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Health movement and politics in times of democratization/democracy and neoliberalism in Brazil (1970s to 2014)

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Sumário

Abstract

This paper explores the ways which the Brazilian Collective Health Movement and its main representatives have changed its discourse and political action during both the transition and consolidation period of democracy in Brazil (1970s-2013). The methodology involved a bibliographic and documental review. We have also interviewed policymakers, representatives of the health movement and members of health councils.

Three key periods were identified: 1) Between late 1970s and 1988 we see the formation of the health movement, and the development of a socially rooted political struggle for the creation of the new National Unified Health System (SUS), leading to its creation in the Constitutional process of 1988. 2) Between 1989 and 2002 were implemented the main institutional basis of the new Brazilian health system. 3) Between 2003 and 2006 a managerial and participative line was formed; and then (after 2007) kept allied to an effort to tie health policy to the development model.

The mapping of those three key moments enabled us to answer two main questions: In what ways the Brazilian collective health community/actors and its ideas have been influencing the policymaking process of health policy in the country? Why and in what context can we understand the present call of the collective health community for a renewal of the health movement in the Brazil?

The results indicate that although the ideas of the collective health movement have been influential during the whole period, they were less dominant in the later years, characterized by the institutionalization of society participation in health councils and by a more institutionalized political action of the leaders of the movement in local/state Secretariats and in the National Ministry of Health. At present, and mainly after the mass and health movement protests in June 2013, a renewal of the movement is considered essential to guarantee not only the promotion of a universal health system, but also to demand better quality of public health services in the country.

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

Introduction

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

The new system was sustained with the help of a proactive social health movement (collective health movement), called "sanitaristas", comprised of medical doctors, bureaucrats and politicians. As asserted by Nelson Rodrigues dos Santos, one of the main representatives of the collective health movement, "what unifies those actors is the historical importance they give to the movement in the achievement of citizenship in health, through the organization of the Unified Health System". (Interview made in 2003) (Ministério da Saúde, 2006, p. 100).

Although in different ways, along the 25 years after the creation of the SUS the Brazilian collective health movement continued to play an important role in the new participative type of policymaking process. Those years witnessed the construction of SUS´s legislations, and its implementation in more than 5.000 Brazilian municipalities. Besides gaining new shapes and a huge number of representatives, the actions` of the collective health movement took place in a more diverse and contradictory political economic context. However the collective health movement continued to be characterized by one common goal, though more diverse and sometimes less prominent: to guarantee the full realization of the right to health to Brazilians thorough the implementation of the constitutional principles of SUS.

According to Santos` perspective, the collective health movement "have had the capacity to join diverse sectors of society, from the lowest to the highest income levels, around the utopia of a new society, a new democratic state … this trademark has

mobilized hearts and minds in a way that has been strong and sufficient enough to resist to neoliberalism during 15 years" (Ministerio da Saúde, 2006, p. 100).

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

In order to answer those main questions, we have mapped three key periods that comprehended changes in the power coalition of the federal government, as well as new limits and possibilities for the collective health movement in its advocacy of the right to health in the country. This paper is divided according to those key periods. Firstly we will explore the years of political transition (1970s - 1988), where we see the formation of the collective health movement, and the development of a socially rooted political struggle for the creation of the new Unified Health System (SUS), leading to its creation in the Constitutional process of 1988. Secondly, we will present the years of the construction and implementation of the main institutional bases of the new universal health system, after the emergence of neoliberalism in Brazil (1989 - 2002). Thirdly, we will focus on the period of Lula`s and Rousseff`s Governments, when a managerial and participative line was formed (2003-2006); and afterwards kept allied to an effort to tie health policy to the development model (Between 2007 onwards).

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

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

In the 1970s and 1980s Brazil witnessed the years of the authoritarian situation (Linz, 1977) and beginning of the democratization in the country. The economic development

was at stake, and economics no longer constituted the main element to foster political cohesion of the civil-military group in power since 1964. The rise of social pressures pointed out the need to conciliate the economic "desenvolvimentismo" with less authoritarian social policies. This was the view point of President Geisel (1974), who planned and implemented a slow, gradual and save transition to democracy.

The socio-organizational roots of the movement

This context favored the development and consolidation of a critical social movement related to health in the country. They comprehend a collective health movement, known as the "sanitaristas" engaged in the promotion of both social and political mobilizations that would led to changes in the Brazilian public health system (SADDI, 2004). Most of them had criticized the health system promoted in the military years, and acted in left wing organizations during those years.

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

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

Therefore, the influence of the realm of preventive medicine and public health, contributed to the dissemination of a new and alternative body of ideas regarding collective health. According to the field of collective health, health and diseases cannot be explained exclusively through biological dimensions, as they constitute social and historical phenomena.

As a result, Brazil saw the emergence of young practitioners, who were committed to those alternative ideas coming from collective health, who turned theoretical critics into communitarian practices. Many communitarian practices raised in the country, like the

social movement occurred in Campinas, when students from the Department of Social Medicine of the University of Campinas started to develop a communitarian work in the poorest part of the city (Lavras, interview 2003) (Silva, interview 2003) (Santos, interview 2003).

Another mark was the creation of the Brazilian Center for Health Studies (CEBES) in 1976. CEBES was formed by "santaristas" like David Capistrano Filho and Ermerson Merhy with the aim of building a critical space for the dissemination of ideas attached to collective health. They were linked to labour unions, led moviments against the torture of doctors, attraced feminists movements to their cause, and became deeply involved and linked to social and health community movements in the favelas and periphery of big cities. Those communities promoted actions aiming at developing better living conditions for the poor at the favelas and periphery of big cities in Brazil. They promote a national mobilization with academics in the field in order to form the institution. In December 1976, there were already five thousand people associated with CEBES (Mehy, interview 2003) (Escorel, interview 2003) (Escorel, 1998).

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

Furthermore, the health movement also **started engaging into political action**. By means of establishing closer relationships to parties, they formed a strong political coalition in the fighting for the new health system. This happened especially during the works that preceded the new Constitution (Escorel, interview 2003) (Escorel, 1998)

Sarah Escorel reminds us that "the health movement is not an institutionalized political party, as it has the characteristics of a social movement. It is not a bureaucracy, nor holds a constituent law. It gathers people identified with the same theoretical approach, discourse and fight" (Ministerio da Saude, 2006, p.66)

The formation of ABRASCO also represented an important step for mobilizations and consolidation of the field of Collective health in Brazil. This organization was and still is the academic arm of the movement. The main academics in the field were and still are gathered at ABRASCO, whose aim is to produce knowledge related to collective health.

ABRASCO organized seminars and conferences at the National Congress and at Universities as well, contributing to speed discussions regarding the new system.

The politics of mobilizations in health

The context of political transition created opportunities for the movement to start making coalitions and pressures at the political sphere, and enabled the health movement to conquer spaces for participation. The main events of the period were the mobilizations held at the 8th National Health Conference and at the 1988 National Constituent Assembly. These events consists the apex of social mobilizations and participation.

The 8th National Health Conference

The 8th National Health Conference took place in March 1986 and is considered one of the two apogees of the health reform movement, when discussions take place concerning the transference of the Social Security Medical Services (INAMPS) to the Health Minister. Arouca explains that the idea was to transfer the INAMPS to the Health Minister, integrating both systems. Sarney authorized the move of INAMPS to the Health Minister. Although the former Conferences used to be a bureaucratic space, the 8th Conference comprehended a social political event, in which 50% of the participants consisted of regular citizens and users of the health system (Arouca, 2003, p.4).

The 8th Conference assumed the format of a social-political mobilization, legitimating the need to construct a new health system in the country. More than 4 thousand people took part in the discussions held for 14 hours. Besides, the main representatives of the private sector left the conference, saying unanimously that the main decisions had already been previously discussed" (Pereira, 1996, p.13).

The negotiation at the Constituent Assembly

Two main polemic themes characterized the fight about health in the Constituent Assembly, which were 1) the redefinition of the nature of the public policy and the role of the private sector in it, and 2) the funding of public health (Rodriguez Neto, 1988). The results were negotiated between the representatives of the social security system, the private sector and the collective health movement (Arouca, 1988) (Rodriguez Neto, 1988). Negotiation took place at closed doors, as the private sector advocated the

possibility to continue having access of public funds and maintaining a secondary system alongside the new public system.

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

Institutionalization of participation in health

The years of Collor, Itamar and Cardoso (1990-2002), as a whole, consisted the years of the introduction of neoliberalism and consolidation of the new democracy (Teixeira and Pinto, 2012). In this period, the tensions between the economic and social departments of the government will be a constant. As far the health movement is concerned, they will no longer be characterized by a broad process of social and political mobilizations, but by the development of a long process of institutionalization, in which forms of mobilizations and participation will not only be gradually framed by the new legislations and channels of participation, but also confronted by the new coalitions of power committed to neoliberalism, in the years of Collor (1990-1992), Itamar (1992-1994) and Cardoso (1994-2002) (SADDI, 2004). The health movement will slowly be characterized by either emptiness or depoliticization, as asserted by some of the representatives of the movement (Pinheiro, interview 2003). The main locus of political fight in the period will be in the government, at the Minster of Economics, Minister of Health and the National Congress. They will try to halt or slow down the process of realization of health rights that would became a reality with the implementation of the main principles of the new universal, comprehensive and decentralized health system.

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

Health legislation vetoed by Collor

Collor's vetoes regarding SUS complementary law were made due to pressures coming from the economic field of the government, as publicly declared by the minister of health at that time. The three main vetoes made by Collor were concerned to funding and participation matters as approved by the Constitution. 1) He blocked the transference of funding to be made directly to states and municipalities, as negotiated in

the Constitution, and maintained the transference by means of payment by procedure, practiced by INAMPS. 2) He also blocked the constitutional articles that forecast the deliberative participation of the population in the new system, in the conferences and health councils. 3) The president refused to close the former INAMPS as approved in the Constituent process. As a result, there was a mobilization from civil society who started demanding that the president should act in accordance with the principles and guidelines approved by the Constitution.

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

The elaboration of the Basic Operational Norm (NOB-91) consisted of another attempt of the federal government to centralize health budget. This norm proposed the full centralization of the budget by the federal government. It received many critics, and especially from the cities movement, which were allied to the health movement at this initial time of implementation of SUS. Those discussions contributed, in the following years, to the building of laws regarding the transference of fundings from the federal to state and municipal governments.

The reaction of the health movement together with the city movement took place at the 9th National Health Conference. In this the "sanitaristas" and academics joined thousand Brazilians in parades against the Collor government.

1993 Basic Operational Norm (NOB-93)

In the midst of a political instability produced by Collor`s impeachment, the new president Itamar Franco tried to reestablish a commitment with the implementation of SUS, by means of elaborating the complementary legislation for SUS, known as "1993's Basic Operational Law" (NOB-93). The new health reform legislation is in tandem with the demand made by both the health and city movement. The new legislation 1) established stages for the implementation of SUS in the municipalities and 2) instituted the formation of management commissions as a locus of negotiations regarding health. As far as participation is concerned, the NOB-93 instituted the Commissions for health managers with the aim to promote a debate between managers of the three level of government of the health system (federal, state and municipal),

contributing thus to the formulation of proposals concerning the implementation of SUS.

Closing the previous Health Care Security System (INAMPS)

The closure of the former INAMPS consist another event influenced by pressures coming from the health movement. Carlos Mosconi who was one of the main representatives of the health movement took over INAMPS and played a central role in the process of closure of INAMPS in the years of Itamar (Mosconi, Interview 2003).

Confiscating health funds

In parallel with the closure of INAMPS, the minister of social security decided confiscate the money that should be transferred from Social Security Ministry to the Ministry of Health. In reaction, Deputy Eduardo Jorge, another main representative of the health movement at the National Congress, proposed a law that determines what percentages of federal, state and municipality's budgets that should be allocated to health. This law project resulted in the Constitutional Emend 29/2000, approved in 2000.

Politics of health in times of neoliberalism and democracy (from mid 90s)

In the new Brazilian democracy it was only after a period of both economic and governability crises that neoliberalism finally started playing a more eminent role in Brazil. The promotion of economic stability was the main political goal of the new political coalition that took over power in 1995. Brazil now had a new currency and started developing an even more restrictive and stable fiscal policy which was considered essential to the maintenance of political power and legitimacy (SADDI, 2004) (Teixeira and Pinto, 2012).

The politics of policy-making

In the first two years of Cardoso the participation and influence of the health movement in the policy-making process is more significant. This can be seen 1) in the process of elaboration of the Basic Operational Norm of 1996, 2) in the fact that the executive did not manage to approve PEC-32 at the Congress, withdrawing the proposal, and 3) in the

political alliances formed by the minister of health (Jatene) in favor of the creation of a compulsory specific tax to be directed to the health sector, the called CPMF.

However, as a whole, the Cardoso years are characterized by a decline of the direct influence of the health movement in the policymaking and decision process. This is highlighted 1) in the fact that other forms of budgetary transference to health had been blocked after the emergence of CPMF, 2) in the consequent revival of the fight to increment the amount of funding allocated to health, 3) in the adaptation of new bills and decrees from the federal government, which produced significant changes regarding NOB-96 and 4) in the implementation of a modified version of NOB-96 when Jose Serra took over the Ministry of Health. At this period, new policies were privileged, such as programmes related to generic medicines and HIV/Aids. However, those were also the period of institutionalization of new channels of participation regarding health.

Institutionalization Health Plenaries in times of neoliberalism

The FHC's period is also considered as a period in which participation has been fostered in the SUS. Some experts consider this as a period of institutionalization of participation in health that occurred firstly at the National Health Plenaries and secondly at the Health Councils National Plenaries. Health plenaries comprehended a space of pressure and debate, gathering representatives of society mainly. The Health Councils Plenary, on the other hand is formed by representatives of both society and the states.

The national health plenary was very active until 1997. In 1996 more than two hundred health councils participated in the plenary. The final report stated that "it was clear the need of promoting a better organization and mobilization of the health movement, as a means to unify all sector in favor of the health reform and SUS" (p. 178). In 1997 the plenary report asserts that the health movement had been revived after the 10th Conference, promoting activities and debates in favor of the implementation of SUS, such as those occurred with representatives of the main newspapers and television channels in the country.

Those activities demonstrate that the health movement not only continued to mobilize the society, but also developed a more institutionalized form of participation in the plenaries. The end of the health plenaries occurred in parallel with the formation of

health councils meetings in the country that afterwards gained the name of Health Councils Plenaries. Their initial activities took place in 1994, being finally created in April 1995. Although presenting a different nature in relation to the health plenaries, the agenda of both movements was committed with the advocacy of SUS and its principles. The first health councils plenary occurred in Brasilia in November 1996.

Although the health movement had to face the government initiatives that tried to reshape the health reform or even block the development of SUS according to its main constitutional principles, by means of procuring distinct infra-institutional new legislations, representatives of the health movement have highlighted some achievements occurred in the period, such as: 1) the development of participative forms of management in councils, spread all over the country, 2) the articulation of a new modality of participation in the plenaries, with an intense agenda during the whole period, 3) and the approval of the constitutional Emend nº 29/00. The election of the new president, coming from the left wing party, which supported the health movement in many occasions, was seen as a time of new opportunity in which health movement would gain a more direct participation in policymaking.

Institutionalized participation in health (2003-2013)

The election of the new president coming from the left wing party that supported the health movement in many occasions, although consisted of a time of new opportunity of direct participation of the health movement representatives in policymaking, and seen by many as an opportunity to realize the principles of SUS, in fact it did not result in a period of broad social and political changes regarding mobilizations towards the realization of constitutional health rights. Ideas and pressures coming from bellow were channeled and institutionalized in health councils mainly, revealing the fact that the health movement actions' became more diverse, disperse and depoliticized in the period. All Health ministers from this period belonged to the sanitary movement, and were one the sanitaristas of the health reform, and were linked to the government coalition that took place.

In the years of Lula and in the first three years of Rousseff as a whole (from 2003 to 2013), the policymaking process related to health was characterized by both the

formation and prevalence of a managerial line that was afterwards (in 2007) kept allied to an effort to tie health policy to the development model. As far as the possibilities of participation were concerned, inclusive participation became not only more complex, but also more institutionalized in the sense that discussions and negotiations were focused more on technical or managerial demands coming from the Ministry of Health mainly, than on broader health reforms themes coming from counter-hegemonic movements.

The institutionalized politics of policymaking

Research reveals that the Lula Government gave priority to four types of health policies, and that there have remained the main structural problems related to SUS (Machado et al, 2011). Priorities were given to the continuation of the Family Health Programme, and adoption of new policies such as Smiling Brazil, Mobile Emergency Services and Popular Drugstore (Machado et al, 2001). The persistence of structural health problems is highlighted "in the fragmentation of policies, limits imposed to funding, distortions in public-private relations, inequalities in health (Machado et al, 2011).

The introduction of the Health Pact was directed by various forms of discussions that took place in the Health Councils in 2003 and 2004, and especially at the Three-parties Health Comission (CIT) and National Health Council (CNS). CIT's is constitute by representants of the secretariat of health from states and municipalities, and the health minister. Therefore all three federative unities are represented at CIT. After discussions and negotiations in those councils, the new "Health Pact 2006" was approved, involving a strategy that reconfigures intergovernmental relations in the sector.

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

This strategy gives priority to basic health care focusing on the extension the Family Health Program (FHP) in the whole country, qualification of professionals of superior levels working at FHP, Smiling Brazil, and communitarian health agents, that would

now work at schools as well" (Menicucci, 2011, p. 527) (Paim, Travassos, Almeida et al, 2011)).

As a whole, the period presented two key moments. The development of managerial line in health, in the first period of Lula's government, guided by a democratic and managerial action, characterized by an intense debate inside the health ministry and with other actors (from the federal, state and municipal spheres of government). From Lula's second period of government (2007-2010), as well as in the years of Rousseff (2011-2013) the managerial line has been kept allied to an effort to tie health policy to the development model (Machado et al, 2010; Menicucci).

It is also necessary to mention that the governability crises occurred in the Lula's government and at the National Congress, as result of the misuse of both public and private money to fund electoral campaigns, had deteriorated the credibility of the political coalition in power as well as affected the management of policies in a general way.

Jandira Feghli, as representative of or aligned with the health movement, made it clear that one of the difficulties of the Lula government is that a great number of health militants are allied to parties that form the political base of the government. She asserts that "this gave generated defensive actions from the health movement, contributing to paralyze or immobilize the movement, because people were afraid to compromise or damage even more the credibility of the government. Parties started to assume defensive positions turning difficulty the actions of the health movement … and also generated a certain institutionalization. Although we have promoted a health plenary, mobilizations comprehended a much smaller scope" (Ministerio da Saude, 2006, p. 275)

The institutionalized politics of prioritization of basic health policies

In the years of Rousseff primary health became the Ministry of Health's first priority, as clearly stated several times by minister Alexandre Padilla. The government continued not only to implement the new National Policy of Basic health (PNAB), elaborated in 2011, but also elaborated the "National Program for Improving the Access and Quality of Basic Health Care" (PMAQ). The objective of PMAQ is to promote better services with better qualities, and for this it introduces the adoption of payment for performance system, that comprises the transference of economic incentives to front line actors

involved in basic health at thousands of health unities allocated in the country, in 5.556 cities. Both the commissioning (of units and health teams) and monitoring of the process has been made by municipal health secretariats, and it implied the provision and use of software system and internet in all unities.

The program was elaborated by the team that worked at the department of basic care at the health minister and presented to CIT, to be discussed and validated. Although there had been disagreement regarding many aspects of the policy, such as adoption of flexible payments and choice of indicators, the general consensus moved in direction of its approval. Besides great pressure coming from the federal government, PMAQ was also considered as a starting point to develop better qualities of services. Discussions occurred mainly at CIT, first with the group of work formed by assessors from CONASS, CONASEMS and the DAP, as an introduction to discussions that took place in the CIT's plenary, involving state and city secretariats of health and the minister of health as well (Sousa, interview 2014) (Evangelista, Interview 2014) (Bretas, Interview 2014).

There had been the development of closer relationships between basic health policy and social development programs. The elaboration and discussions surrounding the new health strategies linking the FHP to the Family cash transference program and health education followed the path of PMAQ, being presented and approved by the CIT.

As emphasized by Santos, health counselors have not yet internalized the values of SUS and are not ready to turn its principles into political negotiations. "This will depend on the continuation of social pressures from bellow, on the degree of politicization, political engagement. The politicization of the Brazilian society that is reflected in the politicization of health counselors, have not yet achieved a degree sufficient enough to promote changes from one model to another. They all shave the banner of universality, integrality and equity, but they are empty banners. The question is how they could transform them into effective political banners" (Ministerio da Saude, 2006, p.275).

From the view-point of participation in policymaking, we see the continuation or even the deepening of a pattern of action already emphasized by Amelia Cohn in 2009, which is the emptiness of the political dimensions in favor of technical and managerial formulations. Also, this refers to the fact that representatives of the health movement

now have to deal with political conflicts and dilemmas involved in the policymaking, as they have taken position in many health secretariats in the country, at both the state and municipality levels.

Various and Disperse forms movements coming from bellow

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

In this process, the popular and health massive national protests of 2013 will not only be differentiated from the other mobilization, but will also put into evidence the limits regarding the persistence of institutionalized forms of participation in health. The national mobilization against privatization and the "More 10 movement" are probably the main broader movements recently supported by the representatives of the Brazilian health movement, like CEBES and ABRASCO.

National Front against Privatization in Health

The Front against health privatization consists of various forums formed in the main Brazilian stated, by representatives of the public sector, demanding that SUS belongs 100% to the state. They mobilize public servants in conferences and seminars and through their internet page[1] and regular emails. They also take part at the national health conferences, like the 14th Conference from December 2012 that target privatization as main theme of the meeting. Although Conferences had become a national mode of social participation in many fields of governments' policies, following the example given primarily by the health sector, it no longer had the some influence of the 8th Conference that predated the Constitution.

[1] They can be followed at http://www.contraprivatizacao.com.br/

The "Health +10" movement

Another mobilization supported by health movement was the so-called "Health More 10". This movement was created in March 2012 in a historical meeting with broader participation of diverse entities representative of the Brazilian society, initiating what they have called a National Movement in Defense of Public Health[2]. Although this movement collected 2 million and one hundred signature, in favor of the increase of federal funding allocated to SUS, the National Congress did not approve it. As asserted by the representatives of the movement, popular pressure was not sufficient enough to halt pressures coming from the economic arena.

Popular and health Protests of 2013

As broadly asserted by the collective health movement, the protest of June 2013 have replaced health at the public agenda, and contributed to strength debates in diverse health associations and mobilizations, at the academia, and in the historic entities closely attached to the health reform. Bahia (2013) says that the streets demanded "health at the level of FIFA" and questioned government about health services. This consisted of a turning point in the way we see health in the country, no longer as private asset, but as a public matter".

As a direct result of protests for better and public health in the country, Rousseff announced a new program (More Doctors) that aimed firstly to encourage national practitioners to work on distant regions of the country in the basic unities of health. "More Doctors" would also encourage the immigration of foreign practitioners to Brazil to work in poor and remote areas of Brazil. For decades there had been discussions in the health sector, in diverse associations and councils, about the lack of doctors to work in rural, marginalized and poorest regions of the country and parts of the cities. Given the conflict involved with medical associations mainly, as doctors have worked more on the private sector and on specialized fields of the medicine, this issue had never before reached a solution or resulted in a policy. As recognized by the health movement, "More Doctors" corresponds only to a transitional measure, as more decisive solutions would involve changes in the curriculum of medicine schools by means of attracting new Brazilian doctors to the basic or family health field.

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

As a whole, this third broad phase of the long root of institutionalization of participation in health highlights that legitimacy and governability issues are closely related to public policies concerns in a democratic government. Democracy imposes some political limits to the policymaking process, in the sense that it needs to be responsible to society. Those limits became clear when we make a retrospective analysis of the process of institutionalization of participation in health.

Conclusion

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

In the last decade few individual voices have predicted the need to promote either a revival or reformulation of the health movement. Among them, as good examples, are the voices of a closer representative of the health movement and an analytical academic one. Rodriguez Neto, in a book edited by CEBES (2003), had well summarized the process in which he participated closely. According to him, "the movement became more complex, with the involvement of new actors, resulting in the emptiness of one or other entity, and in the strengthening of others, generating confusions of whether there might had been or not a retreat of the movement. In reality the high peak of the movement occurred at the 8th Conference, and afterwards in the Health Plenaries. Moreover, the movement has never before been so meddled with the government, at the state, municipal and federal levels, nor has been so limited by economic and technical pressures. This happened exactly at the moment when society started to demanded concrete answers from institutions" (Rodriguez Neto, 2003, p.126).

Reflecting on the Brazilian National Health Reform after 20 years of experience with the Unified National Health System, Amelia Cohn highlights a deep question that needs to be faced by the collective health sector and those engaged in public health policies in Brazil. According to Cohn (2009), "The deep question to be asked today, concerning

reflections on new alternatives and on the rebirth of 1988`s victories, should be whether those reflections would mean “a reform of the reform” or a “a counter-reform”. The first alternative would comprehend a choice for the present technicalization of the politics, while the second one would entail the rebirth of both the political and social dimensions of health” (Cohn, p.1616, 2009)… “The answer to this deep question might be that the collective health field has been incapable to formulate a new project in health that would have to be articulated with society. This might be the greatest challenge” (Cohn, p. 1618, 2009)

Those individual voices are no longer separated from many other voices in the field. At present, and mainly after the mass and health movement protests in June 2013, a renewal of the movement is more commonly than individually considered essential to guarantee the full realization of the constitutional right to health (public, universal, integrated/comprehensive, decentralized), but also as a means to demand better quality of public health services in the country. However, the need of revival has not yet been unanimously recognized by all representatives of the movement, nor comprehends a unified and dominant position.

The contribution of the present papers lies in the fact that the reconstruction of the process enables us to highlight some meaningful and relevant political lessons regarding the health movement’s possibilities of effective revival in the years to come, and if they decide to take on or deepen the counter-hegemonic path asserted by Cohn (2009). But before we consider pertinent to note that the SUS is now a state policy and one of the great challenges concerns the construction of care models based on the expanded concept of health and the values that guide the SUS : universality , participation, equality , equity, completeness. The undeniable progress of SUS as a policy now requires the consolidation of models of care to ensure the achievement of the Constitutional SUS principles.

According to Santos, " is included in this context the practice of "high level of equity desired by the health movement” , for example, in the allocation of additional resources directed to ensure full accessibility of all levels of attention to groups and individuals excluded and poorly included, in contrast to current "low level equity " coming from underfunded and sub-services offered, with the adhesion of private health plans/firms".

As it has been said there are many health challenges to the health movement in times of democracy, so as to realize the principles of SUS. Citizens expects that SUS will respond to their health needs. Or in the words of Matus " Democracy can not defend itself if it does not show success in solving problems that affect people ."

It is undeniable the efforts of recent governments towards inclusion and improvements in health services through the structuring of attention to community-based model and seated in a multidisciplinary team. This demonstrates that there is a political will to move forward and even daring. The present More Doctors Program for Brazil is a recent example of that. It is also undeniable, as emphasized by Nelson Rodrigues dos Santos, that the SUS cannot be content to be a service for poor and with low resoluteness. Advance towards a truly inclusive system, and recognized by citizens, requires a lot from both the "policy" and "politics" reams. The Brazilian policy environment is complex, and this complexity is reflected in the administrative machine and its management capacity at the three levels of government. The relationship between civil society and state under the aegis of participation and popular mobilization, the presence of social movements, in the scenario set up by the narrative of democratization, is not enough if it is not combined with the management capacity of those who believe in the Constitutional SUS.

In times of democracy, such a revival would require the health movement to recognize the very limits regarding the continuation of this institutionalized form of participation, characterized by the depoliticization or restriction of health debate in politics, a part from society. Statements like “the main problems involving the realization of health rights and implementation of SUS are not financial, but political” should be accompanied by consistent actions.

1. To reconstruct a cohesive health movement that would foster mobilizations strong enough to pressure the political realm, generating policies more in accordance with the principals of SUS.
2. This united and cohesive movement would have to be in alliance to broader social demands as happened in 2013, or closely related to social or health experiences taking place on the ground, like happened in early 80s.
3. A renewal of the political activism from the main representatives of the health movement would be essential as well. There would be the formation of a new

generation of specialists in public health or practitioners interested in taking positions at the national, state and city assemblies, as well as in health secretariats and at the minister of Health.

4. It would also entail the reinsertion of Brazilian general practitioners and young doctors in the health movement, as occurred at the birth of SUS. This renascence would have to be accompanied by the establishment of closer relationships and actions between doctors and the public, like the favela movements occurred at the beginning of SUS. Therefore changes in the curriculum of medicine schools would be essential.
5. Also, the movement should act as a united counter-hegemonic bloc allied to more progressive (or government opposition) blocs of power, monitoring the actions taking place at the legislatives and health minister, proposing alternative programs to new policies being elaborated or voted in the main decision and policy-making arenas responsible for the formulation/decision regarding SUS in the country.

As emphasized by Ligia Bahia, "The health reform project and the process to reach it have either been ignored or undermined its relevance in function of a militancy that seems to be incapable of conciliating the needs of health with the rationality of political parties… the task ahead would mean the rebuilding of the basis of the progressive alliance that approved the constitutional text, and the advocacy and promotion of the debate and the implementation of the Brazilian Health Reform" (Bahia, 2014, p.2).

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