walked. Nonetheless, there is no doubt that the implementation of public control over health care policy and management have had as their greatest contribution the expansion and furthering of public participation in Brazilian society; a necessary condition towards a democratic society.

Conclusion: Where do we go from here?

Even after 20 years of existence the SUS is still a process under construction. Along its history it has faced periods of financial resource instability and resistance against changes to the existing welfare paradigm of health care. From a model of sporadic, spontaneous health care it has become one with a much more active presence in health promotion and prevention. Meanwhile, it has had to deal with difficulties derived from a complex process of decentralization which was, at times, ambiguous in relation to the responsibilities among the three federal levels.

On the other hand, during this period the Ministry of Health's responsibilities were progressively increased. It implemented programs for dental care, women's health and geriatric care, occupational health, and care for STD and HIV infections. It introduced generic medicines and programs targeting infantile mortality, malnutrition and contagious diseases. The range of free services provided by the SUS is remarkable; it goes from vaccination to organ and tissue transplants.

The starting point was an eminently private health care system funded essentially by the public. Today, this reality is being inverted. We need only point to the fact that in 1995 the relation of public hospital beds per thousand people was 0.71 while that of private hospital beds was 2.29/1,000; in 2005 these proportions were 0.84 and 1.19, respectively.¹² This demonstrates the significant investment in public infrastructure, a novel fact in Brazilian history. Together with the rapid expansion of basic health care we see clearly what was stated before: the increasing universality of health care coverage under the SUS through the strategy of PSF. These guarantee simultaneously the integral nature

of health attention and the investment at all levels in the health care system.

There are still enormous challenges to overcome: long lines of people seeking attention (especially in the case of hospital treatment and particularly of elective surgery), the growing number of cases of dengue, yellow fever, etc. Opinion polls also provide an interesting finding: those who evaluate the SUS negatively are exactly those who do not use it, those who do, rate the attention received positively and show satisfaction with the treatment of their case.

Strengthening management and organization is one of the priorities for those responsible for health care policy today. In order to solve the issues of bureaucracy, characteristic of direct public management, it has been suggested to hire public-interest society organizations that would operate under public supervision. This example could be seen as a “basic package,” thus fueling a counter-reform.

This counter-reform proposal was defeated in the last National Health Care Conference of 2007, at least for now. This is one more example of the deep social roots of the health care reform. The roots guarantee that it will resist the attacks of the (defeated) private interests so that it may continue, in spite of the geopolitical trends of neo-liberalism and globalization, in furthering the construction of a universal, democratic, and public health care system.

As we know, no process is linear and much less without contradictions. Once characterized as a Big Bang reform, today we may describe it as an incremental reform. What is at play today is the furthering and consolidation of the achievements of the movement. This requires institutional and scientific innovation from the managerial perspective, as well as new forms of health care service delivery and of the relations between the state and the society. This links health care to the larger society. The big lesson learned is that, while health sector reforms need to be effective, they must also be open to dialogue with other areas of state participation. What is certain is that the advances made since 1988 in the SUS have been irreversible, in spite of the ups and downs in their implementation. This is the great success.

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