Expert community and sectoral policy: the Brazilian Sanitary Reform*

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This chapter addresses the policy analysis that underpinned the Brazilian Sanitary Reform (SR), responsible for defining the Unified Health System (Sistema Único Saúde/SUS) and for the proposal to make universal health care a right under the Federal Constitution of 1988 (FC1988). The expert community that produced the policy analysis of the health sector reform has been referred to as the *sanitaristas* (Weyland, 1995; Arretche, 2010). In the social sciences, the 'policy community' of experts is defined as the set of individuals spread across government agencies, research departments and institutes, political parties, non-governmental organisations and interest groups that act within a specific public policy area (Majone, 1989). The sanitaristas exhibited the features of a policy community as described in the literature, in light of their specific role in the national debate on reorganisation of the health system.

From the perspective of social status, the more relevant sanitarista trait was their position as teachers and researchers at public agencies and universities. In the 1980s, the sanitaristas held a very special place in the state structure: they enjoyed the conditions of a Weberian organisational bureaucracy (particularly job stability), combined with the decision-making autonomy typical of professional and academic bureaucracies. Their professional isolation was reinforced by the expressive participation of medical doctors from the academic sphere who were at the helm of the SR. The influence wielded by the sanitaristas' social and professional status was crucial to the scope of the SR.

As analysts of the Brazilian health system, the sanitaristas displayed singular attributes: they worked in a specialised area and shared the worldview and independence of a professional public bureaucracy. Their policy analysis, which led to the adoption of a project of universalist right to health within the 1980s atmosphere of democratic transition, was undertaken inside the state apparatus and not based on a massive mobilisation of civil society or the social movement. The international

literature has not ignored the role of policy analysis by the specialised public bureaucracy (Dobuzinskis, et al, 2007).

It should also be emphasised that the sanitaristas carried influence primarily because their policy analysis was opportune, timely and propositional. Nevertheless, their successful formation and implementation of a political agenda ***was not*** grounded in the mass dissemination of longstanding, consolidated 'scientific evidence' that lent legitimacy to the proposed health system reform. Explorations of the role of expert communities highlight the use of scientific authority to overcome doubts about the adequacy or plausibility of public policy implementation. Reliance on scientific evidence is usually necessary when decision-makers cannot fully distinguish true from false (Haas, 1992). Majone points out, however, that scientific evidence alone is not enough to legitimize the options offered by policy analysis. Specialists have to convince social actors within the diverse realms where they propose to act, and in this case, arguments are more efficacious than scientific evidence (Majone, 1989).

According to Hall (1989), one must account for the circumstances that afford the dissemination of innovative ideas. With this perspective in mind, the present chapter shows that the SR was the product of the organisation of new political subjects who took advantage of Brazil's pro-democratisation environment in the 1980s and defined the SUS as an institutional objective by means of arguments.

Why did these arguments win out? The national political elites accepted the SUS project in a conjuncture where an authoritarian regime (1964-84) was in crisis and democratic transition was on the order of the day (1985-90). There were three essential features to the Brazilian institutional process that enabled the sanitaristas to act so efficaciously. First, there was no veto power against a sectoral policy agenda by relevant social actors, like the corporatist trade union sector that had controlled social security and access to individual medical care down through the history of the republic. In the course of the authoritarian regime, unions had suffered specific, concentrated losses that cast worker representatives out of the decision-making process within the sphere of social security and, consequently, out of the decision-making process concerning the organisation of medical care. Malloy shows that Brazil's post-1964 authoritarian military regime worked diligently to control the labour movement (Malloy, 1979).

Second, the bankruptcy of the authoritarian regime's centralised decision making automatically brought into the political arena the voices of leaders of the

legislative and judicial branches; states and municipalities, that is, federative levels that were then secondary; and coalitions of sectoral experts. From the perspective of the federation, authoritarian centralisation undermined states and municipalities of the possibility of social intervention in three ways: by concentrating financial resources in the hands of the federal executive, by defining general norms applicable to social policies and by subjecting applications for federal funds to federal government approval, thus avoiding any automatic transfer of such funds (Draibe, 1999).

Third, in their arguments about the FC1988, the sanitaristas received the support of the democratizing political elite that defended redemption of the Brazilian 'social debt'. At the time, Jaguaribe and other intellectual leaders, for example, argued that a stable democracy would not be viable in Brazil until the 'yawning chasm between the great masses and the upper strata of the population was substantially reduced' (Jaguaribe, et al, 1986, p 15).

In the context of democratic transition, the scope of institutional choices was greatly broadened, temporarily suspending structural constraints on changes in public policies. Interest groups found themselves able to wield influence in the management of new policies. Collective action gained pluralist form, as described by Granados and Knoke (2005), given the heavy competition between emerging interest groups and the fragmentation of power. The transfer of political coordination to the constitutional process (1987-88) reduced the authoritarian government's role in interest mediation.

In the paradigm theory approach to public agenda setting, the policy window is the moment when advocates of unique proposals 'push' their solutions to problems. Within this window, entrepreneurs act decisively to link solutions to problems, overcoming constraints by adapting proposals to circumstances (Kingdon, 2003). In this regard, the period of democratic transition in Brazil offered a window for new institutional choices in public health policy given the fragmentation of the sectoral arena and the weak veto power held by relevant interest groups, especially trade unions, as mentioned earlier, or even healthcare companies or organisations that benefitted from the military regime. In light of this picture, the health sector could be taken over by **'**public policy entrepreneurs'.

Authoritarianism, national developmentalism and health policy

Over the course of its existence, Brazilian authoritarianism was not completely omissive when it came to the social question. It engaged in redistributive efforts especially during the second half of the 1970s. This intervention was a response to criticisms that the regime's social policy was bankrupt, especially in health. Two sure signs of how its social policy was indeed bankrupt were the increased infant mortality rate noted in the city of São Paulo in the late 1960s — at the height of a cycle of steady economic growth in GDP touted by the regime as the 'Brazilian economic miracle' — and the devastating effects of the 1974 meningitis epidemic (Malloy, 1979).

The Geisel government (1974-79) engineered a specific response to the collective perception of social crisis in Brazil. The social activism of the military regime during his autocratic administration led to the 1974 establishment of the Ministry of Social Security and Assistance (Ministério da Previdência e Assistência Social/MPAS). Santos has identified a substantial strengthening of social protection following creation of the MPAS (Santos, 1979). Noronha and Levcovitz see the Prompt Action Plan (Plano de Pronta Ação/PPA) as an inclusive initiative in health assistance that yielded 'an unprecedented rise in the production of services' after 1974 (Noronha and Levcovitz, 1994, p 78).

In 1977, the increased complexity of the social security system led to the establishment of the National Social Security and Assistance System (Sistema Nacional de Previdência e Assistência Social/SINPAS), which comprised the Financial Administration Institute (Instituto de Administração Financeira/IAPS), the National Social Security Institute (Instituto Nacional de Previdência Social/INPS) and the National Social Security Healthcare Institute (Instituto Nacional de Assistência Médica/INAMPS). INAMPS was charged with providing individual health care to urban workers, government employees and rural workers (Braga and Paula, 1981).

The universalisation of social security made it an imperative to ensure that health services like hospitals and clinics were accessible to an unexpectedly large contingent of the population. Malloy shows that Brazilian social security encompassed 80% of Brazil's urban population (Malloy, 1979). The self-employed, housemaids and the rural population were no longer denied access to social security health services. This attempt at mass provision of social citizenship required investments in the supply of new medical services. The authoritarian regime opted to rely on combinations of the public and private spheres to expand social security services (Braga and Paula, 1981).

Nevertheless, the military regime had such a tenuous hold on legitimacy that the Executive was capable neither of garnering recognition nor of providing intellectual leadership in sectoral initiatives. It should, however, be pointed out that the social policy debate in the latter half of the 1970s was no longer restricted to the issue of social inclusion (Santos, 1979). Social policy reflection had turned to new questions: excess spending and the inefficient allocation of public resources. Weyland is perspicacious in his understanding of the complexity of this new scenario:

> Health professionals and experts from academia and research institutes criticized this unequal and wasteful model of health care ever more vocally. In the mid 1970s, they formed a 'sanitary movement' demanding profound reform. This social movement attributed the problems of the established system to its heavy reliance on the private sector. It therefore called for strengthening the public sector in order to guarantee all citizens equal rights and effective access to health care and to shift the emphasis from curative treatments to preventive measures, such as vaccination and sanitation. … It would also limit the explosion of health spending by diminishing the need for the expensive treatment of people falling ill with diseases that are easy to prevent. (Weyland, 1995, p 15)

The author highlights criticisms of the initial scholarship produced by the sanitaristas regarding the Brazilian military's national developmentalist decision to favour private companies in the expansion of hospitals and specialised clinics by authorizing social security to purchase goods and services from them. Policy analysis in health thus dialogued with decisions that broadened Brazil's social protection structure in the 1970s while not, however, recognizing these decisions as legitimate or even necessary.

The legitimacy crisis faced by the health sector expansion model jeopardized the late social protection system shaped by the authoritarian regime, modelled on a partnership between the state and private companies that provided health services to the social security system. Noronha and Levcovitz note that there was disagreement about the model even within the social security bureaucracy itself (Noronha and Levcovitz, 1994).

Policy analysis by the sanitaristas

The intellectual foundations of the SR were informed primarily by the results of research contracted by FINEP (Financiadora de Estudos e Projetos), a body of the federal executive branch headquartered in the city of Rio de Janeiro that was responsible for executing a portion of the program to modernize scientific and technological research under the Geisel administration (Costa, 1992).

Although the sanitaristas had bureaucratic ties to the state apparatus of an authoritarian regime, their scientific production was paradoxically focused on deconstruction of the government's medical assistance policy. For the sanitaristas, more than serving as an instrument for broadening social protection, the expansion of health assistance as fostered by the regime subordinated the health sector to the logic of capitalist development in unacceptable terms. Oliveira and Teixeira provide examples of the functional-structural perspective that underpinned the veto of arrangements combining the state sphere and the health market in that context. For the authors, the expansion of social security within the sphere of health was part of the accumulation process, facilitated by the special blending of state and monopoly capital in Brazil.

Oliveira and Teixeira identified three unique features of this arrangement between social policy and accumulation. The first was the extension of social security coverage to encompass almost all of Brazil's urban population as well as part of its rural; the second was the favouring of curative, individual, welfare-based and specialised medicine in detriment to preventive public health measures of collective interest; and third, the formation of a medical-industrial complex, responsible for the high rates of capital accumulation by large international monopolies in the area of medications and medical equipment manufacture (Oliveira and Teixeira, 1985).

Within the same institutional context, Cordeiro's early 1980s policy analysis emphasised the process of capitalisation of medical practice, which was to forge links between the institutions that provided healthcare and trained human resources and the emerging medical-industrial complex that produced drugs and equipment (Cordeiro, 1980).

The author states:

> The material foundations for the privatisation of medicine, a process that stepped up pace as of 1976, lay in both the for-profit and not-for-profit private hospital sectors. … This policy option took as its rational

> justification the existence of a private hospital sector … together with growing demand generated by the incorporation of large contingents of urban wage earners into the social security system. (Cordeiro 1980, p. 162)

Those in scientific research enjoyed paradoxical intellectual autonomy that allowed them to reaffirm the functional-structural theoretical perspective that tied growing state provision of health services to accumulation. Scientific research by the sanitaristas reaffirmed structuralist representations of the relation between the economy and politics then dominating the Brazilian social sciences. In 1973, for example, Donnangelo, a preeminent intellectual in social science research in health that decade, stated:

> The following can be identified as the prime means through which state interference has preserved the private sector: by sustaining quantitatively and qualitatively greater demand through concentrated manipulation of resources; by guaranteeing the continuity and expansion, under private control, of a network of services that progressively incorporates modern technology; and by keeping private producers in direct control of production processes. (Donnangelo, 1975, p 37)

The author did warn, however, that the preferential treatment accorded the private producer was constrained by the need to reconcile it with guarantees that wage earners would be able to access and consume services. Still, this same advantage rendered policy decisions less permeable to rationalisation and concentrated pressure on the state to expand the sphere of private action (Donnangelo, 1975).

What is particularly intriguing about the experience of the sanitaristas is that the constitutional process demanded institutional arguments that would justify the sectoral reform project. Such arguments were in fact produced, but the imperative of the institutional agenda distanced sanitarista policy analysis from the anti-capitalist representations found in their initial intellectual production.

Within the constitutional process, the sanitaristas' policy analysis became diffused at a national level through two bodies that in the 1970s brought together professors and researchers at the departments of social or preventive medicine within state or federal medical schools and at Fiocruz's National Public Health School (ENSP): the Brazilian Centre for Health Studies (Centro Brasileiro de Estudos de Saúde/CEBES)

and the Brazilian Post-Graduate Association in Collective Health (Associação Brasileira de Pós-Graduação em Saúde Coletiva/ABRASCO). Even though the sanitaristas were intellectually independent, their social status as part of the public bureaucracy demanded they create these two civil bodies in order to disseminate their reform agenda. In the 1970s, the authoritarian regime still had the power to limit direct political activism by public organisations.

CEBES was founded in 1976 as an outgrowth of *Revista Saúde em Debate*. As Cohn has pointed out, its members were academics or health professionals from the public sector whose chosen focus of policy analysis was reform of the health system from the perspective of universalisation and equity under the aegis of the state. Two CEBES leaders who were especially important during the constitutional process were physicians Antônio Sérgio Arouca and Eleutério Rodriguez Neto. The same role was played by ABRASCO, created in 1979, another vital actor in the shaping of health reform policy in the context of resistance to the military regime and of democratic transition (Cohn, 1989).

Cohn rightfully calls attention to the influence of the Italian sanitary reform experience, mainly through Giovanni Berlinguer's *Medicina e Politica*, translated into Portuguese by CEBES in the late 1970s. In this now classic work, published in Italy in 1973 and in Brazil in 1979, Berlinguer defended the ***institutional*** construction of a national sanitary service with integrated health protection functions, assuaging the anti-capitalist resistance then endemic to the Italian left (Berlinguer, 1979).

The important presence of this physician and senator for the Italian Communist Party reflected CEBES' great affinity for the strategy of occupying institutional spaces, which were expanded by democratic transition, as Cohn reminds us (1989). Combining its outlook of institutional cooperation with the institutional lessons of the Italian experience, CEBES was able to present a tremendously original proposal for the Brazilian SR. The document 'A Questão Democrática na Área da Saúde', (The democratic question in the area of health), presented at the First Symposium on National Health Policy, held in the Federal Chamber in October 1979 (Escorel, Nascimento and Edler, 2005), was the main instrument of this innovative policy analysis.

CEBES proposed that the democratisation of health should present the following components: 1- recognition of the universal right to health; 2- recognition of the social nature of health conditions (employment, wages, nutrition, sanitation, housing and

environmental protection); 3- state responsibility for the right to health; 4- creation of the Unified Health System (SUS); 5- the establishment of funding mechanisms, with the defined participation of health within federal, state and municipal budgets; 6- decentralised management, with links between the federal, state and municipal levels; 7- entrusting direction of the SUS to the Health Ministry, along with the task of planning and implementing the National Health Policy in cooperation with states and municipalities (Fleury, Bahia and Amarante, 2007).

The sanitaristas eliminated or minimized the anti-capitalist components of their original intellectual production, instead positing as a crucial strategic choice in SR the development of the state sector of the health economy. In the section entitled 'Política de Assistência Médica' (Medical assistance policy), the document 'A Questão Democrática na Área da Saúde' called for:

> … the immediate suspension of agreements or payment contracts by service units involving the purchase of physician services from the private entrepreneurial sector, replacing them with general subsidies; … the immediate creation … of a regionalised network of [government] clinics and health posts focused on the provision of preventive measures, in coordination with primary health care, emergency care and work accident care. SUS physicians should be used to staff these posts; … definition of a policy for the production and distribution of medications and medical equipment … aimed at reducing dependence on foreign capital, through greater state participation in research, researcher training and the development of national technology aimed at the production of raw materials vital to the industrialisation of essential medications. (Fleury, Bahia and Amarante, 2007, pp 14-15)

CEBES' sectoral reform proposal was further fortified by the successful experimentalism in health management practiced by municipal governments. In the frail and restricted federative context that outlived the military regime, the sanitaristas enthusiastically disseminated experiences in the organisation of health care by progressive municipal governments. Municipal governments adopted the proposals to expand primary care that were disseminated through channels of interaction within the public health policy community. At this stage, the development of municipal policy depended above all on the idiosyncratic characteristics of local governments and

progressive municipal leaders (Costa, et al, 2011). Municipalism soon became a fundamental value on the democratizing agenda of the sanitaristas: the Integrated Health Actions (Ações Integradas de Saúde/AIS) policy, in place during the brief period of democratic transition, reinforced the policy community's localist outlook. In 1986, 2,500 municipalities threw their support behind the Integrated Health Actions proposal (Noronha and Levcovitz, 1994).

The document 'Pelo Direito Universal à Saúde' (For the universal right to health; ABRASCO, 1985) was the sanitaristas' second show of force in policy analysis during the democratic transition. The document ratifies their advocacy of 'including health in the Constitution of Brazil as one of the basic elements in affirming the citizenship of the Brazilian people, defining it as a right to be safeguarded by the state' (ABRASCO, 1985, p 7). According to ABRASCO, the reorganisation of the Brazilian health system would be grounded in the universalisation and equalisation of health care, managerial decentralisation of service management, institutional integration among bodies and agencies and among the various levels of care, new relations between public and private services, the definition of a human resource policy and a science and technology policy and the development of forms of participation for health professionals and users of services (ABRASCO, 1985).

Falleti (2010) is correct when she says that the sanitaristas arrived at both the Eighth National Health Conference (8th CNS), held in 1986, and at the constitutional process with their own agenda. Elias and Cohn also highlight the fact that:

> When the National Congress elaborated the country's new constitution in 1988, it was the health sector that presented the most complete proposal both in terms of governing principles and in the organisation of the system. (Elias and Cohn, 2003, p 45)

The same impression was had by physician Carlos Mosconi, an influential member of the constitutional assembly from the PMDB (Partido da Mobilização Democrática do Brasil), Minas Gerais, who said:

> I have received a number of proposals from all areas. Of the proposals I received, in the health area, perhaps the most wide-ranging of all is [that] of the National Commission for Sanitary Reform, a proposal already in constitutional terms. I ask Your Honour's permission to read the proposal, which goes as follows: Art. 1 - Health is a right

> guaranteed by the state to all inhabitants of the national territory without distinction. (Mosconi, 1987, p 6)

The recommendations of the 8th CNS ratified CEBES' and ABRASCO's theses that the health of each individual is a collective interest, that the state's duty in health should be given priority treatment in social policies and that the right to health and equal access should be extended to actions and services to promote, protect and recover health at all levels of complexity (Comissão Nacional da Reforma Sanitária, 1987). The 8th CNS reiterated the need to change the historical standard of government action in health through the decentralisation of health services at sub-national levels.

To fund the new Unified Health System, the 8th CNS proposed that the sector be allocated 'a minimum percentage over public revenue' or 'a minimum percentage equal to 15% of public revenue' (Comissão Nacional da Reforma Sanitária, 1987, p 24). The 8th CNS held that direct subsidies to private health plans be vetoed by revising the personal income tax deduction and by eliminating deductions allowed companies for health care costs (Comissão Nacional da Reforma Sanitária, 1987, p 24).

Ratified by democratizing political leaders, the 8th CNS document called for the reorganisation of the Ministry of Health as a coordinating body for the sector; the shifting of the centre of financial decisions to states and municipalities; democratized decision making through establishment of state and municipal Deliberative Councils, comprising workers, employers, health professionals and the government; and a steady increase in tax-based funding of health until reaching 8% of GDP in 1990 (Brasil, 2007).

Some of the more distributive items on the agenda drawn up by the 8th CNS had inarguably garnered broad support from the political leaders who had risen to victory in 1985 under the New Republic (1985-90). It should be remembered that one of the most representative intellectuals and physicians in the sanitary field during the New Republic became president of INAMPS in 1985: Hésio Cordeiro. It was in this environment that the Unified and Decentralised Health System (Sistema Unificado e Descentralizado de Saúde/SUDS) was created by decree law, as a continuation of the Integrated Health Actions program, especially to reinforce the role of state governments within the federative public system then taking shape (Ministério da Saúde, 1985).

The mobilizing strength of the 8th CNS influenced establishment of the National Commission on Sanitary Reform (Comissão Nacional da Reforma Sanitária/CNRS), a consultative board entrusted with drawing up suggestions on the institutional and legal

reshaping of the health system. Existing from August 1986 to May 1987 (Comissão Nacional da Reforma Sanitária, 1987), the CNRS devoted itself to further developing the Final Report produced by the 8th CNS, to systematizing proposals and to the national integration of the sanitary movement, with special attention to legislative power and the constitutional process (Ministério da Saúde, 2006).

The chapter on health in the FC1988 and its subsequent laws and administrative rulings would essentially ratify the organisational engineering that followed from the sanitarista policy community's proposition (see Attachment A). The FC1988 continues to hold the idea of health as a universal, equal right delivered through promotion, protection and recovery actions (Brasil, 1988). From the angle of systemic organisation, the FC1988 adopted the proposal for a unified, decentralised, integrated system with social participation (Brasil, 1988).

Institutional incentives for expanded, participative decision making found expression in the decision to provide for Health Conferences (Conferências de Saúde) and Health Councils (Conselhos de Saúde) within the SUS at all levels of government (Ministério da Saúde, 1993). The Health Councils were to be ongoing, deliberative bodies comprising government, service providers, professionals and users. They were to help oversee the implementation of health policy at their corresponding level, and decisions would be homologated by the legal head of the executive branch in each sphere of government (Ministério da Saúde, 1993). The legislation that instituted the National Health Council (Conselho Nacional de Saúde/CNS) (Decree no. 99.438/1990) gave it the power to 'act in the formulation of strategy and in the control of the execution of National Health Policy' at the federal level.

Conclusion

Assessments of development of the SUS in the 1990s were overridingly pessimistic. It is widely, and surprisingly, maintained that the reform unfolded under precarious conditions and was incomplete, distorting its formulators' original conception. It is generally argued that there is a dissociation between the formulation and implementation of the SR. In this regard, the literature has stressed the complex relation between the public and private spheres. Paim (2008) and Ocké-Reis and Marmor (2010) have said that the SUS imagined by the community of sanitaristas became 'a broken promise'. Ocké-Reis and Marmor state:

> The state is incapable of responding to the coverage-related problems caused by budget constraints and this both prevents the SUS from becoming stronger and leaves ample room for the growth of an oligopolistic private health insurance market. (Ocké-Reis and Marmor, 2010, p 327)

Paim, Travassos, Almeida, Bahia and Macinko are in surprising agreement in their diagnosis that 'implementation of the SUS has been complicated by state support for the private sector, the concentration of health services in more developed regions and chronic underfunding' (Paim, et al, 2011, p 1778).

Now, more than twenty years after enactment of the FC1988, the Brazilian health system has solidified into a hybrid system. The prevalence of funding for private insurance and out-of-pocket pay for medical care by families is pushing the sector towards organisational fragmentation. At the level of collective action, the institutionality of the FC1988 has served merely as a civic reference for individuals who can use it to ensure enforcement of the right to universal access to health care and to expensive medications.

Some authors have endeavoured to attribute the dissociation between the formulation and implementation of the SUS to Brazil's historical legacy of individual medical care. The origin of health care, grounded on differentiation in the realm of Brazil's retirement and pension institutes, has not favoured the Brazilian working class's universalist values of solidarity (Cohn and Elias, 2003; Menicucci, 2006).

Others underline the constraints of developing an agenda based on the expansion of the state's role and of public spending in the early 1990s environment of monetary stability and fiscal adjustment (Pereira, 1996). From this viewpoint, even the theme of federative decentralisation is seen as an expression of the minimal state agenda that was part of the executive branch's neoliberal project in the 1990s (Ugá, 1997). Gerschman and Pereira, proponents of this perspective, hold that the SR coincided with a new era of Brazilian liberalism, where social policies were subordinated to macro-economic policy (Gerschman, 1997; Pereira, 1996).

From another prism, Diniz underscores how the new Brazilian democracy broke with a rigid state institutionality that showed little potential for political incorporation. The new democracy brought a multi-faceted system of interest representation, rendering anachronistic the model of the omnipotent, concentrating state (Diniz, 1997). Furthermore, the new political party system was to support segmentation in the composition of interests (Vianna, 1998).

Menicucci (2006) and Vianna (1998) call special attention to the role of the trade union movement, which did not support the SR, immersed as it was in the contradictions between an egalitarian ideological posture and the defence of corporatist interests. Concomitant with implementation of the SR, the demand for private medical care became an item on the collective bargaining agenda of various trade unions, constituting an 'implicit veto' of the reform's public, universal model (Vianna, 1998; Menicucci, 2006).

Faveret and Oliveira (1990), on the other hand, raise the hypothesis of excluding universalisation, that is, when the SUS was set up, the preferential option for providing care to the poor distanced the middle class and unions from state-based care. Public underfunding and the massification of access prompted social actors with stronger voices to exit the public sphere. The authors see the entrenchment of the private health care insurance market as a consequence of the strategy of focusing the SUS on the poor and of limiting services (Faveret and Oliveira, 1990).

A less sceptical reading of the performance of the SUS ties into the decentralisation experience. Arretche defends the thesis that the SR was especially successful in establishing federative decentralisation. She notes that local autonomy in program management, incentivized by the Ministry of Health, created institutional opportunities for government leaders to implement decisions in tune with their own preferences within the realm of the SUS (Arretche, 2002; 2003). The preferences of municipal executives have not produced any collective ill will; the main advances in health indicators in Brazil are seen as attributable to the decentralisation process (Falleti, 2010; Hunter and Sugiyama, 2009).

The social sciences recognize the public bureaucracy's ability to put in place distributive developmentalist policies (Evans, 1999). The features of distributive policy are very attractive to national elites: social costs are spread out and benefits concentrated in certain social sectors and strata. Distributive developmentalist decisions

have a marked presence in Brazilian economic history because they generate no opposition or veto from any social group.

This chapter has shown that the SR proposal included an agenda of a redistributive nature, which clashed openly with the distributive decisions of Brazil's authoritarian regime, in the grips of a legitimacy crisis. There is no doubt that implementation of a redistributive agenda under the SR in the context of the new democracy would mean specific, concentrated losses for entrepreneurial sectors and health professionals. The literature on redistributive institutional models is, however, sceptical about the public bureaucracy's ability to enforce a redistributive agenda on its own, without the acquiescence of social groups that wield obstructionist power (Esping-Andersen, 1996). The analysis of the institutional limits of redistributive public policies in Brazil presents a challenge to the SR's epistemic community today.

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The Agenda Setting of SUS in Brazil

Document / Topic	The Democratic Question in Health	Eighth National Health Conference	Federal Constitution of 1988	Law 8080 of 1990	Law 8142 of 1990
Concept of health / Universalisation	Universal right to health. Recognition of the social determinants of health.	Health as a product of the social organisation of production.	Health as a right of all, guaranteed through social and economic policies that seek to reduce the risk of illness and achieve universal access.	A human right. Advocacy of universal and equal access to actions and services to promote, protect and restore health.	-
Health as a duty of the state	Health as a responsibility of the state	Health as a duty of the state	Duty of the state	Duty of the state	-
SUS	Creation of the SUS	Creation of the SUS	Creation of the SUS	Enactment of the SUS	-
Decentralisation / Municipalisation / Equity	Decentralisation of the SUS, aimed at local needs.	Decentralisation and equal access. Strengthening of the role of municipalities.	-	Emphasis on decentralisation down to the municipal level.	-
Democratic participation / Health Councils	Democratic participation of the population at different levels of the SUS.	People's participation in policy formulation and in planning, management, execution, and evaluation of health actions. Creation of Health Councils.	Community participation.	Veto of joint bodies (Health Conferences and Health Councils).	Within each sphere of government, the SUS will have Health Conferences and Health Councils.
Leadership of the SUS	Health Ministry will direct the SUS. INAMPS becomes part of this system.	The SUS should have a single leadership.	The SUS has a single leadership in each sphere of government.	Political and administrative decentralization, with a single leadership in each sphere of government.	-
Regionalization / Integrality	Creation of own regionalized network.	The SUS should be regionalised and hierarchised and should provide integrated care. Progressive nationalization of sector.	Regionalised, hierarchical network. Integrated care, with priority on preventive action.	Emphasis on regionalisation and hierarquisation of the health service network. Integrated execution of healthcare and preventive action.	-
SUS funding	Expansion of the proportional participation of the health sector in federal, state and municipal budgets.	Creation of the social policy budget. Creation of Unified Health Funds (Fundos Únicos de Saúde) at federal, state and municipal levels. Setting of a minimum percentage of public revenue.	The SUS is funded with resources from social security and from federal, state (including the Federal District) and municipal budgets, in addition to other sources.	In accordance with estimated revenue, the social security budget will allocate to the SUS the funds needed to achieve its purposes.	Speaks to the allocation of funds from the National Health Fund (Fundo Nacional de Saúde) and the transfer of funds to municipalities, states and Federal District.