Health reform and the creation of the Sistema Único de Saúde: notes on contexts and authors

Carlos Henrique Assunção Paiva
Researcher, Casa de Oswaldo Cruz/Fiocruz; professor, Mestrado em Saúde da Família/Universidade Estácio de Sá.
Av. Brasil, 4036, sala 414
21040-361– Rio de Janeiro – RJ – Brasil
cpaiva@coc.fiocruz.br

Luiz Antonio Teixeira
Researcher, Casa de Oswaldo Cruz/Fiocruz; professor, Mestrado em Saúde da Família/Universidade Estácio de Sá.
Av. Brasil, 4036, sala 403
21040-361 – Rio de Janeiro – RJ – Brasil
teixeira@coc.fiocruz.br

Received for publication in September 2013.
Approved for publication in January 2014.

Translated by Derrick Guy Phillips.

http://dx.doi.org/10.1590/S0104-59702014000100002

PAIVA, Carlos Henrique Assunção; TEIXEIRA, Luiz Antonio. Health reform and the creation of the Sistema Único de Saúde: notes on contexts and authors. *História, Ciências, Saúde – Manguinhos*, Rio de Janeiro. v.21, n.1, jan.-mar. 2014. Available at: http://www.scielo.br/hcsm.

Abstract

Within the context of the return to democracy, the new constitution enacted in 1988 transformed health into an individual right and initiated the process of creating a public, universal and decentralized health system, profoundly altering the organization of public health in Brazil. This article discusses the main institutional, political and social aspects of this health reform, along with the changes, the continuities and the major initiatives, based on the literature published by the most widely read authors in this field of study. Without purporting to offer an exhaustive analysis, we discuss how the historiography written by authors who were also actors in the process assess its main features, along with the genesis of the process and the legacy of health reform in Brazil.

Keywords: history of public health; collective health; health reform; Unified Health System (*Sistema Único de Saúde – SUS*); health policy.

In October 1988 the enactment of the new Federal Constitution completed the process of the return to democracy in Brazil. Within the context of the effort to set up a welfare state, the new constitution made health the right of every citizen and launched the process of creating a public, universal and decentralized health system. It was thus responsible for a profound change in the organization of public health in Brazil. Old problems, such as the traditional duplication involving the division of the system between public health and social security treatment, began to be tackled structurally. Others, such as the possibilities for financing a system on a universal scale still present difficulties that appear intractable.

In the context of commemorating 25 years since this important national development, the scope of this article is to trace the process of construction of this new health system with respect to the main aspects that were retained and those that were changed, along with its general guiding principles and the varying ways in which they were interpreted. As far as the narrative comprising our understanding of this historical process is concerned, we have selected three aspects to guide the discussion, namely (1) the idea of health reform as a political and social movement; (2) its origins and organization; (3) its legacy.

Without exhausting the various possible interpretations, the questions above represent, so to speak, the fundamental points of inquiry for an understanding of a movement which, although originally concerned with health, became entwined with the struggle against dictatorship and in favor of a return to democracy. In view of the extent and complexity of the literature on the subject, as well as the different perspectives and approaches involved, we have chosen to set out a non-exhaustive analysis of the subject.

We shall discuss some of the most widely read authors in this field, who have produced studies on the aspects noted. From the outset of our historiographical review, we adopted the policy of looking at those persons who played a part in the health reforms, a large number of whom became analysts, namely both author and actors. This choice has allowed us to bypass a number of contributions which, albeit important, were the work of commentators who played no part in health reform and were not necessarily committed to its ideas. Besides the authors of first instance, we have had recourse to the main works in the form of books, which are also directed towards the aspects noted above. In choosing these books, instead of articles and other forms of dissemination, we have concentrated on those commentators who, for at least a period in their careers, have made health reform a central theme, in our effort to provide a full and thorough analysis.

The category of "author-actors" thus comprises a very diverse set of views as to the perspectives and problems associated with reform, but at the same time allows us to look at the writings of commentators who, in one way or another, provide reflections on their own careers and their role in the construction of a public health system and democratic institutions in Brazil. An analysis of studies in book form reflects the importance of this type of publication in consolidating and disseminating knowledge of the subject. In other words, they are works that have made a solid contribution to the historiography of health reform, and have been decisive in forming the ways in which the subject is viewed.

Health under the dictatorship

The 1960s commenced with an intensification of the Cold War. In a world divided between capitalist and socialist powers and subject to constant political instability, a number of Latin-American countries experienced coups d'état and the installation of authoritarian regimes.[1] The establishment of a socialist regime in Cuba, following the revolution of 1959, encouraged the rise of various national movements with similar objectives. In a contrary tendency, the USA, which at the time was emerging as the leading capitalist power, began to encourage the overthrow of governments which opposed its interests (Dreifuss, 1981).

In Brazil, this scenario would lead to great social and political changes. In 1964, less than two decades after the country had returned to a democratic regime, a military coup marked the beginning of a new state of emergency in the country. Promising to restore order, strengthen the economy and restore democratic government within a short space of time, the military ended up by retaining power for more than two decades. Characterized from the beginning by a ban on social participation, the first military governments, in a progressive hardening of political attitudes, sought to destroy all initiatives that might be identified as emanating from socialist ideology.

In the sphere of economics, the period was marked by the opening up of the economy to foreign capital, along with wage restraint and a ban on strikes. In the social and political field, the civil rights of opponents of the system were abrogated, and the political system was redeveloped with the creation of a two-party system and the subordination of Congress to the interests of the Executive, on the basis of the proclamation of the institutional acts.[2] Changes in the electoral system from 1965, with the suppression of multi-party politics and the legalization of just two parties – the government party Arena and the opposition grouped within the MDB – together with the introduction of the so-called sub-party system in November 1966 (regulated in 1968), gave the government, in particular, an important advantage in majority elections, i.e. in the votes for mayors (except in state capital cities) and for members of the Senate.

In short, it can be seen that, by blocking the careers of many political leaders, and by changing the rules which governed the political system and generated sources of political capital, which remained firmly with the leadership of the armed forces, the long military dictatorship (1964-1985) had an important effect in hampering organized political activity in Brazil (Miguel, 2003). It is the case that a new political generation was in the process of being formed and, as we shall see, part of it arose from, and modeled its discourse on, interests and ideas connected with the field of health.

As regards the public health system itself, Brazil experienced the duplication of a system split between social security-funded treatment and public health. The first sector was directed towards the health of individual workers, urban areas constituting its priority, and was run by pension funds.[3] Public health policy, under the direction of the Ministry of Health, was targeted mainly at rural areas and at the poorer sections of the population, and its aims were mainly of a preventive nature.

In this context, the health policies of the military governments sought to encourage the expansion of the private sector. With this aim, the purchase of medical services through

social security was extended, and tax incentives were given to companies to contract private firms or medical cooperatives for the provision of health services for their employees – the corporate conventions (Almeida, 1998). Those who devised these policies also aimed at the privatization of some government medical services, which were then considered inadequate because they did not make a profit.[4]

In contrast however, the policies of the period continued the principles of previous governments in extending state social security cover for medical assistance to the less favored sectors of society. With this in mind, various measures were enacted, such as the inclusion of accidents at work in state social security schemes (1967); the extension of state social security to rural workers, with the creation of the Rural Workers Assistance Program (Prorural) in 1971; and the extension of state social security cover to domestic employees in 1972, and to self-employed workers the following year.[5]

On the pretext that the IAPs, set up during the first Vargas administration, were in a state of insolvency (Braga, Paula, 1986), the military government created the National Social Security Institute (Instituto Nacional de Previdência Social, INPS). This introduced uniformity in benefits for those contributing and abolished the tripartite management system (Federal Government, employers and employees), which guaranteed users, at least in theory, representation in decision-making processes (Santos, 1994). As well as overseeing the progressive exclusion of social participation in the management of the funds, the INPS started to prioritize the contracting of private services for attending to the needs of beneficiaries. The method of remuneration by reference to unit of services, brought in by the INPS to pay its suppliers, was to prove highly prejudicial because it encouraged corruption, witnessed a huge expansion in unnecessary medical treatment and prevented any planning of services to be prioritized (Braga, Paula, 1986; Escorel, Nascimento, Edler, 2005).

As regards public health, the period is marked by the onset of a crisis in resources and by a weakening of the powers of the Ministry of Health. An example of this process is the fall in the share of the health portfolio in the total federal budget from 2.21% to 1.40% between 1968 and 1972 (Braga, Paula, 1986). During the same period, the Ministry of Transport and the armed forces received 12% and 18% of the budget respectively (Médici, 1987).

Between the end of the 1960s and the first three years of the following decade, due to an economic policy of reducing expenditure on social programs and a favorable international outlook, which saw the entry of large amounts of foreign capital into Brazil, the country experienced a period of great economic vitality, growing at rates of around 11% per year (Lago, 1990). However, this growth did not translate into an improvement in the living standards of the majority of the population. Income concentration, loss of the minimum salary's purchasing power, price increases and a crisis in public transport and health services constituted the price to be paid for an economic model that prioritized development through the concentration of wealth.[6] From the end of the 1970s, the country was severely affected by the international economic crisis caused by the increase in the price of oil, which began in 1974. Although the government continued for several years to support various investment initiatives, the cycle of strong economic growth was nearing its end, and this aspect favored an increase in social tensions and the growth of various forms of popular movement through

political changes and alterations in social conditions. This melting pot would give rise to the first movements for reforms in the field of health.

The 1970s and health policies

In global terms, the 1970s saw a relative decline in the cycle of economic and social prosperity that started in the post-war period. This cycle had resulted in the expansion of the so-called welfare state, which saw levels of social solidarity never attained before. In the capitalist West, there was a progressive dismantling of the consensus with regard to the role played by the state as a productive entity, a promoter of development and social solidarity, and a direct provider of services considered essential, such as social security, health, education and welfare assistance (Fiori, 1997). The rise of neo-liberal doctrines, which rose to power in England in 1979 with the election of Margaret Thatcher and in the USA in 1980 with Ronald Reagan, marked the pinnacle of this process (Hobsbawm, 1995).[7]

However, transnational circulation was not restricted to ideologies. In the specific field of health, surveys made on a continental scale, particularly that sponsored by the Pan American Health Organization (PAHO), emphasized a worrying picture with regard to health, combining poor coverage of health care with the spread of specific poverty-related diseases, such as those transmitted by vermin and water-borne infections. The methods indicated for confronting this picture involved planning and evaluating policies, which involved the institution of specialist units in health ministries and the proper recording of death and health statistics. It also involved the coordinated management of health services with respect to national and local programs, the integration of prevention with treatment measures and an emphasis on the education and training of human resources (OEA, 1961).

The idea of planning, as the way of proceeding to a programmed mobilization of available resources, for the purpose of achieving objectives and targets defined in accordance with particular diagnoses, confirmed in the field of health the need for epidemiological research and statistical information as requirements for the establishment of priorities. In the same way, it called for the development of methodologies for what was to be "the integrated planning of economic development and welfare" (Opas, 1963).[8]

In addition to these rationalist principles, the new ways of thinking about health included the search for wider coverage by services. The force of this idea was capable of setting institutional guidelines, while at the same time there was increasing criticism of intervention of the vertical type, oriented by type of illness, and of curative medicine centered on a hospital and on an increasing use of complex technologies. This environment of criticism, of which the health movement in Brazil was an expression, was accompanied by the growing popularity of approaches claimed to be integral and of the simplified medicine practiced in developing countries, among which was the system involving the use of the Barefoot Doctors in the People's Republic of China (Cueto, 2004a). In international terms all these trends culminated in the institution in 1977 of the goal entitled "Health for all by the year 2000" and, in the following year, the Alma-Ata Conference with the proposal of primary health care as the core strategy to attain it (Cueto, 2004b; OMS, 1978).

In Brazil, these debates about health took place during the occurrence of major political and social changes. Politically, the 1970s were a time of repression, but they also saw the first steps towards the reestablishment of democracy. Elections for the senate (1974, 1976 and 1978), the reduction of censorship (1975 and 1979), the amnesty law (1979), the return to a multi-party system and the repeal of institutional act no. 5 (1979) all set the tone for the transformations which are customarily referred to as a slow and gradual openness.[9] In the view of Sarah Escorel, the ideologues of the regime were attempting to restore the worn out basis for the social legitimacy of the system (Escorel, 1999).

An important stage in this process was the launch by the military government of the Second National Development Plan (2nd PND). In the purely economic sphere, still characterized by an enthusiastic development ethos and by the concept of a superpower in the making, the plan aimed at an extension of the policy of import substitution, concentrating its attention on the production of basic raw materials and capital goods, rather than the mere substitution of consumer goods (Veloso, 2009). Although 2nd PND provided the potential for growth in Brazil in the mid-1970s, its effects were limited by the international crisis that was escalating at the same time. Despite these difficulties, 2nd PND had the merit of including in government planning social priorities such as education, health and urban infrastructure.[10]

In the field of health itself, the period witnessed greater activity by the Ministry of Health, which increased funding to the states and started to develop vertical projects aimed at controlling certain diseases, such as leprosy, tuberculosis and cancer (Braga, Paula, 1986). In 1975, by law no. 6229, the regime set up the National Health System. Writers who have studied this period see in the establishment of this health system a measure, which in the Ministry of Health and the Ministry of Social Security consolidated the separation between public health policies and social security medical care. Under the Law, the Ministry of Health was responsible for directing epidemiological policy throughout Brazil, the direction and control of health care, and other measures of a collective nature. The Ministry of Social Security, in its turn, had the responsibility for coordinating health care and for other areas more concerned with the health of the individual (Escorel, 1999; Escorel, Nascimento, Edler, 2005).

In addition, the same law provided the legal foundation for a problem which proved to be central in the running of SUS, and which remains a problem today: the separation between the training of personnel and the needs of the health system. This was because, under the new law, the Ministry of Education and Culture was made responsible for the instruction and training of upper level professionals, technical assistance for the health system, and the maintenance of university teaching hospitals, as well as the issuing of guidelines for the training of health personnel.

The lack of coordination and harmony between the system for training personnel in Brazil and the epidemiological and care needs of the population, as felt within the health services continued to be one of the most urgent problems to be tackled in order to achieve the optimum functioning of the contemporary Brazilian health system (Chaves, 1994; Marsiglia, 1995; Feuerwerker, Marsiglia, 1996; Lampert, 2002 and others).

New ideas and practices in health

The histories of health reform in Brazil normally place the origin of the movement in the second half of the 1970s, a period which coincided with the foundation of the Brazilian Center for Health Studies (Centro Brasileiro de Estudos de Saúde, Cebes) in 1976 and, three years later, the foundation of the Brazilian Association for Post-Graduate Studies in Collective Health (Associação Brasileira de Pós-Graduação em Saúde Coletiva, Abrasco) (Escorel, 1999; Rodriguez Neto, 1997; Paim, 2008). However, the process of training personnel and institutions identified with radical changes in the prevailing health system was related to a number of factors, from the establishment of courses in preventive medicine starting in the 1950s to the strengthening of sentiment against the authoritarian regime, seeing in its overthrow the only way of constructing an efficient and democratic health system.

It is important to stress that the progressive development of measures in the field of health with the aim of improving care and reducing expenditure on resources tended to require technical and scientific personnel who were not always immediately available in the government agencies. This shortage of skills, in the view of Escorel (1999), provided the opportunity for access by a group of medical professionals with innovative ideas to positions in the government technical bureaucracy. Many of these were of a progressive nature, and this group gradually formed a movement for the reform of the health system, as part of the opposition to the regime.

From their new positions in government agencies, these members of the growing health movement in Brazil – ideologically inclined to the left and in favor of state provision of health services – sought to introduce progressive changes in the organization of the health system in the country. One of the steps in this direction was the creation of the Health and Sanitation Program for the Interior (Programa de Interiorização de Ações de Saúde e Saneamento, Piass) (Escorel, 1999). Launched in 1976 under the aegis of the Ministry of Health, Piass was an investment program targeted at expanding the primary health care network in municipalities in the interior of Brazil. Its two principal aims were (1) to increase the reach of cover by medical services, especially in rural areas; (2) with its focus on primary health care, to regionalize medical care and assistance, in a decentralized and hierarchical form. As a strategic program, Piass represented an identification of Brazilian health policy with the principles advocated in an international context by the World Health Organization (WHO) and in a regional context by PAHO. It included an emphasis on increasing cover by medical services in the most remote communities, through the use of auxiliary personnel, recruited locally and trained for the purpose (Escorel, 1999; Pires-Alves, Paiva, 2006).

As a strategic initiative for extending the coverage of medical care, Piass needed a second element: the instruction and training of technical personnel and auxiliary health workers. The Health Personnel Strategic Preparation Program (Programa de Preparação Estratégica de Pessoal de Saúde, Ppreps), launched at the same time as Piass, responded to this need by providing for the decentralized training, in each federal state, of health personnel at various levels. It also supported the setting up of human resources management structures in state health departments, particularly in the north-east of Brazil (Pires-Alves, Paiva, 2006; Nunes, 2007; Paiva, Pires-Alves, Hochman, 2008).

At the same time as these policies were being planned and implemented, the Brazilian health reform movement made advances in organization and procedures and became increasingly institutionalized. In July 1976, a group of health professionals from the Universidade de São Paulo, with the principal aim of producing a specialist periodical, founded Cebes. From then on, *Saúde em Debate* (Discussions on health) became one of the main vehicles for spreading the movement's ideas, and Cebes became an important agency of civil society (Escorel, 1999; Sophia, 2012a, 2012b).

As part of the same movement, Abrasco was set up in September 1979 as a method of organizing post-graduate programs in the field of public health, social medicine and collective health. The following month saw the first Symposium on National Health Policy, in the Chamber of Deputies, an event which brought together the principal leaders of the different strands in the movement.[11] The main debates during this encounter focused on a text produced by Cebes and by researchers at the Institute of Social Medicine (Instituto de Medicina Social, IMS) of Universidade do Estado do Rio de Janeiro, which sought to produce a synthesis of the main demands of the health movement.[12]

The document produced at the First Symposium on National Health Policy set out the central principles to be adopted by the health movement. It included the universal right to health, the inter-sectorial nature of health considerations and the regulatory role of the State with regard to the health market. It also encompassed the decentralized, regionalized and hierarchical character of the system, popular participation, democratic control, and, most importantly, the need to integrate social security healthcare and public health (Cebes, 1980).

The part played by Abrasco and Cebes in this context deserves consideration on its own. In summary, it can be stated that they were key institutions in the process of constructing an identity around an area of knowledge that came to be known in Brazil as collective health. It was an area characterized by diversity in knowledge, disciplines, approaches and perspectives, and formed the stage for an important movement that was critical of the old ways of managing public health.

In place of an authoritarian outlook, Abrasco and Cebes advocated social participation; in place of disease control policies, especially with regard to transmissible diseases, the promotion of health and improvements in the general quality of life; in place of a sector divided between public health and state-insured medicine, a unified and universal health system. Their agenda in this respect was intimately connected with the crisis in the dictatorship and the return of democracy to Brazilian society, because it was understood in these institutions that changes in the field of health meant measures to make the State and its agencies and decision-making processes more democratic (Lima, Santana, 2006; Sophia, 2012a, 2012b).

From this aspect, it is clear that the field of collective health, as viewed by the members of Abrasco and Cebes, may be seen as simultaneously a field for the development of knowledge and an area for democratic practices in health. These two bodies, along with other organizations, were at the heart of the health reform movement in Brazil. Their activities at the eighth National Conference on Health (Conferência Nacional de Saúde, CNS), at other health gatherings, or in the National Council on Health (Conselho Nacional de Saúde), give a fair idea of the range of their vital contribution to the debate and to health reform in Brazil,

as well as to the process of restoring democracy in the country (Rodriguez Neto, 1997; Lima, Santana, 2006; Sophia, 2012a, 2012b).

Health during the process of re-democratization

The end of the 1970s marked a change of course for Brazil. The process of relaxation, which had commenced towards the end of the Geisel government (1974-1979) with the revocation of institutional act no. 5, was overseen by President João Baptista Figueiredo (1979-1985), who, at the start of his government, under intense public pressure, decreed an amnesty for political dissidents. In the economic sphere, as we have already indicated, the country was passing through a crisis caused by the debt policies of the military regime, two oil price hikes – in 1973 and 1979 – and the increase in interest rates presided over by the US Federal Reserve. Brazil's foreign debt rose by 142% between the end of 1978 and the end of 1983 (Souza, 1985), and this exponential increase left Brazil vulnerable to external pressures. This explains the signing, in 1983, of an agreement with the International Monetary Fund (IMF), containing a series of disadvantageous requirements, such as the liberalization of the economy and control of the public deficit. These provisions had a strong recessionary effect on the economy, contributing to the growth of social dissatisfaction with the military regime and to the appearance of the 'Elections Now' Movement between 1983 and 1984. This development prevented the Figueiredo government from nominating its successor and accelerated the transition to democracy (Sallum Jr., 1994).

Without contradicting the view put forward by Escorel of the entry of progressive health professionals into the government bureaucracy on the importance for the reform of the health system, Silvia Gerschman (2004) took the view that the relaxation that occurred at the end of the 1970s also made possible the development of social movements which played an important part in the genesis of this process. The popular health movement and the doctors' movement were the two main examples. The former occurred among groups supported by the Catholic Church and by leftist militants, in poor neighborhoods on the outskirts of the major cities, where one of the principal demands was an improvement in health conditions in these areas. During the 1980s, these groups became prominent on a national scale as a result of the national community health meetings, and within a short space of time changed the focus of their attentions from community activism on a local basis to demands for social control of health services. They also called for improvements in the quality of preventive medicine and the development of prevention programs, along with improvements in living conditions so as to make better health possible.

The doctors' movement arose from criticisms of the existing health system and a collective struggle for employment rights. Led by doctors' associations and unions, strikes and other forms of mobilization called for better working conditions and changes to the health system. It was also characterized as a form of resistance to the changes in medicine which were transforming doctors – typically liberal professionals – into salaried workers, and as a struggle for the restoration of democracy. From the middle of the 1980s, according to Gerschman (2004), the doctors' movement experienced a change of direction and became principally concerned with specific corporate interests, linked to the quest for liberal activism in the profession.[13]

In this view, both the doctors' movement and the popular movement were extremely important in broadening the scope of the discussion with regard to health reform. They helped in the formation of the health movement, particularly through the activities of organized groups at the eighth CNS, even though both movements grew weaker after the mid-1980s (Gerschman, 2004).

At the institutional level, the beginning of the 1980s saw the emergence of new initiatives that gave greater visibility to health topics. The first of these, as we have already indicated, was the first Symposium on National Health Policy, in the Chamber of Deputies. March 1980 saw the holding of the seventh CNS, a meeting organized periodically to promote the spread of information among health professionals and to facilitate relations with state agencies. Its central theme was the expansion of health care through basic services, which reflected a union of the concerns of health professionals as regards the extension of health cover, at the time denied by the government, with the principles of international agencies such as the WHO and PAHO as regards the widening of basic health care.

These initiatives were accompanied by a worsening of the financial problems of social security funds. The crisis had become public knowledge in 1980. In addition to the fact that the economic crisis and unemployment had significantly reduced social security revenue, the crisis was also related to the extension of cover in medical and social security assistance. The lack of adequate financing and the extremely expensive model for the purchase of private services had given rise to a growing deficit. Government action to control the crisis ended up fostering the idea that the existing system was no longer viable. The Advisory Council for the Management and Control of Social Security (Conselho Consultivo de Administração e Controle da Previdência, Conasp), set up under the auspices of the Ministry of Social Security in order to suggest measures which might help to end the crisis, among other measures brought in a new system for paying hospitals. It abandoned the idea of payment per unit of service, and moved towards the remuneration of private sector producers in an aggregate manner in accordance with demand and capacity. It also provided for the establishment of contracts between the states of the federation, the Ministry of Health and the Ministry of Social Security (Escorel, 1999).

With the entry of various leaders of the health movement into executive posts in the Ministry of Social Security, the period saw the consolidation of the idea that there had to be a coordinated approximation or fusion between state insured medicine and public health. The response to the crisis by the National Institute for Social Security Medical Assistance (Instituto Nacional de Assistência Médica da Previdência Social, Inamps) took the form of measures to cut expenditure under contracts with the private sector and expand operations in the public sector. The most important of these measures was known as Integrated Action on Health (Ações Integradas de Saúde, AIS) which, based on regional and hierarchical mechanisms, sought to interlink the public health system on a federal, state and municipal basis.[14] Such initiatives started to make changes to the logic of the existing system, anticipating the institutional proposals for health reform at the end of the 1980s.

In addition to state concerns to extend the coverage of the social security health system and, even more importantly, to carry through an administrative reorganization which would solve the chronic problems of inefficiency, corruption and the budget deficits in the

health system, a reformist ideology started to develop among health professionals. It sought to extend health protection to all Brazilians and argued that the desired improvement in health matters was directly related to an extension of the rights of citizenship, i.e. the return of democracy. Such proposals were in harmony with the policies of the international health agencies (PAHO and the WHO) which, starting from the Alma-Ata Conference (organized by the WHO in 1978), proposed to extend basic health care as a means for achieving the target of health for all by the year 2000 (Giovanella, Mendonça, 2012).

Health and the return of democracy

With the indirect election of the then senator Tancredo Neves in 1985, and the accession to the presidency of his vice-president, José Sarney, as a result of the former's death, the military regime came to an end. This also meant the unraveling of some of the authoritarian political structures associated with it. The same year saw direct elections for the mayors of capital cities, and in the following year Congress took it upon itself to draft a new constitution which would restore the country to full democracy. However, the return to democracy took place in the midst of an economic crisis, which resulted in emergency economic plans designed to rescue the country from hyperinflation and promote economic growth.

In this context, a milestone in the great social movement to reform the health system was the eighth CNS in 1986. Its groups and its general assembly discussed and approved the main demands of the health movement: the strengthening of the public health sector, the extension of cover to all citizens and the integration of social security medicine with public health, thereby forming a unified system.

The eighth CNS was convened by the President of Brazil, at the request of the Ministry of Health in July 1985 and started its meetings in March of the following year, bringing together different sections of society. Its plenary sessions were attended by almost five thousand participants, of whom around a thousand were delegates nominated by various institutions and organizations.[15] Among the Conference's main themes were the duties of the State and the rights of citizens in matters of health; the reform of the national health system; and the financing of the sector. Specific themes, such as the hierarchical organization of medical care in accordance with its complexity and specialist nature, and popular participation in health services were also fully discussed (Paim, 2008).

This set of initiatives revolved around an expectation that the end of military dictatorship would coincide with a break with the past in which society, and by extension public health, would be constructed on a new basis. This view, for example, was expressed by Jaime de Oliveira (1988) in *Saúde em Debate*. It presupposed that the measures to rationalize the management of health services – such as the unification of social security and the planned extension of cover – would form part of, or take the place of, the ideology of health reform in Brazil.

It also assumed the possibility that the State would be employed as the principal agent for the transformation of society, including the health sector. Thus, as Escorel claimed, ten years after Oliveira, health reform was made possible, in part, thanks to the occupation of "gaps" in the public administration by personnel of progressive views who were committed to the

reform agenda (Escorel, 1999). What became known as the "Health Party" represented, in these terms, a political grouping in which intellectuals and people of progressive views, avowedly above considerations of social class albeit legitimized by the State, would devise public policies. These would be a break from the content and *modus operandi* of Brazilian social policies, on the way to solutions which, if not identical, would approximate to those of the welfare state.

However, following the approval of SUS and the Organic Health Law (1990), profound political, economic and public policy changes occurred. In the midst of the economic crisis faced by the Sarney government and those that succeeded it, the optimism with regard to a rapid and radical transformation in the health system, expressed at the time in the new Brazilian constitution, began to unravel. The difficulties of putting into practice radical policies, which clashed with the economic interests of highly organized groups, were added to the complexity of the challenge represented by the implementation of a unified health system in a country with enormous regional disparities.

If the context of economic crisis and a return to democracy in the 1980s contributed to the political debate with regard to health in the period that saw the principles of SUS – equity, integration and universality – consolidated during the 1990s, the establishment of these principles caused continual tensions. This was the time when the idea of the minimalist State, propounded by the neo-liberalism then in the ascendant in Europe and the USA, included restrictions on the activities of the State in regulating social matters. A wave of conservative reforms in the political, economic and social fields in a number of countries had a marked effect in Brazil, where it strengthened the trend towards the adoption of policies for opening up the economy and carrying through structural adjustments. The emphasis, from 1994 onwards, was on the stabilization of the currency, the privatization of state companies, and the adoption of institutional reforms strongly oriented towards a reduction in the size and powers of the State. In such a scenario, SUS entered into a structural crisis.

The historiography of the health reform

In the history of health in Brazil, the health reforms of the 1980s and the construction of the Unified Health System (Sistema Único de Saúde, SUS) are among the most studied topics. The importance of this process for social security and public health in Brazil, the identification of the process of change with the struggle for a return to democratic government and the fact that some of its most important exponents occupied central positions in academic institutions concerned with collective health and key posts in the area of health policy, all help to understand the enormous academic output on the subject.

Of the questions that have occupied commentators on the period, many have either gained or lost relevance to the extent that they approximated to or diverged from the problems defined by a fuller political discussion of a particular aspect. Thus, at the time of the reforms, the most urgent questions related to details of the movement, its members and procedures, to what it brought by way of continuity or a break with the past, and to the establishment of a theoretical basis to give it coherence (Campos, 1988; Fleury, 1997; Teixeira, 1988; Arouca, 1988; Oliveira, 1988). Following the establishment of the new health system, the discussions

became more and more concerned with the ways in which the new system might be made more viable and be evaluated.

In this process of constructing narratives and analyses, we have identified certain central questions which, faced with the impossibility of drawing up an exhaustive bibliographical balance sheet, will form the basis of our examination. They are:

(1) A description of health reform. What did the movement represent? What was new in it? Did the formal creation of a new system for health represent a break with the past or a continuation of it?

(2) The emergence, development and organization of the movement. What were the factors that caused it to appear? What groups played a leading role in its organization? How did it relate to the overall picture of the period?

(3) Scope and achievements of the reform movement. What was its legacy? What did reform represent? What benefits did it introduce?

We shall seek to examine how these questions were framed and how they were answered by the writers who have produced studies of the reforms. The limited space available to us has forced us to restrict our analysis to certain authors – in accordance with the guidelines set out at the beginning of this article – with an emphasis on the works of Jairnilson Paim, Silvia Gerschman and Sarah Escorel.

As regards the first aspect, those who have produced studies on health reform have had a genuine dispute as to the overall meaning of the movement, even before the creation of the SUS. Was the health movement during the period of the return to democracy (1986-1988) characterized by a search for reforms that would provide a new basis for health in Brazil, and would see the emergence of a new project which, in the long term, would reform the social security State within the context of democratic changes? Jaime de Oliveira (1988) answers the question in the affirmative, maintaining that by 1986 the health movement had taken on a reformist character and had adopted alternative policies. These were centered on the struggle for democracy and the formulation of a counter-authoritarian program directed towards the heightening of awareness in health matters and the right to health, and looking to the reconstruction of society on a new basis.

A contrary view is to be found in Gastão Wagner de Sousa Campos (1988), who noted more elements of institutional continuity in the organization of health from the end of the military period to the establishment of health reform. In his view, the health changes during the period can be characterized as a continuation of the same model for the production of health services, but on a new basis (Campos, 1988).[16] Contrary to the experience of other countries, where social reforms have been undertaken involving alliances between different social classes (Esping-Andersen, 1985), his view of health reform in Brazil sees a movement by an enlightened intellectual elite. It was identified with progressive ideas, which, having captured strategic positions in the State, particularly in the executive branch, concentrated its efforts on introducing social policies which broke with the status quo, without altering the existing structure.

This view, which was contemporary with the development of health reform, was connected with the difficulties and uncertainties of the process, at a time in which the different views

of the health model under construction amounted to an analysis of the course of the health movement. Whatever the truth of it, the quest for more profound changes in the system led to the development of a more critical analysis of the process up to that time.

Years later, when the SUS had become a reality, views on the movement and the reform process took another direction. Making a distinction between the health movement and the health system introduced by the reforms, Paim (2008) analyzed the reforms at different levels, characterizing them simultaneously as an idea, a proposal, a project, a movement and a process.[17] In his view, although the health movement did not succeed in achieving the reforms it hoped for – by a transformation not only of health provision but of society itself – it contributed towards the spread of the idea of the right to health as part of the attributes of citizenship and towards the democratic reform of the State.

Viewing the matter as a many-sided process, Paim (2008) stresses the idea of the ongoing nature of reform. This model formed the basis of several analyses, among them that of Sonia Fleury (2009). In an attempt, in her words, to analyze the conflict between the status quo and what was proposed in its place, she claims that the reforms did not succeed in introducing a new level of civilization, which would involve profound political and institutional changes capable of transforming health into a public asset. In this sense, and on the basis of an analysis of the problems and contradictions, it becomes necessary to continue the reform program. Reform, therefore, is a process that is still incomplete.

As we have seen, the analyses made contemporaneously with the first steps in the process of health reform have been supplemented by new analyses that classify the movement afresh by reference to the difference between its proposed nature (the project) and its operation in practice. They thus afford an opportunity for an understanding of the process incorporating the transforming impetus that launched the social and political experiment and at the same time marked its limits.

As regards question (2), the emergence, development and organization of the health movement, the starting point for the main interpretations is the activities of the organized social movements.

The work which had the greatest influence on the subject appeared in 1987. The thesis of Sarah Escorel, entitled *Reviravolta na saúde: origem e articulação do movimento sanitário* (The about-turn in health: the origins and development of the health movement), analyzed the social movement which gave impetus to the reform of health services which had commenced in the preceding decade. Escorel's narrative, which served as a basis for part of the first section of this article, was published in book form in 1999 and became the most widely read discussion of the process of health reform in Brazil. Referred to in a number of other texts and reproduced by her in various articles and chapters of books, her analysis has the merit of describing the movements directed towards the destruction of the authoritarian regime, highlighting also the institutional initiatives that served as a spearhead for the health reforms (Escorel, 1999, 2008; Escorel, Nascimento, Edler, 2005).

For Escorel, the principal engines of reform were the academic movements, i.e. those in the departments of preventive and social medicine, in the schools of public health, and in the post-graduate programs in community health. They included the student movement, the medical movements (The Resident Doctors' Movement and the Movement for Medical

Renewal), the institutional projects, such as the Montes Claros Project and Piass. They also included the institutions of civil society, such as Cebes; and those government institutions susceptible to action by the left, such as the Program for Socio-Economic Studies in Health (Programa de Estudos Socioeconômicos em Saúde). In her view, in the face of the health crisis, the activities of these individuals and institutions, during a process in which the bankruptcy of the regime became clear, were responsible for the change in course in Brazilian health policy.

Following in the footsteps of Escorel, Eleutério Rodriguez Neto (2003) points to the foundation of Cebes as the starting point of the health movement and the basis for constructing the model for social care. The document already referred to submitted by Cebes/Abrasco to the National Symposium on Health Policy, organized by the Health Committee of the Chamber of Deputies in 1979, is characterized by the author as a milestone in the process of reform. In his opinion it led to the gradual inclusion of the ideas of health professionals on the questions of health which were to be debated in Congress (Rodriguez Neto, 1994, 1997). His most thorough study is an analysis of health reform focusing on the activities of Congress during the process of drafting the constitution, stressing the importance of the activities of the left for the process of health reform.[18]

With specific regard to the social movements which gave rise to the process of health reform, the work of Silvia Gerschman, *A democracia inconclusa*: *um estudo da Reforma Sanitária brasileira* (2004) (Incomplete democracy: a study of health reform in Brazil) was also important for an understanding of the social basis of the reform movement.[19] Her study analyzes the role of popular health movements and the doctors' movement, which she considers the prime movers in the process of developing and implementing health policies between 1970 and 1994. Viewing health reform as something that stemmed from the process of transition to democracy, Gerschman notes the important role of these social movements in formulating the ideas expressed at the eighth CNS, and enlarges our understanding of the bases of the reform movement.

The work of Gerschman also highlights the question of the limits to reform. In her view, the characteristics of the movement and the results it achieved are related to the process of democratization in Brazilian society. As a social policy, health policy depends on a conception of social rights, and although the society of the time could be formally characterized by its democratic aspects – such as periodic elections and the existence of political parties – the limits to the views on fairness then prevailing imposed restrictions on the health model possible. With Gerschman, the limitations of health reform, seen then as defeats or simply as a process in the course of construction, take their place in a wider and "incomplete" process involving the construction of democracy.

When it comes to a consideration of question (3), the legacy of health reform in Brazil, in a balanced perspective, the analyses tend, as a rule, to adopt very positive positions. That legacy is assessed from a historical perspective which considers the story of health in Brazil and does not fail to take account of the extent of exclusion from health care prior to SUS. Conversely, it notes the advances expressed in the 1988 Constitution, particularly with the confirmation of health as a social right and an obligation of the State (Cohn, Edison, Karsch, 1991). In addition, many authors draw attention to the implementation and extension of

concrete initiatives to make the rights set out in the constitution a reality. Prominent among these are the establishment and expansion of the Family Health Program (Programa Saúde da Família), as a part of primary health care (Giovanella, Mendonça, 2012) and the advances in psychiatric reforms (Amarante, 2005). Also, the institution of a series of programs and initiatives which are considered to have been very successful in various areas, such as health surveillance and vaccination (Souto, 2004; Teixeira, Costa, 2008).

The balance tends to be less positive when one considers that SUS was only one part of the health reform agenda, and should not therefore be confused with it. Following this line of thinking, Paim (2008, p.34), even while recognizing the advances contained in the quality of certain initiatives and programs of the present health system, calls our attention to a cooling of reformist ideas. These are expressed either in the form of a certain "conformism" with regard to health realities, or in the absence of "more radical proposals for health reform in Brazil."

According to the same author, the radicalization of reform beyond a program for a health system with the current features of SUS would involve the establishment of a political movement with the capacity to bring about change in the structure of capitalist society. It should work towards a model of society less committed to inequality, the production of illness and the poor living conditions that afflict the general population.

In this sense, health reform constituted an agenda for political changes in society, going far beyond matters of finance, management and the political accord that enabled the construction of a health system. From this point of view, SUS, as the legacy of the health reform movement, was something much less than (some of) the reformers contemplated.

Such expectations co-existed with a view of reform as a long-term historical process, which, in the context of the development of new political forces and a revival of democracy, would be capable of ushering in new forms of social policy and a renewed covenant between State and society. From this standpoint, the potential for reform would not be exhausted by the kind of management initiatives with which SUS was identified (such as AIS and the Unified and Decentralized Health System [Sistema Único e Descentralizado de Saúde, Suds]), by the CNS or by the Constituent Assembly and the Constitution. In the view of Paim, for example, reform would require continual vigilance and militancy, the purpose of which, from the 1990s onwards, would be not only the establishment of SUS based on the Constitution, but also the construction of a renewed society.

From the point of view of health reform as an historical fact, viewed symbolically, this interpretation conflicts with those that ultimately look upon it as a landmark in the history of public health in Brazil. In this latter view, the health reforms, in an almost mythical manner, were a watershed that led to the emergence of a new chapter in the history of social policy in Brazil.

Final considerations

From this rapid incursion into some of the literature on the subject, it can be inferred that the histories of health reform are not unanimous, and, in some cases, are conflicting. They present very different pictures of health reform in Brazil, both with regard to its course and with regard to its legacy. What we refer to as the Brazilian health reform movement

therefore, when examined critically, involves very distinct positions and views with respect to the organization of health, and with respect to the relationship of the health sector with society and society itself as an objective phenomenon.

These differing views, which are sometimes doctrinal, cannot fail to have an effect on how the history of reform is reported and understood. Moreover, they construct and legitimize some of their different ways of presentation, as well as feeding the expectations and frustrations experienced by the very different parties involved at the present time.

In summary, what was the nature of health reform in Brazil? And what is SUS? These are far from being questions that are obvious or free from disagreements. In one way or another, the way in which we reconstruct the past experience of the reform movement and SUS does not fail to produce constraints or even to elicit problems which are not obvious to be brought into focus. Part of the political process of bringing about reform is the formation of an image and a cognitive environment that governs the actions of those involved and, in a productive feedback process, the political process of reform itself. In these circumstances, the history of health reform in Brazil, along with its different interpretations, remains a matrix for present and future experience.

ACKNOWLEDEMENT

To Paulo Henrique Rodrigues for his reading of the first version of this text and his suggestions.

NOTES

[1] In 1964, in Bolivia and Brazil, coups marked the start of periods of dictatorship; two years later, Argentina also experienced a coup in which power passed to the generals; in Colombia, in the mid-1960s, the rise of the Revolutionary Armed Forces of Colombia – People'sArmy (Fuerzas Armadas Revolucionarias de Colombia – Ejército del Pueblo, Farc) and the Ejército de Liberación Nacional (ELN, National Liberation Army) reinvigorated the guerilla movement. In 1968 there was also a coup in Peru, leading to the establishment of a dictatorship; in 1973, in Chile, General Augusto Pinochet overthrew the elected government of Salvador Allende. For the military coups in Latin America and the influence of the US in the region, see Bandeira (2005).

[2] In April 1964, Institutional Act no. 1 (AI-1) granted powers to the Executive to annul the mandates of elected representatives and to suspend political rights. The following year, AI-2 increased the powers of the Executive, disbanded all political parties and confirmed the mechanisms for indirect presidential elections in Congress. In February 1966, AI-3 provided for the indirect election of state governors and the appointment of the mayors of state capitals by these governors. In 1967, the new constitution gave even more powers to the Executive. Finally, 1968 saw the issue of AI-5, which gave absolute powers to the Executive and ordered the closure of Congress for more than a year. For the period of authoritarian rule in Brazil, see Castro (1995).

[3] In the 1920s, institutions were created holding funds based on contributions paid by workers and employers in certain companies, which were intended to provide retirement pensions and, in some cases, medical assistance to members. Under the administration of Getúlio Vargas, retirement pension funds (caixas de aposentadorias e pensões, CAPs) were incorporated into the Ministry of Labor, Industry and Trade under the name of Institutes for Retirement and Pensions (Institutos de Aposentadorias e Pensões, IAPs) and organized into professional categories (Oliveira, Teixeira, 1985).

[4] One example of this policy was the attempted privatization of the National Cancer Institute (Instituto Nacional de Câncer, Inca), by the then Minister of Health, Leonel Miranda, in 1969. On the frustrated attempt to privatize Inca, see Teixeira, Porto, Noronha (2012).

[5] The seeming contradictions in government policy during this period (extension of cover/privatization of part of the system) may be understood by noting that, at the time, views on health stemming from neo-liberal economic thought favored a residual system on the basis of assistance only to those without means; or a meritocratic scheme based on social security health in which the workers participated financially and the sale of services by the private sector (Oliveira, Teixeira, 1985).

[6] See the famous remark of Delfim Neto, Minister of Finance in the Costa e Silva and Médici governments (1967-1973), uttered during an impromptu speech at the third National Conference of the Working Classes (Conferência Nacional das Classes Trabalhadoras, Conclap): "We must make the cake grow so that we can divide it" (A distribuição..., 23 mar. 1972, p.1).

[7] This period also saw the so-called crisis in US foreign policy, which began with the defeat in Vietnam in 1975 and continued with events such as the Iranian Revolution of 1979, which overthrew Shah Reza Pahlevi, a US ally, and the Sandinista Revolution in Nicaragua in 1979 (Hobsbawm, 1995). In South America, the various military coups – mentioned in note 1 – contributed towards the creation of an anti-democratic atmosphere that was hostile to civil rights.

[8] International bodies concerned with health, such as PAHO, recommended the setting up, in the health ministries of every country of the continent, units specializing in methodologies for the planning and evaluation of programs, in the systematic gathering of health and hospital statistics, and the instruction and training of personnel for these specific activities. This technocratic perspective, which would become an established tradition in Brazil, would find expression in some of the personalities of health reform in Brazil and would have a long life in the way in which it would define the relationship between the federal government and the other levels of management in the Unified Health System (Rivera, Artmann, 2012).

[9] This process did not develop in a linear fashion. It met with many problems and setbacks, notably the 'April Package' (*Pacote de Abril*), issued by the Geisel government in 1977 when, after his attempted reform of the courts was defeated, Ernesto Geisel ordered the closure of Congress and issued a series of political reforms by decree (Castro, 1995).

[10] According to Escorel (1999), 2nd PND sought to restore the by then discredited basis for the social legitimacy of the regime. Other assessments believe that it reflected the high level of patronage which still existed in Brazilian politics (Aguirre, Sadi, 1997) or was related to structural conditions, particularly the process of political distortion during the period (Fonseca, Monteiro, 2008).

[11] For an overall view of the early years of the health movement, see Escorel (1999) and Paim (2008). See also Campos (1988), for the medical student movement during these years.

[12] According to Cordeiro (2004), the basis of the document was a text written by Hésio Cordeiro, José Luiz Fiori and Reinaldo Guimarães.

[13] According to Gerschman (2004, p.173), during this period "the diversity of interests started to be expressed by means of the inclusion of doctors in the labor market, in a departure from the preceding period, when medical entities, particularly the Doctors' Union represented salaried doctors".

[14] In Escorel's view (2008, p.422-423), as from 1984, the strategy for implementing AIS was based on the following principles: "inter-institutional integration, centered on the public sector; definition of proposals on an epidemiological basis; the regional and hierarchical character of all public and private services; assessment of basic activities and guaranteed reference; priority for the full use of the potential capacity of the public network; decentralization of planning and administration; planned cover for health care; development of human resources and recognition of the legitimate participation of various sections of society in the entire process."

[15] In the view of Paim (2008), the eighth CNS passed through various stages. The early discussions sought to define the aims and agenda of the procedure, and took place in state and municipal health institutions. This was followed by the state and municipal conferences, which brought together the principal local proposals.

[16] On this view, the movement which resulted in health reform marked a victory for the public health legacy of the 1950s, because the measures for administrative rationalization in the ensuing decades did no more than permit the extension of medical care, through state financing in accordance with the logic of the market, to those sectors of the population to whom it had previously been unavailable, thereby maintaining both the logic of the capitalist economy and, in large part, the logic of the political institutions existing at the time (Campos, 1988).

[17] "The idea is to be found in the initial perceptions and thinking; the proposal in an articulated set of principles and political programs; the project as a contradictory synthesis of policies; the movement as the articulation of ideological, political and cultural practices; and the process as a linking of acts, at different times and places, which resulted in social practices – economic, political, ideological and symbolic" (Paim, 2008, p.35).

[18] Eleutério Rodrigues Neto was one of the founders and president of Cebes, and was vice-president of Abrasco 1986-1987. His doctoral thesis was submitted in 1988 to the Department of Preventive Medicine at

the Medical Faculty of the University of São Paulo, but, owing to internal problems in the department, was not examined. It was published in 2003 by Fiocruz, after being revised and updated (Rodrigues Neto, 2003).

[19] The work by Gerschman is not confined to an analysis of the social movements involved in the implementation of reforms. She also discusses the process of transition to democracy and its relationship to the changes in the field of health and the process of implementing reforms in the 1990s.

REFERENCES

A DISTRIBUIÇÃO...
A distribuição do bolo. *O Globo*, Rio de Janeiro, p.1. 23 mar. 1972.

AGUIRRE, Basilia; SADDI, Fabiana C.
Uma alternativa de interpretação do II PND. *Revista de Economia Política*, São Paulo. v.17, n.68, p.78-98. 1997.

ALMEIDA, Celia.
O mercado privado de serviços de saúde no Brasil: panorama atual e tendências da assistência médica suplementar. *Texto para discussão* n.599, Brasília: Ipea. 1998.

AMARANTE, Paulo (Coord.).
Loucos pela vida: a trajetória da reforma psiquiátrica no Brasil. Rio de Janeiro: Editora Fiocruz. 2005.

AROUCA, Antônio Sérgio da Silva.
A reforma sanitária brasileira. *Tema/Radis*, Rio de Janeiro, n.11, p.2-4. 1988.

BANDEIRA, Luiz A.M.
Formação do Império Americano, da guerra contra a Espanha à Guerra no Iraque. Rio de Janeiro: Editora Civilização Brasileira. 2005.

BRAGA, José C.S.; PAULA, Sergio G.
Saúde e previdência, estudos de política social. São Paulo: Hucitec. 1986.

CAMPOS, Gastão Wagner de Sousa.
A reforma sanitária necessária. In: Berlinguer, Giovanni; Teixeira, Sonia Fleury; Campos, Gastão Wagner de Sousa. *Reforma sanitária*: Itália e Brasil. São Paulo: Editora Cebes; Hucitec. p.179-194. 1988.

CASTRO, Celso.
Os militares e a República: um estudo sobre cultura e ação política. Rio de Janeiro: Zahar. 1995.

CEBES.
Centro Brasileiro de Estudos de Saúde.
A questão democrática na área de saúde. *Revista Saúde em Debate*, Rio de Janeiro, n.9, p.11-13. 1980.

CHAVES, Mario M.
Algumas reflexões sobre IDA: antecedentes do ideário UNI. *Divulgação em Saúde para Debate*, Londrina, n.9, p.5-9. 1994.

COHN, Amélia; EDISON, Jacobi R.; KARSCH, Ursula.
A saúde como direito e como serviço. São Paulo: Cortez. 1991.

CORDEIRO, Hésio.
O Instituto de Medicina Social e a luta pela reforma sanitária: contribuição à história do SUS. *Physis*, Rio de Janeiro, v.14, n.2, p.343-362. 2004.

CUETO, Marcos.
The origins of primary health care and selective primary health care. *American Journal of Public Health*, Washington, v.94, n.11, p.1864-1874, 2004a.

CUETO Marcos.
El valor de la salud: história de la Organización Panamericana de la Salud. Washington: OPS. 2004b.

DREIFUSS, René.
A conquista do Estado: ação política, poder e golpe de classe. Petrópolis: Vozes. 1981.

ESCOREL, Sarah.
História da política de saúde no Brasil: 1964 a 1990: do golpe militar à reforma sanitária. In: Giovanella, Ligia et al. (Ed.). *Políticas e sistema de saúde no Brasil*. Rio de Janeiro: Fiocruz/Cebes. p.385-434. 2008.

ESCOREL, Sarah.
Reviravolta na saúde: origem e articulação do movimento sanitário. Rio de Janeiro: Editora Fiocruz. 1999.

ESCOREL, Sarah; NASCIMENTO, Dilene R.; EDLER, Flavio.
As origens da reforma sanitária e do SUS. In: Lima, Nísia Trindade et al. (Org.). *Saúde e democracia*: história e perspectivas do SUS. Rio de Janeiro: Editora Fiocruz. p.59-81. 2005.

ESPING-ANDERSEN, Gösta.
Politics against markets: the social democratic road to power. New Jersey: Princeton University Press. 1985.

FEUERWERKER, Laura C.; MARSIGLIA, Regina.
Estratégias para mudanças na formação de RHs com base nas experiências IDA/UNI. *Divulgação em Saúde Para Debate*, Londrina, n.12, p.24-28. 1996.

FIORI, José L.
Globalização, hegemonia e império. In: Tavares, Maria C.; Fiori, José L. (Org.). *Poder e dinheiro*, uma economia política da globalização. Petrópolis: Vozes. p.87-147. 1997.

FLEURY, Sonia.
Revisitando a questão democrática na área da saúde: quase 30 anos depois. *Saúde em Debate*, Rio de Janeiro, v.33, p.156-164. 2009.

FLEURY, Sonia.
A questão democrática na saúde. In: Fleury, Sonia (Org.). *Saúde e democracia*: a luta do Cebes. São Paulo: Lemos Editorial. p.25-44. 1997.

FONSECA, Pedro Cezar Dutra; MONTEIRO, Sergio Marley Modesto.
O Estado e suas razões: o II PND. *Revista de Economia Política*, São Paulo, v.28, n.1, 2008, p.28-46. 2008.

GERSCHMAN, Silvia.
A democracia inconclusa: um estudo da reforma sanitária brasileira. Rio de Janeiro: Editora Fiocruz. 2004.

GIOVANELLA, Ligia; MENDONÇA, Maria Helena Magalhães.
Atenção primária à saúde. In: Giovanella, Ligia et al. (Ed.). *Políticas e sistema de saúde no Brasil*. Rio de Janeiro: Fiocruz; Cebes. p.493-546. 2012.

HOBSBAWN, Eric J.
A era dos extremos: o breve século XX: 1914-1991. São Paulo: Companhia das Letras. 1995.

LAGO, Luiz Aranha Correa.
A retomada do crescimento e as distorções do milagre: 1967-1973. In: Abreu, Marcelo de Paiva. *A ordem do progresso*: cem anos de política econômica republicana: 1889-1989. Rio de Janeiro: Campus. p.233-294. 1990.

LAMPERT, Jadete B.
Tendências de mudanças na formação médica no Brasil: tipologia das escolas. São Paulo: Hucitec; Abem. 2002.

LIMA, Nisia Trindade; SANTANA, José Paranaguá de (Org.).
Saúde coletiva como compromisso: a trajetória da Abrasco. Rio de Janeiro: Editora Fiocruz. 2006.

MARSIGLIA, Regina.
Relação ensino/serviços: dez anos de integração docente-assistencial (IDA) no Brasil. São Paulo: Hucitec. 1995.

MÉDICI, Andre C.
Financiamento da saúde. *Boletin de la Oficina sanitária Panamericana*, Washington, v.103, n.6, p.571-598. 1987.

MIGUEL, Luís Felipe.
Capital político e carreira eleitoral: algumas variáveis na eleição para o Congresso Brasileiro. *Revista de Sociologia Política*, Curitiba, n.20, p.115-134. 2003.

NUNES, Tânia Celeste Matos.
Democracia no ensino e nas instituições: a face pedagógica do SUS. Rio de Janeiro: Editora Fiocruz. 2007.

OEA.
Organização dos Estados Americanos.
Carta de Punta del Este. *Boletin de la Oficina Sanitária Panamericana*, Washington, v.51, n.5, p.477-488. 1961.

OLIVEIRA, Jaime A.
Reformas e reformismo: "democracia progressiva" e políticas sociais (ou "para uma teoria política da reforma sanitária"). *Cadernos de Saúde Pública*, Rio de Janeiro, v.3, n.4, p.360-387. 1988.

OLIVEIRA, Jaime de; TEIXEIRA, Sonia Fleury.
(Im)previdência social: 60 anos de história da previdência social. Petrópolis: Vozes. 1985.

OMS.
Organización Mundial de la Salud.
Atención primaria de salud, informe de la Conferencia Internacional de Atención Primaria de Salud. Genebra: OMS. 1978.

OPAS.
Organización Panamericana de la Salud.
Reunión de Ministros de Salud (grupo de estudio). Washington: Oficina Sanitária Panamericana. 1963.

PAIM, Jairnilson Silva.
Reforma sanitária brasileira: contribuição para a compreensão e crítica. Salvador: Edufba; Rio de Janeiro: Editora Fiocruz. 2008.

PAIVA, Carlos Henrique Assunção; PIRES-ALVES, Fernando; HOCHMAN, Gilberto.
A cooperação técnica Opas-Brasil na formação de trabalhadores para a saúde (1973-1983). *Ciência e saúde coletiva*, Rio de Janeiro, v.3, n.3, p.929-939. 2008.

PIRES-ALVES, Fernando Antonio; PAIVA, Carlos Henrique.
Recursos críticos: história da cooperação Opas-Brasil em recursos humanos em saúde (1975-1988). Rio de Janeiro: Editora Fiocruz. 2006.

RIVERA, Francisco Javier Uribe; ARTMANN, Elizabeth.
Planejamento e gestão em saúde: conceitos, história e propostas. Rio de Janeiro: Editora Fiocruz. 2012.

RODRIGUEZ NETO, Eleutério.
Saúde: promessas e limites da Constituição. Rio de Janeiro: Editora Fiocruz. 2003.

RODRIGUEZ NETO, Eleutério.
A via do Parlamento. In: Fleury, Sonia (Org.). *Saúde e democracia*: a luta do Cebes. São Paulo: Lemos Editorial. p.63-92. 1997.

RODRIGUEZ NETO, Eleutério.
A reforma sanitária e o Sistema Único de Saúde: suas origens, suas propostas, sua implantação, suas dificuldades e suas perspectivas. In: Ministério da Saúde / Projeto Nordeste. "Informação, Educação e Comunicação/IEC. Incentivo à participação popular e ao controle social no SUS: Textos técnicos para Conselheiros de Saúde". Brasília: Ministério da Saúde. p.7-17. 1994.

SALLUM JR., Brasílio.
Transição política e crise do Estado. *Lua Nova*, São Paulo, n.32, p.133-167. 1994.

SANTOS, Wanderley Guilherme dos.
Cidadania e justiça: a política social na ordem brasileira. Rio de Janeiro: Campus. 1994.

SOPHIA, Daniela de Carvalho.
O Cebes e o movimento de reforma sanitária: história, política e saúde pública (Rio de Janeiro, 1970-1980). Tese (Doutorado em História das Ciências e da Saúde) – Casa de Oswaldo Cruz, Fiocruz, Rio de Janeiro. 2012a.

SOPHIA, Daniela Carvalho.
Notas de participação do Cebes na organização da 8ª Conferência Nacional de Saúde: o papel da revista *Saúde em Debate*. *Saúde em Debate*, Rio de Janeiro, v.36, n.95, p.554-561. 2012b.

SOUTO, Ana Cristina.
Saúde e política: a vigilância sanitária no Brasil 1976-1994. Rio de Janeiro: Sobravime. 2004.

SOUZA, Francisco E.P.
Metamorfoses do endividamento externo. In: Castro, Antonio B.; Souza, Francisco E.P. *A economia brasileira em marcha forçada*. Rio de Janeiro: Paz e Terra. p.97-190. 1985.

TEIXEIRA, Maria Glória; COSTA, Maria da Conceição Nascimento.
Vigilância epidemiológica: políticas, sistemas e serviços. In: Ligia Giovanella; Escorel, Sarah; Lobato, Lenaura de Vasconcelos Costa (Org.). *Políticas e sistema de saúde no Brasil*. Rio de Janeiro: Editora Fiocruz. p.795-817. 2008.

TEIXEIRA, Luiz Antonio; PORTO, Marco Antonio; NORONHA, Claudio Pompeiano.
O câncer no Brasil: passado e presente. Rio de Janeiro: Outras Letras. 2012.

TEIXEIRA, Sonia Fleury.
O dilema da reforma sanitária Brasileira. In: Berlinguer, Giovanni; Teixeira, Sonia Fleury; Campos, Gastão Wagner de Sousa. *Reforma sanitária*: Itália e Brasil. São Paulo: Editora Cebes; Hucitec. p.195-207. 1988.

VELOSO, Fernando A.
Uma análise econométrica do crescimento econômico brasileiro. Set. 2009. Disponível em: http://bibliotecadigital.fgv.br/ocs/index.php/sceesp/ce/paper/viewFile/1212/398. Acesso em: 29 mar. 2013. 2009.