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Health policies in Brazil in times of contradiction: paths and pitfalls in the construction of a universal system

Políticas de saúde no Brasil em tempos contraditórios: caminhos e tropeços na construção de um sistema universal

Políticas de salud en Brasil en una época contradictoria: avances y tropiezos en la construcción de un sistema universal

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Abstract

This article analyzes the trajectory of national health policy in Brazil from 1990 to 2016 and explores the policy's contradictions and conditioning factors during the same period. Continuities and changes were seen in the policy's context, process, and content in five distinct moments. The analysis of the policy's conditioning factors showed that the Constitutional framework, institutional arrangements, and action by health sector stakeholders were central to the expansion of public programs and services, providing the material foundations and expanding the basis of support for the Brazilian Unified National Health System at the health sector level. However, historical and structural limitations, institutional legacies, and the dispute between projects for the sector have influenced national health policy. Interaction between these conditioning factors explains the policy's contradictions during the period, for example with regard to health's position in the national development model and social security system and the financing and public-private relations in health. Expansion of public services occurred simultaneously with the strengthening of private segments. Dynamic health markets that compete for resources from government and families, limit the possibility of consolidating a universal health system, and reiterate social stratification and inequalities in health.

Unified Health System; Health Systems; Health Policy; Public Policy

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Introduction

Brazil is a populous, extensive, economically important and extremely unequal Latin American country. The socioeconomic inequalities, rooted in its colonial past, were not overcome by capitalist modernization between 1930 and 1980, characterized by industrialization in strategic segments, generally under authoritarian regimes, and scarce social redistribution [1].

Health policy in this period was marked by a dual trajectory, represented on the one hand by public health care, aimed at controlling specific diseases; and on the other by social insurance medical care, based on corporate structures and geared toward the workers of the formal urban market [2]. Other characteristics of the health system until the early 1980s included: the exclusion of a significant portion of the population, a largely ineffective care model and the prominence of the State-subsidized private sector in service provision.

The public health reform of the 1980s, against the backdrop of redemocratization and financial crisis, was based on critical review of these characteristics to build a comprehensive proposal, incorporated into the *1988 Federal Constitution* [3,4,5]. Despite the incongruences in the constitutional text [6,7], Brazil was the only capitalist country of Latin America to establish a universal health system in that decade, developed within a broad concept of Social Security and upon a universalist basis, uniting the areas of Social Insurance, Health and Social Welfare, which was to be funded by general tax revenues and social contributions.

The rights ensured by the *Constitution* and the process of building the Brazilian Unified National Health System (SUS) gave rise to advances in subsequent decades in terms of political-administrative decentralization, social participation, changes in the care model, expanded access to public services and improved health indicators [8].

However, implementation of the SUS was thwarted by various obstacles. In the 1990s the dominance of neoliberal economic policies and State reform agendas imposed constraints on the Social Security logic and on the expansion of universal social policies [9]. The rise to power of left-wing governments from 2003 onwards raised expectations for the configuration of a redistributive development model, but several problems with the health system were not faced.

This article analyzes a 26-year trajectory of the health policy – from 1990 to May 2016 – involving the implementation of SUS under a democratic regime. The central proposal is to understand whether national administration of the policy during this period has expressed transformations to the State's role that are required for the consolidation of a public and universal health system. Therefore an effort has been made to identify aspects of continuity and change between different moments, as well as to explore contradictions and conditioning factors of the policy.

The trajectory of the policy was described with reference to literature about public policy analysis. The historical institutionalism approach was particularly important to bring to the fore the state institutions, the action of political actors grounded in institutional contexts [10], and the temporal dimension of the policy [11].

The study assumed taht health express structural contradictions inherent to social policy in the capitalism system. Thus, it is necessary to consider health policy's insertion into the mode of capitalist production, as well as its peculiarities in historical processes of societies [12].

As regards the factors that influence the policy, it was considered that social determination consists of a "*complex and interrelated process of limits and pressures*" [13] (p. 87). The idea of determination includes fixing limits that condition the agency (negative determinations), but also the existence of pressures, desires and purposes (positive determinations). Social processes occur under certain conditions, which does not mean fixed laws or the impotence of the participants.

It is argued that health policy has been influenced by different conditioning factors and conflicting projects, the interaction of which explains the contradictions observed in the period.

The moments of the health policy: context, process and content

The health policy trajectory was analyzed in five moments, considering three aspects: national context; political process; and policy content (Figure 1) [14].

Figure 1

National context and health policies in Brazil, from 1990 to 2016.

Fernando Collor de Melo administration (1990-1992)		
National context	**Political process of health**	**Agenda of the health policy**
Public administration and economy: - Neoliberal economic policies; open market economics. - Strategies to reduce public spending, agencies and civil service. *Policy:* - Center-right coalition; limited liaisons with the National Congress. - Accusations of corruption involving ministries and the Presidency - impeachment process – presidential resignation. *Work and social policies:* - Reafilliation of Social Insurance into the Ministry of Work. - Emphasis on flexible work relations and cutting costs. - Social policy: financial constraints, obstacles to enacting Social Security laws, decentralization with emphasis on municipalities, in adverse conditions.	*Alceni Guerra – PFL-Paraná State (Mar/1990 to Feb/1992)* - Minister with limited political power in the government and in health. - Executive Secretary of the Ministry chosen by the President. - Limits on social participation. - Start of Tripartite Inter-management Committee (CIT). *Adib Jatene – no party-São Paulo State (Feb/1992 to Oct/1992)* - Distinguished physician is invited to become minister to restore credibility of the Ministry of Health. - Top tier managers selected by the Minister. - 1992 - organization of IX National Health Conference. - Short term in office (President's impeachment and resignation).	- 1990: Inamps is incorporated into the Ministry of Health. - 1990: Enactment of the Organic Health Law (LOS 8080 and 8142) - Community Health Agents Program (PACS) launched to reduce infant mortality in poor areas. - AIDS – start of antiretroviral therapy. - *Basic Operational Standard* (NOB) *1991* - decentralization of services (intense) and resources (limited). - Emphasis on strengthening the social debate and federal capacity for SUS coordination, as well as in expanding health services in the country.
Itamar Franco administration (1992-1994)		
National context	**Political process of health**	**Agenda of the health policy**
Public administration and economy: - Economic instability and high turnover of Finance Ministers. - Launch of the Real Plan (1994) *Policy* - Vice President assumes power after Collor's impeachment process. - Heterogeneous governmental coalition. *Work and social policies:* - Decentralization and instability of social funding; - 1993 - Interrupted allocation of social contributions made by workers for funding health.	*Jamil Haddad – PSB-Rio de Janeiro State (Oct/1992 to Aug/1993)* - Minister with limited political power in the government, but well thought of in the health sector. - Conflicts with government's economic authorities. - Emphasis on strengthening municipalities and on social participation. *Henrique Santillo – PMDB-Góias State (Oct/1993 to Jan/1995)* - Minister with considerable legitimacy in the health sector. - Conflicts with government's economic authorities.	- Formulation of the NOB 1993 (proposal) – Decentralization with emphasis on municipalities, creation of bipartite inter-management committees in the states. - Extinction of the Inamps. - Initial implementation of NOB 1993 - Decentralization with emphasis on municipalities. - 1994 – Family Health Program launched.

(continues)

Figure 1 (continued)

Fernando Henrique Cardoso administrations (1st term: 1995-1998; 2nd term 1999-2002)		
National context	**Political process of health**	**Agenda of the health policy**
Public administration and economy: - Emphasis on: macroeconomic stability (Real Plan-1994); privatization of state companies; open trade and finance; adjustment to international trade rules (intellectual property laws and regulations). - Changes in the macroeconomic policy after the financial crisis and 1998 elections (devaluation of the real, adoption of floating exchange rates). - Stagnation relative to domestic industry. - State Reform Master Plan (1995) - Creation of regulatory agencies. - Shrinking trend of the Federal Civil Service. *Policy:* - Center-right coalition; many ministries filled by members of the PSDB and PFL. - Constitutional Amendment of reelection (1997). *Work and social policies:* - Modest increase to minimum wage (but reduced share of salaries in national GDP). - Attempts at reforming social insurance are opposed by workers - prevalence of incremental parametric reforms (e.g. creation of the social insurance factor). - "Solidary Community" strategy - conflicts with guidelines and actors from the Social Welfare area. - Expansion of anti-poverty programs; from 1998 - conditioned income transfer programs. - Education: decentralization and expansion of elementary education; restrictions on federal funding and expansion of private universities.	*Adib Jatene – no party-São Paulo State (Jan/1995 to Nov/1996)* - Top tier managers selected by the Minister. - Conflicts with economic authorities; Minister negotiates with Congress a new tax to fund health (Provisional Contribution on Financial Transactions – CPMF); leaves the position after its approval; - X National Health Conference (1996) and Minister's participation in the National Health Council; - Intergovernmental negotiations. *Carlos Albuquerque – PSDB-Rio Grande do Sul State (Dec/1996 to Mar/1998)* - Minister with limited political power in the government and in relation to most actors in the health sector. - Stance of avoiding conflicts with the Presidency and economic authorities. - Executive Secretary (economist Barjas Negri) chosen by the President. *José Serra – PSDB-São Paulo State (Mar/1998 to Feb/2002)* - Economist minister, with political clout in the government - long and stable administration; leaves the office to dispute the 2002 presidential elections; - Top tier managers – economists and sanitarians with political ties to the government, but recognised in the health sector. Internal conflicts. - Negotiations with the Presidency, economic authorities and the Congress – approval of *Constitutional Amendment 29/2000*, establishing new rules for health funding in the three spheres (looser for the federal sphere). *Barjas Negri – PSDB-São Paulo State (Feb/2002 to Dec/2002)* - Executive Secretary Barjas Negri becomes Minister and maintains good relations with the Presidency and economic authorities; temporary administration (election year).	- Adoption of the Family Health Program as a strategy to strengthen primary health care. - Expansion of the anti-AIDS policy – multiple antiretroviral therapy (specific law). - Continuation and expansion of traditional public health policies. Emphasis on tobacco control. - Formulation of the Basic Operational Standard – NOB 1996 – changes to the criteria of system decentralization, funding and organization. - Adhesion to the State reform agenda and emphasis on the efficiency of management and in decentralization. - Expansion of the Famiy Health Program; creation of the Basic Care Department. - Continuity of traditional public health policies and in the AIDS policy - international debate on intellectual property and adjustments to national laws and regulations. - Issue of the *Operational Health Care Standard* (NOAS) *01/02* - Pharmaceutical assistance – proliferation, fragmentation and decentralization of programs; expanded spending on high cost drugs; generics program. - Creation of agencies aimed at regulating public health issues (Anvisa) and private health plans (ANS). - Aspects of previous policies predominantly continued.

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Figure 1 (continued)

Luiz Inácio Lula da Silva administrations (1st term: 2003-2006; 2nd term 2007-2010)		
National context	**Political process of health**	**Agenda of the health policy**
Public administration and economy: - 2003-2005 – low growth; 2008-2009 – economic growth; 2008-2009 – international crisis and adoption of anti-cyclical policies. - Emphasis on macroeconomic stability; as from 2007 expansion of developmentalist strategies. - Gradual changes in the role of the national banks and in industrial policies. - Launch of the Growth Acceleration Plan (PAC I – 2007) and the Productive Development Policy (PDP). -New plan for Federal Administration; expansion of civil service admission exams. - Emphasis on social participation in policy formulation. *Policy:* - 2003-2005: creation of new ministries and national secretaries; priorities defined by area; many ministries occupied by PT members. - 2005-2006: political crisis and changes in the politcal coalition and top echelon of the government; Lula reelected. - 2007-2010: stronger PMDB presence in the government; political stability: increasing approval rates of the President and the government. - Candidacy and election of Dilma Rousseff as President of the Republic, supported by Lula and the PMDB. *Work and social policies:* - Emphasis on the creation and formalization of jobs, increases in the minimum wage, policies to combat poverty and enhanced rights of socially vulnerable groups, with reduced income inequalities. - Incremental reform of the social insurance system of civil servants (stricter rules for full pension, like minimum time spent in civil service and in career) - Federal expansion in tertiary education: new federal universities and campuses and funding for the private sector.	*Humberto Costa – PT-Pernambuco State (Jan/2003 to Jul/2005)* - Composition of the top echelon of the Ministry considers the governmental coalition; - Outline plans for changes and emphasis on participative management; - Internal conflicts in the top echelon and departure of the Executive Secretary in 2004. - XII National Health Conference brought forwards (2003). - Minister frequently participates in National Health Council (CNS) meetings. *José Saraiva Felipe – PMDB-Minas Gerais State (Aug/2005 to Feb/2006)* - Recomposition of government's support base after the 2005 crisis influences choice of Health Minister. - Recomposition of the top echelon; departure of managers connected to the PT. - Departure of the Minister to dispute elections in the Chamber of Deputies. *José Agenor A. da Silva – no party-Minas Gerais State (Feb/2006 to Mar/2007)* - Executive Secretary fills the role of Minister with support within sector, but less political force. - Period of temporary posts and disputes for the position of Minister. *José Gomes Temporão – PMDB-Rio de Janeiro State (Mar/2007 to Dec/2010)* - Health Care Secretary, sanitarian and Fiocruz researcher, assumes the role of Minister, with the disapproval of parliamentarians from his own party (PMDB). - Internal conflicts in the top echelon and departure of the Health Care Secretary in 2008. - Conflicts between the Ministry and National Health Council (e.g. issue of state foundations). - XIII National Health Conference held. - 2007 – Senate votes to end the CPMF in the same week that the Ministry of Health launches the sectoral investment More Health Plan.	- Change in the Ministry framework, with the creation of new secretaries (of Health Surveillance, of Work and Education Management in Health, of Science, Technology and Strategic Supplied, and of Participative Management), aimed at strategic areas and unification of the Health Care Department; - Definition government brands in health (i.e., Smiling Brazil, SAMU, Popular Pharmacy). - Development of the National Health Plan (2004-2007). - Priority governmental policies continued; - Start of changes in handling of some policy areas in relation to the period 2003-2005 (e.g. area of education in health) and greater emphasis on the centrality of some strategies (i.e., Family Health). - Priority governmental policies continued; - Predominance of continuation of policies in relation to the previous administration. - Finalization and announcement of the Pact for Health. - Broadening of the strategic agenda, with emphasis on promoting health and on correlations between health and development. - Prominence for the strengthening of the economic-industrial complex of health care. - Continuity and expansion of priority policies. - Development in 2007 of the More Health Plan (2008-2011), influenced by the PAC.

(continues)

Figure 1 (continued)

Dilma Rousseff administrations (1st term: 2011-2014; 2nd term 2015-2016)		
National context	**Political process of health**	**Agenda of the health policy**
Public administration and economy: - Effects of the international crisis, with slowing economy; relative preservation of economic indicators until 2013; slight downward trend in 2014 and 2015, with growing pressures for adjustment measures. - Conflicts between pro-adjustment projects and maintenance of the social-developmentalist strategy; in 2015 - developmentalist Finance Minisiter is replaced by one with technocratic profile and with links to the financial system; - Progressive pressure for containment of public spending. *Policy:* - Strengthening of conservative and liberal ideas, expressed in the political struggle in the government and in society; - Polarization and heated presidential dispute in 2014 between Dilma Rousseff and Aécio Neves (PSDB), with Dilma reelected by a narrow margin (51.64% v 48.36% of the valid votes; difference of 3,459,963 votes). - Mainstream media opposed to the President; - In 2014-2015: political crisis, characterized by: accusations of corruption in state companies, hitting members of the government and the National Congress; criticisms of governmental policies; diminished support from the PMDB for the President (including from the Vice President and President of the Congress, hit by corruption accusations); fall in public approval of the government and the President; impeachment process opened, although questioned legally; President removed from office temporarily in May and definitively in August 2016. *Work and social policies:* - Labor market indicators relatively kept at same levels until 2014 (low unemployment, increased formalization and real worth of salaries); in 2015, downward trend (i.e., unemployment rises). - Policies to increase real worth of minimum wage maintained. - Growing contraints on social spending, with unstable sources, contingency and containment of growing spending, including in health. - Reforms in the social insurance system: for civil servants (same maximum limit as general workers and creation of complementary fund) and for general workers (measures of restricted access to pensions and retirement plans).	*Alexandre Padilha – PT-São Paulo State (Jan/2011 to Feb/2014)* - Young minister, from the PT leadership and with legitimacy in health and successful career in government; moderate political clout; leaves the Ministry to dispute election for São Paulo State governor; - Secretariat with strong political ranks in the PT and others in the coalition, in general with experience in collective health/SUS - Good relationship between the Ministry and other spheres of government, with the CNS and social movements. - Intense conflicts with the medical organizations, due to the 'More Medics' Program. - XIV National Health Conference held. *Arthur Chioro – PT-São Paulo State (Feb/2014 to Oct/2015)* - Minister: PT staff with experience in municipal management in health, who occupied posts in the Ministry since 2003; less political power. - Secretariat with strong political ranks in the PT and others in the coalition, in general with experience in collective health/SUS - Tensions between the Ministry and the CNS and in relation to public health movement bodies, for defending controversial governmental measures in conflict with the Constitution, such as opening health to foreign capital. - Left the Ministry due to need to concede offices to the PMDB in an effort to recompose support in view of the political crisis. *Marcelo Castro – PMDB-Piauí State (Oct/2015 to May/2016)* - Appointed by the PMDB as Health Minister; a parliamentarian with a more conservative profile, with resistane by actors from the industry; - Filling of 1st to 3rd echelon posts expresses wide range of profiles and criteria. - Start of management marked by protests by organizations and groups of actors from public health and anti-asylum movements due to appointment of a former director of the country's biggest psychiatric hospital (closed amid the anti-asylum struggle after decades of reported abuses) to the post of National Coordinator of Mental Health.	- Continuity in priority policies during the Lula governments (Smiling Brasil, Popular Pharmacy, SAMU), with incremental changes; - Governmental adopts as a flagship policy the Emergency Care Units (UPA), which already existed, with substantially increased services; - Launch and expansion of the More Medics Program, in 4 strands: provision of doctors in remote locations and with shortages (including foreign doctors with no recognition of their diplomas, in particular Cubans hired through a PAHO agreement in the 1st phase of the Program); increased Medicine courses and places in the country; increased medical residency places; curricular changes encouraged in Medical training. - At the end of 2014 - measure to open the health industry to foreign capital (including service provision). - Increase in arboviruses – dengue fever, chikungunya and zika - and identification of the association between zika virus (when contracted during pregnancy) and microcephaly leads to emphasis on strategies aimed at epidemiological control of these diseases.

ANS: National Health Agency; Anvisa: National Public Health Surveillance Agency; Fiocruz: Oswaldo Cruz Foundation; GDP: Gross Domestic Product; Inamps: National Institute of Social Insurance Medical Care; PFL: Liberal Front Party; PMDB: *Democratic Movement Party of Brazil*; PSB: Brazilian Socialist Party; PSDB: Social Democratic Party of Brazil; PT: Workers' Party; SAMU: Mobile Emergency Medical Service; SUS: Brazilian Unified National Health System.
Source: developed by the authors, based on several sources used in the study.

The start of the SUS in turbulent times (1990-1992)

The Brazilian presidential election of 1989 had 24 candidates. Fernando Collor de Mello, of the National Reconstruction Party (PRN) a representative of a political oligarchy of the state of Alagoas, was elected after a second round dispute with Luiz Inácio Lula da Silva, of the Workers' Party (PT). Collor's victory was supported by a center-right coalition, steered by a discourse of moralization of politics, economic liberalization and trade openness.

The Collor government adopted an austere economic policy which confiscated people's savings and flattened salaries, tuned to adjustments determined by creditor nations and following the neoliberal proposals of the *Washington Consensus* [15].

During 1990 the Ministries, political coalitions and party representations in the National Congress were reorganized. In its first year the government introduced changes in the economic and institutional area, concentrated and rationalized activities in areas connected to the infrastructure and economy [15].

The low priority given to the social area was expressed in strategies that contradicted the *1988 Federal Constitution*, such as the (re)affiliation of the *Previdência* (Social Insurance) to the Ministry of Labor [16]. The lack of any legislation to guarantee the allocation of social insurance funds to the Ministry of Health, which at the start of 1990 incorporated the National Institute of Social Insurance Medical Care (Inamps), threatened the financial sustainability of the SUS.

In this context, separate laws for each area of Social Security were enacted [16]. The approval of the Organic Health Act (*Law 8,080/1990*) occurred with vetoes, revealing a dispute between reformists and the government. In the same year a new law (*Law 8,142/1990*) retrieved aspects relative to funding and social participation, leaving other crucial definitions open, such as the human resources policy and the relationship with private providers.

Once the law was enacted, the Executive regulations that established the financing directives were published, centralizing health care resources in the federal sphere. Mechanisms to allocate funds to service providers were defined, reinforcing a covenantal logic with the municipalities and weakening the possibilities of intergovernmental articulation towards an integrated health system [17].

In the early 1990s the Social Security resources were compromised by deliberate delays in fund allocations at a time of high inflation (greater than 1,000% per year). This led to frequent cuts in health and welfare policies, while the levels of funding for social insurance were preserved. From 1990 onwards the health budget included the retirement expenses of Federal employees [6].

Despite these restrictions, significant strategies were adopted in motion which would influence policies in subsequent years, such as the Community Health Agents Program (PACS) and the national provision of antiretroviral treatment for people with AIDS.

In 1992 Brazil's political situation went into turmoil, with reports of fraud in the State macrostructure, involving the President and ministerial staffs. In health, the Ministry change paved the way for the resumption of the public-private sector debate and the planning of actions for the decentralization project, expressed in the call for the IX National Health Conference. The decentralization process was redirected, including debates on a new operational norm and innovations in health system organization.

Still in 1992 a Commission was established to study the social insurance system, which indicated the dilemma of the economic sustainability of the social security apparatus and the need for a revision of the pact established in the *1988 Federal Constitution*. At the end of 1992, following an impeachment process, President Collor resigned and the Vice-president Itamar Franco (Democratic Movement Party of Brazil – PMDB) took office.

The SUS in times of financial crisis and decentralization (1993-1994)

The political strategy of the Itamar administration characterized by a realignment with the economic elites in a conservative block, in line with the demands of the international capitalist order, but without the excesses of the previous neoliberal rhetoric. The most important development in the economic area was the launch of the Plano Real in 1994, led by the Finance Minister Fernando Henrique

Cardoso. The plan aimed at stabilizing the currency and controlling inflation, and achieved success within the first months of its implementation.

The Itamar years were marked by intersecting interests and political alliances. The social security debate was reopened from the perspective of revising the commitments assumed in 1988. In 1993 the proposal for specialized sources from the Ministry of Social Insurance was implemented and payroll contributions became bound only to social insurance. The interrupted funding from the social insurance fund, associated to the instability of other sources, meant that in 1993 the health sector decreed a "situation of public calamity". Nevertheless, important policies were developed in this period, especially in relation to decentralization.

Transition strategies were defined for states and municipalities to assume control of local health policy, including the establishment of mechanisms of direct and automatic transfer of resources from the National Health Fund, with the aim of breaking from the covenantal logic. Furthermore, progress was made in the installation of intergovernmental committees for policy agreement at a national level (Tripartite Intergovernmental Committee – CIT) and state level (Bipartite Intergovernmental Committee – CIB) [17].

Another important development was the institutionalization of the PACS and the Family Health Program (PSF). A health care model was sought that would prioritize health promotion and preventive interventions directed to individuals and families, as opposed to the traditional model, centered on illness and on the hospital. Initially, these programs were targeted at the poor population identified by the "Hunger Map".

However, the institutional advances in health were paralyzed due to the economic crisis of the period. The inaccuracies of the constitutional text came to the fore and health care was weakened by the government's failure to take definitive action.

Health care between conflicting agendas (1995-2002)

The results of the economic stabilization in the first months of the *Real* Plan rendered political reward: in 1994 the presidential election was won in the first round by former Finance Minister Fernando Henrique Cardoso (FHC), sociologist, professor at the University of São Paulo and one of the founders of the Social Democratic Party of Brazil (PSDB).

The period corresponding to the two FHC administrations was marked, in terms of the economy, by an emphasis on monetary stabilization, privatization of state companies, continuation of open market strategies and adhesion to international trade rules [18].

Also of importance was the launch of State downsizing strategies, the approval of legislation for administrative reform and containment of spending on the civil service (Camata Act, of 1996; Fiscal Responsibility Act, of 2000), favored by a majority coalition of support for the government in the National Congress. Such strategies would come to affect not only the federal administration, but also public management at state and municipal levels. Besides the reduction of federal civil servants [19], there was a marked decentralization of responsabilities and health services subnational governments and the creation of two federal health regulatory agencies in specific areas.

The government was sustained by a center-right coalition that held a majority in the ministries and the National Congress, which allowed it to implement a significant portion of its political agenda. However, the composition of the government was not entirely homogenous, which was expressed in the differences between the two terms of office and in different areas, with effects on social and health policies.

The orientation of economic policies and State reforms did not favor advances in labor policies. The period was marked by the low generation of qualified jobs, given the relative industrial stagnation, an emphasis on more flexible employment relations, increased outsourcing in the public and private sectors and a fall in the wage share of the Gross Domestic Product (GDP) [20].

Social policies suffered financial constraints by virtue of macroeconomic priorities (monetary stabilization, primary surplus and payment of interest on debt), which affected differently the distinct policy areas [21]. The proposals to privatize the pension system were opposed by the union movement, the civil service and players inside the government itself, whose views were grounded in the solidity of the Brazilian public pension system and the constitutional pact. These movements resulted in an

incremental reform with the adoption of the social insurance factor, which amplified the connection between time of contribution, age and pension amounts, with its predominantly public character being preserved.

In social welfare, one can highlight the Solidary Community program, under the command of the First Lady, who invested in the configuration of focused social programs with civil society participation. The Continuous Cash Benefit (BPC), established in the *Constitution*, began to be implemented in 1996, aimed at the low income elderly and disabled, and composed of a mechanism for non-contributive income transfer. From 1998 onwards, the income transfer programs were expanded to consider cross compliances (School Allowance, Food Allowance and Gas Vouchers), in a fragmented and still restricted manner, under the command of different ministries. Despite the difficulties, federal social spending increased in these areas [21].

Health expressed the tensions between the State reform agenda and the public health reform agenda. The former was conducted by the federal government and supported by conservative and liberal forces in the National Congress and society, especially economic elites and business groups with a vested interest in expanding the health care markets. Meanwhile the defenders of the latter were represented primarily by health sector actors, such as managers and technicians from the SUS at all three governmental levels and public health organizations (Brazilian Association for Postgraduate Study in Collective Health – ABRASCO, Centre for Brazilian Studies into Health – CEBES, Brazilian Associate of Health Economics – ABRES). Also of note was the growing participation of health care professionals and SUS users, favored by the expansion of public services, the organization of participatory health councils and conferences, against a backdrop of public policy democratization and decentralization.

The conflicts between projects were expressed, for example, in the confrontations regarding sectorial funding. Between actors from health and those from the economic area, prominent clashes included those relative to the creation of a specific source of funding and to binding revenues to health. Significant developments included the creation of the Provisional Contribution charged on Financial Transactions (CPMF) in 1996 (which remained effective for 10 years, although not exclusive for the sector) and the approval of *Constitutional Amendment 29* in 2000. The Amendment bound revenues to health in a stricter manner for states and municipalities, with differentiated rules for the Federal Government which referred to GDP variation [22]. These strategies were defended by sectorial groups and Ministers of Health played an important role in their approval. However, their negotiation and implementation involved agreements and adaptations, entailing the imposition of limits. Intra-sectorial conflicts and negotiations regarding the decentralization of federal resources occupied a large part of the CIT agenda, in view of the financial restrictions under which the SUS was implemented.

On the economic side, measures for opening trade, the relative stagnation of national industry and the approval of intellectual property legislation [18] posed challenges for the production of health care supplies, in a context of growing demand due to the expanded services. This generated a dramatic increase in imports, presenting risks for the sustainability of the policy [23].

The government's State reform agenda had repercussions in health. In 1999-2000 two health regulatory agencies were created: the National Public Health Surveillance Agency (Anvisa) and the National Health Agency (ANS). The former aimed to increase regulatory capacity in an area traditionally under the State's scope, which covers various branches. The latter, meanwhile, was aimed at the supplementary medical care markets, focusing in the first years on establishing the minimum operating rules for companies, systematizing information and regulating contracts, within a consumer protection logic [24].

The guideline for shrinking the civil service hindered the formation of bureaucracies in the Ministry and connected bodies, the hiring of health care professionals for federal public services (whose role as direct providers was diminished), and affected the expanding state and municipal services, favoring the proliferation of alternative employment methods for health professionals to direct administration in the whole country.

In addition to funding, the debate on health policy was dominated by decentralization, favored by its presence both on the State reform agenda and on the SUS agenda. There were progressive efforts to strengthen the role of the states and push regionalization, especially at the end of the period (2000-2002), in contrast to the previous emphasis on municipal responsabilities and management [25].

As from 1995, the PSF has become a priority on the Ministry of Health and federal government agenda, with a view to expanding service coverage changing the care model. This granted new status to primary care and favored changes in its funding (creation of *per capita* mechanism and specific incentives), its organization (creation of the Department of Basic Care in 2000) and innovations in other areas of the policy, such as training. The focus on primary care was compatible with the health reform guidelines in relation to the health care model and with reform proposals that supported more focalized State action, emanating from international agencies or even from the Brazilian government itself [24].

The national policy for HIV/AIDS control strengthened in the period, with the preservation of the commitment to provide free drugs – in force since 1991 – despite the increased regimes and costs of antiretroviral therapy. This led to the approval of a specific law to guarantee these drugs and to Brazil playing a role in international debates on intellectual property and public health interests, as well as in negotiations with the transnational industry to reduce prices. Pharmaceutical care programs were expanded and diversified, with strategies to decentralize funds for basic drugs and the maintenance of centralized purchases of those earmarked for strategic or high cost programs. Also of note was the implementation of the generic drugs program [26].

Other traditional public health policies – such as infectious disease control – presented aspects of continuity, with incremental innovations, featuring prominently on the federal agenda at critical moments, such as in the case of dengue fever.

In brief, there were institutional innovations in health (in the regulation and funding) and advances during the period in terms of the expansion of specific programs and the coverage of decentralized services. However, the macroeconomic policies, the hegemonic State reform agenda and the ruling political coalition were not favorable to overcoming the structural problems of the SUS. Several decisions and strategies adopted during this period conditioned the paths taken by health policy in subsequent governments.

Health put on the back burner in the (re)orientation of social policy (2003-2010)

Luiz Inácio Lula da Silva, who began his political career as a union leader and founded the PT, was elected President of Brazil in 2002, in his fourth attempt, after a tight race against José Serra, of the PSDB.

In the 2002 campaign, through his *Letter to the Brazilian People*, Lula promised to guarantee the conditions to maintain the monetary stability that had been reached following the *Real* Plan. The emphasis on stability represented an element of continuity in relation to the previous government, although economic policy has shown relevant changes, such as strengthening of the role of the National Bank for Social and Economic Development (BNDES) in supporting national industry [27].

Over the course of the two Lula administrations, there were variations in the economic and political context. The period from 2003 to 2004 was characterized by budgetary restrictions. Economic growth resumed from 2006 onwards, supported by the commodities boom. Despite the global economic crisis triggered in 2008 and the reduced GDP in 2009, in its second term the government managed to implement countercyclical policies with increased public investment, including infrastructure projects (Growth Acceleration Plan – PAC) and increased social spending. Despite some variations over time, some authors have identified the configuration of a "social developmentalism" model [28] characterized by the articulation of redistributive economic and social policies, such as: job creation, regulation of labor relations, increases in the minimum wage and in cash transfers for poor families.

The government was initially supported by a coalition of small parties of varied political profiles, with the Vice-president being a businessman from the Liberal Party (PL). From 2005 onwards, the political crisis triggered by reports of irregular campaign funding and co-opting strategies adopted by Congress motivated a search for support and the concession of offices to the PMDB, whose participation in the governments expanded in the years to follow. Despite the political crisis, Lula was reelected as President in 2006 after a race against Geraldo Alckmin, of the PSDB. Throughout his two terms of office, Lula adopted strategies of political conciliation with several segments of the political class, business class, landowners, among other groups. Controversial issues such as political reform and tax reform have not been tackled.

Foreign policy was a political priority in the period, which was characterized by growing trade relations with China, reduced dependence on international and US agencies, increased national sovereignty and stronger ties with other developing countries, especially those in South America, Africa and other BRICS.

In the arena of social policy, during both administrations, the government prioritized policies aimed at fighting poverty and enhancing the rights of socially vulnerable groups. In the first group, the "Zero Hunger" policy, announced in 2003-2004 – which brought together a series of initiatives to eradicate hunger in both rural and urban settings – was displaced by the central position given to the Family Allowance Program (PBF) in subsequent years. The Ministry of Social Development, created in 2004, assumed the coordination of three relevant lines of action to fight poverty: food and nutritional security, social welfare policies and cash transfer policies. Resulting from the unification of four previous strategies, within a few years the PBF was consolidated as the biggest conditional cash transfer program in the world, contributing to the reduction of poverty and infant mortality in the country, among other outcomes [29]. There was also an expressive expansion of the BPC.

In the second group, initiatives were adopted to expand the rights of women, lesbian, gay, bisexual, and transgender (LGBT) people, black and indigenous people and quilombola communities, including the creation of specific federal departments, legislative and administrative measures. Affirmative action policies included incentives for universities to adopt quotas for black, indigenous and public school students, initially by voluntary adhesion and, as of 2012, by a law applicable to federal institutions. Additionally, plans were adopted to expand federal university campuses in needy regions as well as a program establishing federal grants for low income students in private universities. These actions resulted in greater access to higher education, especially among black youngsters, although access to university remains low in Brazil [30].

Social insurance was the subject of incremental reforms that, between 2003 and 2004, reached the civil service, imposing greater demands to qualify for full pensions. In spite of pressures to contain the spending growth, the social insurance system in Brazil was not privatized, maintaining a solid public foundation.

In health, the government adopted three flagship programs: Smiling Brazil, the Mobile Emergency Medical Service (SAMU), and the Popular Pharmacy. The first two stemmed from previous initiatives, while the third introduced into the SUS copayment for drugs purchased from public or private pharmacies. As an element of continuity, one can highlight the coverage of the PSF, which was reinforced as a strategy to restructure the health care model, by incorporating new professionals into primary health care teams [25].

In the second administration, in light of the developmentalist debate and the stability of Health Minister José Temporão, the sectorial agenda was broadened by means of initiatives related to the industrial health care complex, with a view to strengthening the domestic production of strategic supplies for the SUS.

Although these programs and initiatives were relevant for the expansion of health coverage in critical areas, structural problems were not adequately tackled, for example, those related to health funding, public-private relations, human resources and territorial inequalities in health.

In summary, the Lula governments expressed efforts to change the socioeconomic development model, with employment and social policies contributing significantly to the reduction of poverty, income inequalities and to the rise of part of the working population, in a virtuous circle between fostering internal demand and economic performance. The health policy presented elements of continuity and incremental innovations, but was not a prominent area on the governmental agenda. Many structural problems of the SUS persisted [25].

At the end of 2010, Lula left the government with an extremely high national approval rating and international recognition, and managed to elect his successor after another heated electoral dispute. Dilma Rousseff, former Mines and Energy Minister and Chief of Staff, who had coordinated major governmental investment projects, was the first woman to be elected President of Brazil. Michel Temer, of the PMDB, was on her ticket as Vice-president.

Health exposed to new risks in hard times (2011-2016)

Dilma's first administration encountered a more challenging economic and political setting than her predecessor had faced.

In the economic sphere, the decelerated growth of China and prolonged crisis in other countries set the platform for a slowing of Brazilian growth between 2011 and 2014. The primary drivers of growth stagnated and attempts to stimulate investment through economic policy in the initial years were unsuccessful. In 2014 the Dilma administration changed the course of its economic policy and started to defend austerity measures [31].

In the political arena, the government depended on a broad and heterogenous coalition, in which the PMDB gained power progressively [32], while Dilma lost political strenght. As the presuident's governability declined, conservative agendas grew stronger, culminating in tthe political crisis of 2015-2016 [31].

In mid-2013, a wave of protests, unleashed in São Paulo in reaction to a hike in bus fares, spread through the country, incorporating different motives such as criticisms of the party political system and accusations of corruption. Studies suggest that these events favored the reorganization of neo-conservative movements, with the support of the mainstream media and international groups [33].

Equally of note is the Federal Police investigation entitled "Carwash Operation", which began in 2014 The investigation involves charges against politicians from various parties – from the PT to the PSDB – for receiving illegal funds for electoral campaigns, as well as accusations against businessmen officials and employees of state-owned companies, particularly Petrobras. In the months to follow, and especially during the 2014 presidential election campaign, these investigations would be given huge media coverage, including the selective leaking of information. Despite accusations against members of the PT and allied parties, there was no evidence until that year of any involvement of the former President Lula or of President Dilma, who was reelected after another tight race. The presidential campaign exposed political projects that differed in their commitment to implementing redistributive policies in an adverse economic scenario.

The fourth successive defeat of a PSDB presidential candidate in 2014 (this time, Aécio Neves; in 2010, José Serra had been defeated) led to intensified political polarization in 2015, the first year of Dilma's second term in office. A situation of instability developed, with the President's popularity dwindling, and ultraconservative forces organizing in the National Congress alongside threats of impeachment. The extension of Carwash Operation, the politicization of the role of the Judiciary and the Federal Prosecution Service, the antigovernment stance taken by the mainstream media and the opportunistic behavior of parties from the opposition and even from the administration's base accentuated an atmosphere of political and institutional instability, associated to an increase in projections by ultraliberal economists [34].

In light of this unfavorable economic and political scenario, there was very little room to consolidate a national project to expand social policies. In the first administration there were investments in the social and economic infrastructure, including the implementation of popular housing programs, the continuity and expansion of the policies to eradicate poverty, such as the income transfer programs (Family Allowance and BPC), associated to other strategies, under the label of "Brazil Without Misery".

As regards the pensions system, the reforms were incremental, and included cost containment measures, tax deductions and exemptions from Social Security contributions, which undermined revenues. For federal civil servants, entitlement to full pensions was abolished for new admissions, who were subjected to the same contribution and pension limit as general workers, with the possibility of adhering to the State-managed complementary pension scheme. In December 2014, a provisional measure was published imposing more restrictive rules for access and maintenance of pensions and unemployment benefit. In the second administration, pressure mounted from neoliberal groups for drastic reforms of Social Security, founded on an argument of system deficit, which was criticized by experts [35,36].

Health policy, in turn, was again marked by aspects of continuity in some areas – primary care, epidemiological surveillance – and by the adoption of specific governmental flagship programs, without properly tackling the structural problems of the system. During Dilma's first term in office, there

were two health ministers, with experience in public health and strong ties to the PT. The flagship programs were the expansion of Emergency Care Units (UPA) - another component of the emergency care network – and the More Doctors Program.

The More Doctors Program brought controversy and criticism for the government as it proposed the contracting of doctors who had trained abroad (Brazilians and foreigners) without the requirement to validate their diplomas. Several Cuban doctors were hired through an agreement with the Pan-American Health Organization (PAHO). The program established the expansion of undergraduate and medical residency places; curricular amendments; and the provision of doctors in areas of high social vulnerability and high staff rotation. The incorporation of foreign physicians generated a highly negative reaction from the corporate medical community, represented by professional boards. Despite the short term success of the program, it is hard to measure its political costs for the government and the long term effects on the public health system, since the replacement of foreign doctors will be necessary after three years of their contracts.

Throughout the first administration, key questions for the sector, such as funding and the regulation of the private sector were not adequately tackled. Also in late 2014, a controversial measure supported by the government was the opening of the health sector to foreign capital, including in service provision, which was highly criticized by advocates of the SUS.

In 2015, amid deep political crisis, new events impacted negatively on health. The health minister who had been in office since February 2014 was replaced by a PMDB member of parliament, with the aim of broadening the government's support base. Among the controversial measures implemented by the new minister was the appointment to the post of National Coordinator of Mental Health of a former manager of a psychiatric hospital known for adopting stances contrary to the anti-asylum movement.

From an epidemiological point of view, 2015 would also be marked by the outbreak of the Zika virus epidemic and its association to microcephaly and neurological disturbances in babies (when the infection was contracted by the mother), constituting a new public health emergency.

In 2016, Brazilian health policy delved into a phase of uncertainty and instability with the worsening political crisis, which culminated in the temporary removal from office of President Dilma Rousseff in May and confirmation of her impeachment by the Senate in August 2016. In this setting, significant proposals were launched that further weakened the financial basis of the SUS and strengthened health care markets.

In brief, the period of 2011 to 2016 was marked by political instability and brought obstacles and risks of setbacks for social and health policies, the outcomes of which remain uncertain.

Contradictions and conditioning factors of the health policy

Analyzing the health policy over the last 26 years brings to the fore several contradictions, which can be exemplified in three strategic challenges: including health within the development model and in Social Security, funding and public-private relations.

As regards the first challenge, it should be underlined that the Social Security project consolidated in the 1988 *Constitution* presumed a strong connection between economic and social policies [6]. The development model should articulate these policies to promote sustained economic growth, job creation and income redistribution, in order to reduce inequalities and expand social rights.

Over these last decades, social policy has been institutionalized in varying degrees, demonstrating a lesser or greater focus given to the social area and the role of the State in development strategies [37]. From a macroeconomic point of view, the emphasis on fiscal and monetary stability compromised greater advances in the implementation of universal policies due to the restrictions imposed on State intervention and social spending [22].

Brazil experimented gradual poverty alleviation and inequality reduction, which was measured, for example, by the increase in GDP, average municipal income, individual income, the spending power of families and the level of education of the general public [30]. However, the concentration of income in the wealthiest segments of the population remained high, partly due to the regressive tax system in force [38]. In relation to health indicators, the country has also recorded expressive improve-

ments, maintaining the trends of declining infant mortality and increasing life expectancy, verified in recent decades [30].

These changes involved the adoption of various initiatives, among which one can highlight those of a redistributive nature [28,29]. Nonetheless, problems related to low coordination between governments levels were frequent and efforts towards intersectorial articulation remained scarce.

As regards SUS funding, the levels of public spending *per capita* in health and the government commitment to health spending have remained below those witnessed in other countries, despite the greater stability and expansion in the 2000s [39]. There have been efforts to allocate resources to needier regions, but the persistence of problems with the tax distribution system [40], associated to the cyclical character and low economic and fiscal priority of federal spending [41] have nullified any greater redistributive impacts of sectorial transfers.

Advances from the point of view of greater allocation of state or municipal government funds were counterbalanced by the proportional reduction of federal spending, with autonomy in health spending being restricted by the excess of conditional criteria for the application of transferred funds and by the limitations of the effective legislation. In the 2000s, the differences in the conditions for funding and spending in health between the subnational governments remained significant [40].

In terms of public-private relations in health, it is noteworthy that the increase in the supply of and access to public services during the period occurred concomitantly to the private sector's growth in funding and service provision.

Private spending remained at above 50% of the total health spending throughout the period, composed of out-of-pocket expenditures and payments to health insurance plans [41]. Such spending reflects problems related to the chacarteristics of the tax system and tax exemptions [42,43] as well as limits in health funding due to the deviations of Social Security resources, instability of funding sources and low investments [22].

Private service provision to the SUS have remained high in hospitals and have increased in diagnostic and therapeutic support services and, more recently, in primary care, by means of new forms of outsourcing, such as the contracting of Social Organizations.

One can highlight the expansion of private healthcare plans and insurance, in an increasingly dynamic logic from the business and financial perspective, with the buyout of smaller companies by larger groups, constituting a phenomenon of financialization tied to internationalization. The ANS did not impose any constraints on the growth of this segment. On the contrary, at various times it acted in a capacity to organize and promote these markets, under the command of managers whose professional backgrounds had been built in the sector to be regulated [44]. The opening up of health services to foreign capital, which was formalized in late 2014 (previously vetoed by the *Constitution*), was defended and coordinated within the organization itself [45].

The strength of the private health sector was also expressed in the growing role played by these groups in the funding of electoral campaigns [46] and in the representation of their interests in the National Congress.

Furthermore, the role of these private segments is heterogeneous among social groups (considering income, age, employment), urban and rural areas and regions of the country, given their inclination to obtaining profit. The economic decisively influences the health industry's configuration and its strategies to expand customers and products.

Additionally a substantial part of the work force in health – especially doctors – works in both the public and private sectors, under a variety of arrangements, suggesting an overlapping between the sectors and potential conflicts of interests. Therefore, whereas some of the inequalities in service provision and in public health results are attenuated by the amplification of SUS services – especially in primary care – the dynamism of the private sector, boosted by state incentive, tends to reproduce social stratification and inequalities in health, while remaining susceptible to economic cycles.

The character of the relations between State and markets in health – in which the former fosters the latter, public and private overlap, and the distributive conflict is camouflaged, in a scenario of relatively scarce resources – constitutes the central contradiction of health policy in Brazil in the period and the main obstacle to consolidating an effectively universal and egalitarian public system.

Regarding the limits and pressures exerted on health policy in the reviewed period, the conditioning factors identified fall into three groups: historical-structural, institutional and political-circumstantial.

The first group concerns long term historical legacies and macrostructural factors that impose limits on health policies, such as features of the Brazilian capitalist model, of the State-market relations and socioeconomic inequalities, which explain the persistence of a segmented health system, the character of public-private relations and the inequalities in health. On the other hand, the long tradition of the Brazilian State's role in public health [2], in the control of diseases under surveillance, service provision, production of vaccines and drugs, has bestowed a certain material basis and acknowledged legitimacy of the state in coordinating the health system.

In what regards the institutional factors, the constitutional and legal framework reinforced the political struggle to ensure health as a social right and to implement the SUS, even in contexts in which the neoliberal agenda was hegemonic, such as in the 1990s. Specific strategies implemented in health, regulated by federal norms and funding mechanisms, favored the expansion of public services and the continuity of policies over the course of distinct governments, with incremental changes prevailing. It should be stressed, however, that the *Constitution* recognized health as open to private initiative, and that state subsidies to the private sector were maintained or expanded in the period. Moreover, laws were issued that favored the expansion of private provision in health, such as the Fiscal Responsibility Act (which restricted spending on civil servants) and the laws of Social Organizations.

The conjuncture dimension refers to the political processes, events, distribution of power and relationships between political actors in specific, shorter term circumstances. During the period, the main supporters of the SUS were Public Health organizations, some health authoritites, technicians and health professionals from the SUS in the different spheres of government, health councilors and even members of the Prosecution Service and Public Defenders' Office engaged in the field. On the other hand, the implementation of the SUS was adversely affected by actors who defended agendas based on containing social spending (such as economic authorities) and on expanding private markets (health care companies). The different Presidents defended the expansion of specific policies – adopted as governmental flagships – and, depending on their political leaning, afforded varying degrees of space to progressive groups inside the Executive. There were also groups of actors – doctors and unions – whose political agendas were of an eminently corporate nature, defending points that might favor one minute the SUS, the next the lucrative private sector.

The specific advances, difficulties and conditioning factors relative to each challenge are summarized in Figure 2.

Conclusions

The national health policy in the 26 years of Brazilian democracy presented continuities and changes in different contexts, expressed both in the political process and policy content. The constitutional framework, institutional arrangements and political struggle of public health actors were fundamental for the expansion of specific programs and public services, which in turn bestowed materiality, favored positive public health results and broadened to an extent the support basis of the SUS, at least in the sector.

However, historical-structural limits and institutional legacies were strongly expressed in the period. The character of State-market relations in Brazilian capitalism and in health, and striking social stratification limited the transformations required in order to consolidate the SUS. Historical distortions of the health system, hardly envisaged between 1985 and 1990, related to regulation of Social Security, funding and public-private relations, persisted in subsequent years. There were contextual variations between governments, with influences on social and health policies. However, no national government in the period adopted as a political priority the consolidation of a universal health system, which would entail changes in the political statute of health and Social Security, within a more redistributive model for the State and development. Therefore, structural obstacles in the ambit of funding and public-private relations were not tackled; on the contrary, several State

Figure 2

Advances, difficulties and conditioning factors according to strategic challenges for consolidating the public and universal character of health policy in Brazil.

Strategic challenges	Advances	Difficulties	Conditioning factors
Interaction of health in the development model and in Social Security	Increased social spending, reduced poverty and socioeconomic inequalties and health inequalities. Increased social demands for health services. Efforts to integrate social policies with participation in health (e.g. Family Allowance, Pro-Health program).	Persisitance of high rates of inequalities and concentration of income in the wealthiest group of the population. Low priority given to policies of a universal nature. Low integration between organizations, programs and actions. Vertical (between spheres of government) and horizontal (between sectors of social policy) disconnect. Inequalities in access to public services.	Emphasis in fiscal and monetary stability, with open market economics, increased interest rates, increasing public debt, privatization of companies and limits to industrial policy. Permanence of regressive taxation. Expansion of the domestic market concurrent to public and social spending containment. Fragmented trajectory and segmentation of the social policy. Limited "place" for social and health policy in the development project. Difficulties in implementing the Social Security budget.
Funding	More stable funding with increased public spending *per capita* as from the 2000s. Increased participation of states and municipalities in health funding. Redistribution and increase of federal funds allocation to needier regions.	Cyclical character with low economic and fiscal priority of federal funding in health. Insufficient resources to provide for the financial needs of the SUS. Inequality in the funding and spending conditions in health at subnational level. Low share of investments in public spending in health. Persistance of high State-subsidized private spending in health.	Permanence of regressive taxation and inequality in the tax distribution system. Misappropriation and disintegration of revenues from the Social Security Budget, with adoption and maintenance of the Decoupling of Federal Government Revenues (DRU). Expansion of tax subsidies for the private sector. Instable sources for a large part of the period (*Constitutional Amendment 29* only approved in 2000). Difficulties in regulation and compliance with the constitutionally binded funds for health (*Complementary Law 141* only approved in 2011). Progressive increase in automatic transfers ("fund to fund") and adoption of redistributive criteria for the allocation of federal funds for the SUS in states and municipalities. Predominance of vertical relations (between the federal and municipal level) in the redistribution of fiscal and sectoral resources. Excess of conditions for the application of federal funds (as from the late 1990s) and restrictions on health spending (ex: Fiscal Responsibility Law) in the states and municipalities.
Public-private relations	Increased services and access to public service actions in health, especially at a municipal level and in the sphere of basic care. Increased managerial capacity in several states and in thousands of municipalities.	Expansion of the private sector (for profit or not for profit) in the management of services and in the supply of medical technologies. Growth of the supplemental private sector with segmentation of clientele. Maintenance of inequalities and in access to public health service actions. Strong dependence of the public sector on private health service provision, especially specialized services, diagnostic and therapeutic support and hospital services.	Previous trajectory of health policy in Brazil, with substantial overlap between public and private sectors (in funding, management and service provision). Presence of tax incentives and fragility of the regulation of private providers of the SUS and supplemental private sector. Supplementary segment reconfigured with increased mechanisms of financial intermediation and incentives for the formation of large capitalist groups in the area, involving services, finances and industry, of a multinational nature.

SUS: Brazilian Unified National Health System.

Source: developed by the authors, based on several research sources.

incentives for health markets were maintained or intensified. No coalition of far-reaching power was formed, beyond the health sector, focused on an universalist agenda, which would required drastic ruptures to the economic arrangements in place.

The main limitations of the study include the broad time frame which did not allow important issues to the health system to be analyzed in more depth, for example intergovernmental relations, territorial organization, work management, the health care model and social participation. Another limitation concerns the focus on the Federal Executive's role, with little consideration to subnational actors and other important social actors in federative and democratic contexts. Moreover, the study didn't explore other relevant issues, such as transformations of international geopolitics, in macroeconomics and demographics, which may affect health policies.

Brazil categorically expresses the tensions involved in the construction of a universal health system in a peripheral and extremely unequal capitalist nation. A contradictory situation has developed, in which an universal public system of substantial dimensions coexists with dynamic and growing markets, absorb State funds and families' resources, undermine the consolidation of an egalitarian health system, and reinforce social stratification and inequalities. In view of the historical-structural legacy of the social protection system, of the persisting institutional problems and of the strengthening of neoconservative and neoliberal ideas, at a time of economic and political instability, with Brazilian democracy under threat, there is a serious risk of setbacks in health policies.

Contributors

C. V. Machado, L. D. Lima and T. W. F. Baptista participated in the research, in the design, in the writing and in the final revision of the text.

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Resumo

O artigo analisa a trajetória de condução nacional da política de saúde no Brasil de 1990 a 2016, bem como explora as contradições e os condicionantes da política no período. Observaram-se continuidades e mudanças no contexto, processo e conteúdo da política em cinco diferentes momentos. A análise dos condicionantes da política mostrou que o marco constitucional, os arranjos institucionais e a ação de atores setoriais foram fundamentais para a expansão de programas e serviços públicos, que conferiram materialidade e ampliaram a base de apoio ao Sistema Único de Saúde no âmbito setorial. No entanto, limites histórico-estruturais, legados institucionais e a disputa de projetos para o setor influenciaram a política nacional. A interação desses condicionantes explica as contradições na política do período, por exemplo, no que se refere à inserção da saúde no modelo de desenvolvimento e na Seguridade Social, ao caráter do financiamento e das relações público-privadas em saúde. A ampliação dos serviços públicos ocorreu de forma concomitante ao fortalecimento de segmentos privados, configurando mercados dinâmicos em saúde, que disputam os recursos do Estado e das famílias, restringem a possibilidade de consolidação de um sistema de saúde universal, reiteram a estratificação social e as desigualdades em saúde.

Sistema Único de Saúde; Sistemas de Saúde; Política de Saúde; Política Pública

Resumen

El artículo analiza la trayectoria de la política nacional de salud en Brasil de 1990 a 2016, además de explorar las contradicciones y los condicionantes de las políticas durante ese período. Se observó continuidad y cambios en el contexto, proceso y contenido de las políticas en cinco momentos diferentes. El análisis de los condicionantes políticos expuso que el marco constitucional, los acuerdos institucionales y la acción de agentes sectoriales fueron fundamentales para la expansión de programas y servicios públicos, que confirieron materialidad y ampliaron la base de apoyo al Sistema Único de Salud en el ámbito sectorial. No obstante, los límites histórico-estructurales, legados institucionales y la disputa de proyectos para este sector influenciaron la política nacional. La interacción de estos condicionantes explica las contradicciones en la política durante este período, por ejemplo, en lo que se refiere a la inclusión de la salud en el modelo de desarrollo y en la Seguridad Social, al carácter de financiación y de las relaciones público-privadas en salud. La ampliación de los servicios públicos se produjo de forma concomitante al fortalecimiento de segmentos privados, configurando mercados dinámicos en salud, que se disputan los recursos del Estado y de las familias, además de restringir la posibilidad de consolidación de un sistema de salud universal, reiterando la estratificación social y las desigualdades en salud.

Sistema Único de Salud; Sistemas de Salud; Política de Salud; Política Pública

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