# SUS in the labor sphere: the corporatist tradition of rights and the privatization of healthcare

## O SUS no horizonte trabalhista: a tradição corporativa de direitos e a privatização da saúde

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## Abstract

This article investigates the implications of union corporate behavior for the construction of the Brazilian National Health System (SUS) in Brazil. In view of the union struggle for health care, we analyzed the dynamics of the health insurance market based on collective labor negotiations. By documenting this link, we characterize corporatism as a political phenomenon which, over time, shapes the tradition of labor struggles in a way that weakens the social support base for SUS, by affecting the capacity of political forces to act collectively to overcome the hybridity of public and private interests present in the health insurance market. Against this backdrop, we dialogue with collective health theses, pointing out that studies in this area still fail to fully recognize the centrality of Brazilian unions in the realization of the public and universal aims of the Public Health Reform movement. In conclusion, we suggest that political alignment between health workers and union members is a crucial condition for advancing the struggles and public legitimacy of SUS, something that will be necessary to overcome sectoral fragmentation in health access.

**Keywords:** Corporatism; Unionism; Public Health reform; Supplementary Health; SUS.

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## Resumo

Este artigo investiga as implicações do comportamento corporativo sindical para a construção do Sistema Único de Saúde (SUS) no Brasil. Tendo em vista a luta sindical por assistência à saúde, analisamos o dinamismo do mercado de planos de saúde a partir das negociações coletivas de trabalho. Ao documentar esse vínculo, problematizamos o corporativismo como um fenômeno político que, ao se reatualizar no tempo, conforma um momento da tradição de lutas do trabalho que fragiliza a base de apoio social ao SUS, afetando a correlação de forças políticas em torno da superação do hibridismo público e privado de interesses presente no mercado de planos de saúde. Tendo em vista esse cenário, dialogamos com as teses da saúde coletiva, apontando que a centralidade do sindicalismo brasileiro para a realização dos propósitos públicos e universais da Reforma Sanitária ainda carece de pleno reconhecimento nos estudos da área. Como conclusão, apontamos que a aproximação política entre sanitaristas e sindicalistas é condição fundamental para a ampliação das lutas e da legitimação pública do SUS, para o qual será necessário superar o sentido corporativo do acesso à saúde.

**Palavras-chave:** Corporativismo; Sindicalismo; Sanitarismo; Saúde Suplementar; SUS.

## Introduction

The union struggle for workers' health and its implications for the dynamics of the collective health insurance market is the central object of investigation in this article. Our hypothesis is that the foundation of this relationship is driven, to a large extent, by collective labor negotiations, in which active union participation is critical. Seeking to elucidate this connection, we argue that the market dynamics of private health care are strongly dependent on the principle of political corporatism, which shifts the social base of support of the Brazilian National Health System (SUS) by confining the health struggle to union-based workers.

In different approaches to the study of the Welfare State, corporatism is typically associated with the institutional pattern of state interactions with civil society, where variation among central capitalist countries can be distilled into three models: the contributory-corporatist, the social-democratic and, finally, those recognized as liberal-residual (Esping-Andersen, 1990; Kerstenetzky, 2012). In the Brazilian debate, corporatism is generally associated with the principle of political perversion, closer to an institutional heritage of authoritarian relations between the State and social units than to a constructive experience of democratic citizenship that converges with the construction of a welfare state at the national level (Reis, 2000).

Moving away from these interpretations, to understand our object of study we take corporatism as a political phenomenon that describes a dynamic "social practice," an adaptive behavior, which, iterated over time, has become a political tradition that is updated in new forms of work relationships (Sewell Junior, 1980). From this perspective, corporatism can be considered a political language, the effects of which produce historically ambiguous results for the population at large and for the democratization of the country (Santos, 2014).

Interpreted this way, it is important to note, on the one hand, that the corporatist behavior of unions was undeniably the basis of an expansion of rights over time, such as the 13th salary (holiday

bonus), paid vacation and other provisions present in the Consolidation of Labor Laws (CLT). In political terms, the corporatist framing of the union struggle has been central to the process of redemocratization of the Brazilian State since the 1980s, propelling and affirming social policies that make up citizenship today (Reis, 2000). This analysis, however, must also consider any externalities, such as the segmented and asymmetric genesis of rights. In the case of health, this limitation has proven to be particularly problematic, since the construction of corporate access to health insurance plans restores various dysfunctions that hamper progress toward the universal health access articulated as a goal of SUS.

To build an understanding of the effects of this political practice on the Brazilian health system, this article is divided into three sections. In the first, we use secondary data systematically collected by the National Supplementary Health Agency (ANS), the General Employment Registry (CAGED) of the Department of Labor, and the National Household Sample Survey (PNAD), to investigate, in dialogue with the collective health literature, the degree to which it can be said that the expansion and contraction of the private health insurance market in Brazil is mediated by trends in the formalization of employment. In the second section, we explore the relationship between union behavior and the private health sphere, by investigating collective bargaining practices. In analyzing data provided by the Collective Contracting Monitoring System of the Inter-union Department of Statistics and Socioeconomic Studies (SACC/DIEESE), we document how union corporate behavior influences discussions involving worker health, whether within companies, via "CLT contracting," or in the civil service sector, through various interactions with the State. In this section, we also analyze the frequency of national strikes motivated by the demand for health care.

We conclude by pointing out the political challenges that the corporate demand for health access poses for the construction of the public-universal health system. The strength and entrenchment of the struggle for a segmented and restricted access to care suggest that understanding the political foundations of a labor culture is key to making sense of the fragility of the social base of support for SUS. As we will elaborate, the political proximity between union members and public health workers advocating universalism constitutes an essential path for the public legitimacy of SUS and the consequent confrontation of public underfunding and of public and private hybridity of interests. In this sense, we understand that the political formation of a union movement that is conscientious of public health values requires the incorporation of labor into the collective health movement as a political force in its struggle to affirm the public rights of Brazilian citizens.

## The formalization of work and the anatomy of the commodification of health

According to ANS, in 2020 the supplementary health care sector covered approximately 24.9% of the Brazilian population, corresponding to 47.1 million Brazilians (ANS, 2021). As documented by numerous collective health field studies, the trends in this sector became a decisive object of concern over the course of the 1990s, becoming a structuring theme in the first decade of this century in prominent studies dealing with public health in Brazil (Faveret; Oliveira, 1990; Bahia, 2001; Menicucci, 2007).

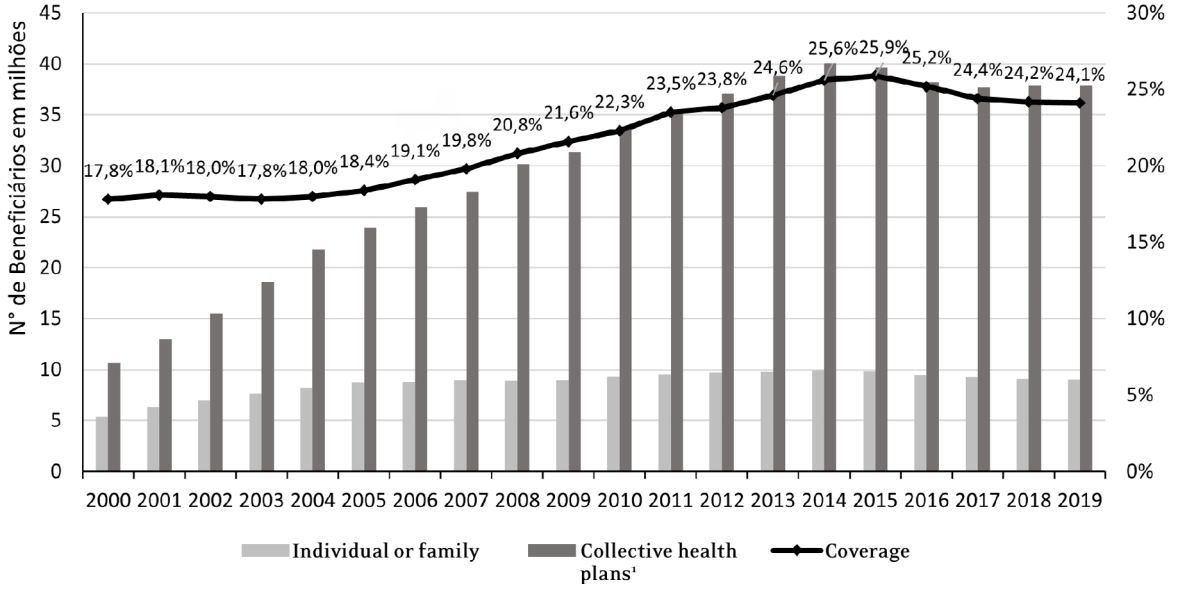
In these studies, four theses from the public health field stand out as an explanation for the expansion of the private health insurance sector in Brazil: (1) the expansion of the financial autonomy of the private sector since the 1980s, which attracted the organized sectors of labor and the middle classes in the face of an "excluding universalization" which was subsequently initiated by SUS (Faveret; Oliveira, 1990); (2) the impact of the institutional design adopted since the 1960s, which reaffirmed State stimuli for this sector over time (Menicucci, 2007); (3) the employer's interest in offering such insurance plans to their workers as a way to reduce absenteeism and encourage productivity (Bahia, 2001); (4) the induction

of economic convergence, in which growth of the health insurance market is predominantly explained by the variation in the Gross Domestic Product (GDP), that is, in the wealth produced in the country in different contexts (Andreazzi; Kornis, 2003).

Despite the undeniable contribution of such studies and the richness of their explanatory detail, they still contain as an invariant feature the undervaluation, or even the absence, of the relevance of organized labor in the expansion of health insurance plans. Considering this framework, we sought to document our investigation which demonstrates that the power and pressure of union mobilization constitutes a political phenomenon that cannot be reduced to a purely reactive condition to variations in the economic sphere, institutional constraints or employer-initiated directives. This argument is not incompatible with the aforementioned theses; it just highlights the relative autonomy of organized workers in the dynamics of public-private hybridity affecting SUS.

Studying ANS records, it is possible to see that in the 2000s supplementary insurance took root as a significant channel for health access in the country, reinforcing recent historical movement toward the normalization of the commodification of health (Menicucci, 2007). In Graph 1, which we present below, it is possible to observe an ascending trend of commodified access to health care which surpassed 25% of the Brazilian population in 2014. Decomposing this trend by plan type, we see that group (employment-based) health plans accounted for 76% of the verified contracts, far surpassing individual contracting plans.

**Graph 1 – Persons insured by private health plans[2] by type of contract and percentage of population coverage[3], Brazil, 2000–2019**




Source: Prepared by the authors based on ANS, 2019; 2021.

[1] Sum of the types of collective plans registered with ANS: company, membership and unidentified collective;

[2] Number of policyholders in the months of September of each year;

[3] Coverage rate reported for the months of December of each year.

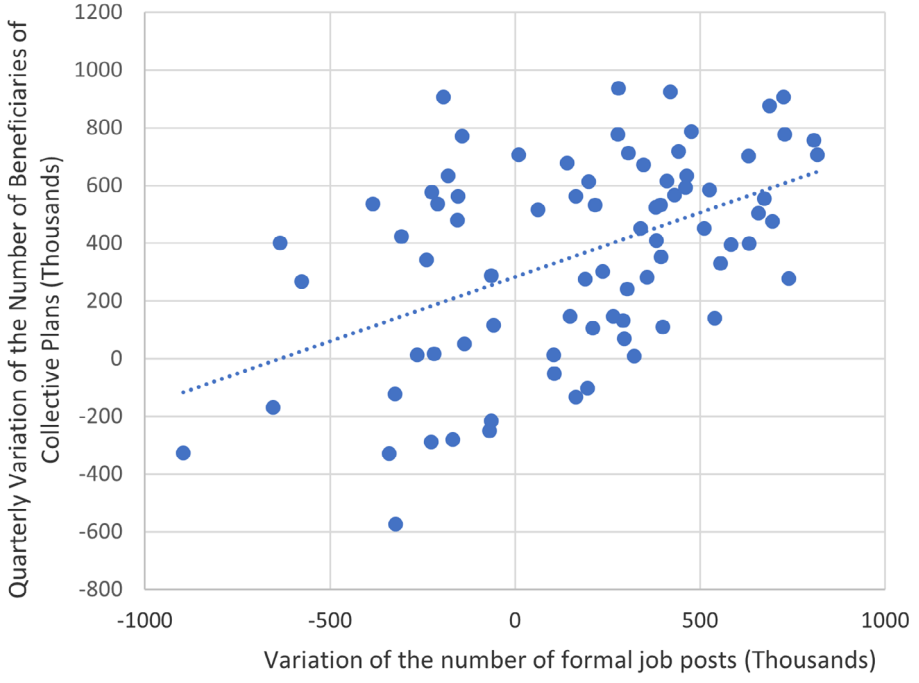
As can be seen in Graph 1, the general increase in consumption of private health plans of any type was accompanied by a reduction in the relative share of individual (rather than group) health plans. Considering other ANS records, it is also noteworthy that the strong dominance of group plans in the private insurance market became a significant phenomenon in the first decade of

this century. In the late 1990s, "Group Access" plans, which are those contracted directly by unions and organizations such as professional councils, associations and cooperatives, accounted for 26.3% of health plans, falling to 13.6% in 2019. In that same time frame, the "Employer Group" plans rose from 38.8% to 69.9% of the total number (ANS, 2019). This market subsumes an important and expanding phenomenon, or so-called "false group plans", whose contracts cover groups of up to 30 people and for which only the presentation of a CNPJ (a legal corporate registration number) is required for its formalization. This is the only method of contracting plans that expanded between 2014 and 2020 (Planos..., 2021).

Considering the general picture shown in Graph 1, the disproportionate evolution between individual and group plans points to the centrality of formal work contracting to support the supplementary health sector in Brazil. This association is evident when we follow IBGE's monthly employment survey reports, which, between 2000 and 2014, indicated, in net terms, the generation of 16.5 million formal jobs - resulting in an average of 1.1 million new positions per year. This information is compatible with the shift of the unemployment rate from 12.4% in 2002 to an average of 5.5% in the last five years also shown in the monthly employment survey (Brasil, 2019). Moving in tandem with this shift in employment contracts, the exclusively collective health plans registered, in net terms, 30.2 million new contracts, reaching an average of 2.1 million beneficiaries per year in the period 2000 to 2014 (ANS, 2019; Brazil, 2019). The association between the dynamics of the formal labor market and the supplementary health sector is also evident between 2015 and 2018, in a context marked by the contraction of both of these indicators. During this period, there was an accumulated reduction of 2.5 million jobs (5%) and 2.6 million beneficiaries of group plans (6%).

As shown in the scatterplot (Graph 2), the association between the expansion of group health plans and the generation of formal jobs in the labor market is statistically significant.

**Graph 2 – Correlation of formal employment and contracting of group health plans in Brazil (2000-2019)**




Note: n=79 trimesters; $R^2 = 0.232$;

Source: Prepared by the authors based on ANS, 2019; BRAZIL, 2019b

Perhaps surprisingly, in light of these data, the process of expansion and the effective commodification of health in the 21st century is still an object of significant controversy in the literature. The dissent stems, specifically, from the divergence between ANS data and PNAD records. As is well known, in 1998, PNAD published its first health supplement. At that time, according to its assessment, 38.7 million Brazilians were already covered by insurance plans, which would correspond to a coverage rate of 24.45% of the population in that year (IBGE, 2000). In the following supplements, in 2003 and 2008, the coverage rate would remain stable, indicating that 24.6% and 25.9% of the population would assume this condition, covering, respectively, 43.2 and 49.2 million people. This striking contrast to the ANS records deserves careful consideration.

As we saw in Graph 1, only from 2010 onwards would the agency's indicators approach the figures that the PNAD had already pointed out to exist since 1998. In this sense, depending on the chosen source, the understanding of the expansion dynamics of the health insurance market in Brazil in the last 30 years changes, and, more importantly, the apparent contradiction weakens the support for the claim that the generation of jobs and the dynamics of formal employment matter for understanding the supplementary care market itself.

In many studies, the disparity in the information seen between PNAD and ANS has been explained by the agency's low institutionalization in the first years of its operations. The argument is that the companies' resistance to providing information on the number of users would have led to a persistent underreporting of their registrations (Bahia, 2001; Duarte, 2003 Menicucci, 2007; Baptista, 2009). According to Bahia (2001), that moment was marked by serious "divergences between health insurance companies and ANS", which sometimes "[transformed] into fierce legal disputes" (p. 339). Duarte (2003), in turn, takes the fact that "until the month of May 2000, only 712 of the 2,686 registered companies" (p. 5) cooperated with the agency as an indicator of the weakness of the information provided by ANS. Another difficulty would be the divergence of contract counting methods, in which the plans measured by ANS would be inflated in comparison with PNAD (Baptista, 2009). However, as a counterpoint, a correction factor adjusting the "number of plans" *vis-à-vis* the "number of people" with plans found more proximate coverage rates across agencies (Pinto; Soranz, 2004).

In weighing the significance of these observations, however, an aspect worth considering that regularly goes unnoticed in existing analyses is that the rates present in PNAD health supplements have always represented the sum of "private plans" and "public plans." ANS, in turn, has always focused on the exclusive measurement of the former. Breaking down these particularities a little more, when disaggregating the data collected by PNAD, we find the following result.

**Table 1 – Coverage by type of health plan (PNAD supplements - 1998, 2003 and 2008 – in millions)**

| PNAD | 1998 | 2003 | 2008 |
|---|---|---|---|
| **Private Plan** | 29 | 34.2 | 38.1 |
| **Public Plan** | 9.7 | 9 | 11.1 |
| **Total** | 38.7 | 43.2 | 49.2 |

Source: Our own preparation based on IBGE (2000; 2005; 2010).

As can be seen, when controlling for the category of exclusively private plans in PNAD supplements, we have the following population coverage rates: 18.35% (1998), 19.43% (2003) and 20.1% (2008) (IBGE, 2000; 2005; 2010). Upon careful scrutiny, PNAD indicators are comparable to the ANS findings, strengthening the argument that the dynamics of the labor market, in which union political action is present, directly impacts commodified care in Brazil.

In PNAD records, the category of public plans includes coverage of state, municipal and military civil servants, such as the Social Security Institute for Civil Servants of Minas Gerais (IPSEMG) and the Medical-Hospital Care System for Army Military Personnel (SAMMED). The inclusion of federal employees in the category of "public plans" was present only in the 1998 supplement, transferred to the segment of "private plans" in the following supplements. In this way, foundations such as GEAP (which maintain an agreement with several

federal ministries and universities) have moved to the accounting category of private care, as well as employees of the postal service, public banks and companies such as Petrobras and Eletrobras.

Beyond these methodological challenges, theoretical issues also allow us to challenge the claim of stagnation of private coverage rates for the first years of this century. As highlighted above, in many studies the expansion of private care that took place in the 1970s, 1980s and 1990s appears, albeit indirectly, associated with the labor market. "Business interests" in the health sector, economic conditions of "labor income," "financial innovations of the supplementary sector" and "State incentives" are frequently-highlighted economic explanations, despite ongoing doubt regarding the central role of union participation in this process (Faveret; Oliveira, 1990; Bahia, 2001; Andreazzi; Kornis, 2003; Menicucci, 2007). Considering the historical evidence, there is no objective reason to conclude these economic factors would no longer be relevant mechanisms in the post-1998 period.

The recognition that formal sector employment is central to sustaining the health market opens the door to understanding the ways union activities structure this sector. As we will see in the next section, the union struggle for workers' health is expressed in different parts of contractual relations and in different labor categories. Situated as a benefit to be achieved in the quest for better working conditions, health insurance plans appear in labor negotiations and as a motivation for mobilizing strikes, leaving no doubt that union action constitutes a central political dynamic important to the understanding of public and private hybridity of interests in the health arena.

## Healthcare in collective bargaining and strike initiatives

The importance of collective bargaining for the expansion of labor benefits and the centrality of union organizations in this process is made evident through Michel Temer and Jair Bolsonaro's repeated attacks on labor protections. With the introduction of unrestricted outsourcing by Law No. 13.429/17 (BRASIL, 2017a), constraints on workers' free access to the Labor Court and the adoption of the "negotiated over the legislated" clause through Law No. 13.467/17 (BRASIL, 20217b), in addition to restrictions on the ability of public authorities and unions to influence the functioning of industry, commerce and services, several CLT articles were changed or outright suppressed. In 2019, Law No. 13.874/19 (BRASIL, 2019a), called "PM for economic freedom," further changed important labor legislation directives. In 2020, with the Emergency Program for the Maintenance of Employment and Income stipulated by Law No. 14.020/20 (BRASIL, 2020), another acute intervention was implemented. Under its protection, the suspension of the employment contract by individual agreement is now allowed, reinforcing the weakening of collective bargaining as a tool to maintain or improve working conditions.

Through this set of transformations, it is possible to observe that the business agenda pays special attention to two platforms: (1) overcoming the legislated model of labor relations, by making collective bargaining infeasible, and (2) increasingly limiting union activities through this concerted institutional shift. This ongoing structural offensive, reminiscent of the 1930s, suggests that the judicial-media-parliamentary coup of 2016, as defined by Wanderley Guilherme dos Santos (2017), was organized, to a large extent, to roll back public rights achieved by Brazilian labor. As in the post-1964 period, the expulsion of workers from the institutional game betrays a willingness to suspend democratic rules (Boschetti, 2006).

As described by Camargos (2009), collective agreements and conventions have become central not only to the CLT labor regime, but also have become consolidated as a practical method of constructing rights for different branches of the civil service - although, in this case, such devices do not have the status of legally-regulated instruments. The analysis of the development of these tools also reveals that there is a historical convergence between the commercialization of health care and the institutional development of this auto-generative way of addressing collective work interests.

Since the 1930s, Brazilian trade union law endows collective bargaining with "the force

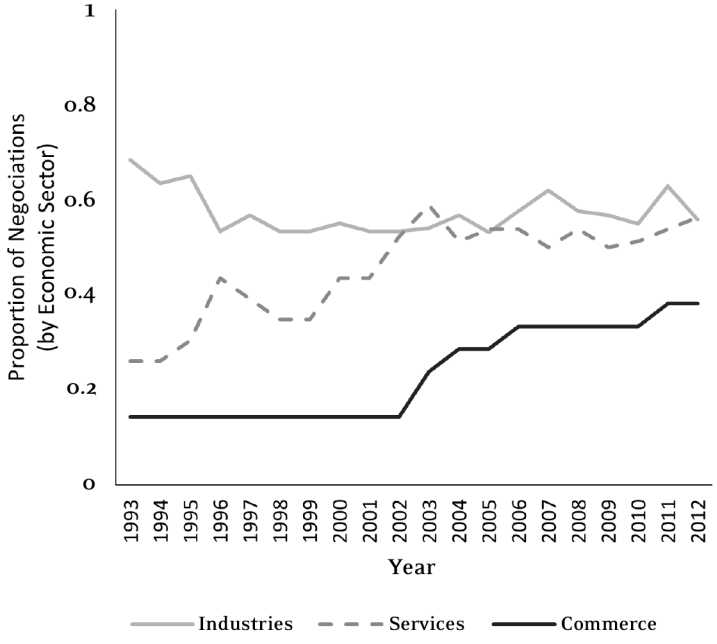
of law", but its centrality in the relationship between employers and employees is the result of a process that took a few decades to develop (Sitrângulo, 1978; Camargos, 2009; Santos, 2014). In a classic study of the legal sociology of labor, Sitrângulo (1978) recorded that between 1947 and 1976, the normative power of the Labor Court had filled the void left by the scarce implementation of collective agreements in Brazil. As noted by Oliveira (apud Camargo 2008), the "historical agreement between the Metallurgists Union of São Bernardo and the Automotive Vehicle Manufacturers Union – SINFAVEA" (p. 81), can be considered a significant turning point favoring the signing of collective agreements that begin without the normative mandate of the Labor Court. In agreement with this observation, Amaury de Souza (1983) identified that, between 1979 and 1982, there had been, in fact, a clear proliferation of collective labor contracts, even though since 1967, with Decree-Law 229, access to Labor justice had become restricted to cases that failed direct negotiation between employees and employers. In his studies, the author also identified that, in addition to salary issues, other themes were becoming routinized agenda items in direct negotiations between employers and employees. More precisely, the strengthening of demands for "working conditions and standards", which would contain provisions for employment stability for pregnant women, injured workers and union leaders, as well as a growing presence of claims for supplemental medical and dental care (Souza, 1983).

According to a survey carried out by the Central Única dos Trabalhadores (CUT), in the late 1980s, workers indicated that access to private health plans and other "social services" were the central reasons for their affiliation with the union (Costa, 1994). The same survey also showed that this policy agenda item was supported by 49.5% of union members in the civil construction, metallurgy, chemical, textile, banking, commercial and public transport sectors in Greater São Paulo. The same motivation was also found in the "agenda of electricians, bank workers, air workers, metallurgical unions in Greater Belo Horizonte and workers in the telecommunications and data processing areas" (Costa, 1994, p. 4).

As we aim to document, the historical convergence between the commercialization of health care and the institutional development of the group bargaining method for reconciling interests can also be understood as a process of political development. It is in identifying the trajectory of transition from public state corporatism, in force since the 1930s, to commercial private business corporatism, consolidated in the 1980s, that we problematize the construction of corporatism as a social practice, a culture of rights. Thus understood, in addition to a purely institutional transformation, the temporal development of this specific behavioral pattern over the course of decades has allowed for its adaptation to the context of labor struggles in the formal employment sector, shaping the evolution of a political conscience that forms a tradition. Understood as an important part of the values undergirding the Brazilian labor movement, the corporatist phenomenon pre-dates the language of universal citizenship embraced by the collectivist public health reform movement and it is, therefore, fundamental to understanding the link between union action and the health market.

With SAAC/DIEESE data, it is also possible to confirm the increased density with which private health care appears on the negotiating agenda for labor contracts in Brazil. The largest database on collective bargaining in the country, SAAC/DIEESE covers 18 Brazilian states, 50 important labor categories and 225 negotiation events (DIEESE, 2006). Between 1993 and 2012, the period covered by DIEESE information, the undisputed expansion of private healthcare-related agendas took on different dynamics in the industry, commerce and service sectors (Santos, 2014). As shown in Graph 3, the popularization of this demand, especially after 2003, became a common theme of the categories under analysis.

**Graph 3 – Proportion of health clauses negotiated in collective agreements, by economic sector, Brazil (1993-2012)**




Source: Taken from Santos (2014).

A qualitative assessment of collective bargaining compiled by SACC/DIEESE shows that the contracting dynamics of the labor categories with respect to the supplementary health market vary depending on company size and the bargaining instrument (whether Agreement or Collective Convention). In corporations such as Petrobras, Correios, Vale do Rio Doce and Ambev, the health clauses present in the Collective Agreements are characterized by a meticulous description of the type of insurance to be offered, detailing, for example, admission conditions and the terms of disenrollment. The analysis of these clauses also reveals a high degree of variation in levels of care across workers, which can be ranked according to an employee's position title and gender. In contrast, when we consider the Collective Agreements, which cover entire categories, the terminology becomes less detailed, presuming that the type of insurance to be offered and the conditions for its use will be determined at a later time, organized according to the economic conditions of each company (DIEESE, 2019a).

A serial analysis of these collective bargaining agreements reveals that the offer of a plan, once secured at a given point in time, tends to be reproduced in future negotiation rounds, indicating an expectation that is reinforced over time (Santos, 2014). This incrementalism in terms of contracted care becomes especially interesting because it helps to understand how access to the supplementary care sector is perceived as a legitimate aim of a class struggle pursued by unions with respect to the employers.

In addition to the presence in Collective Agreements and Conventions, the relevance of private health care for the union milieu can be captured by studying their strike demands which, depending on the situation, can be expansive, maintenance or defensive (DIEESE, 2019b). As Camargo (2009) clarifies, since the negotiated clauses do not definitively pertain to labor relations, once the maximum period of two years has expired, the instability that arises can result in the suppression of negotiated benefits. In 2018, of the 1,453 strikes registered in the country, health care was the third item on the scale of motivations for the initiation of a strike (DIEESE, 2019b). While claims of unpaid wages and wage floor readjustments were the most frequent themes, present in 37.9%

and 37% of the mobilizations, respectively, health care motivated 20.4% of the demands – along with food and transport allowance. Considering only the strikes initiated in the private sector (industry, services and commerce), the demands for health care, always added to the food and transport agenda, reached 29.2% of the motivations for mobilizing strikes, behind only the demands for wage issues. Taking the branch of industry alone, the health care agenda was present in 37% of the mobilizations, while strikes for wage reasons reached 38.1% of the cases (DIEESE, 2019b).

Illustrating this scenario, a nationwide strike initiated in October 2019 by the Interstate Federation of Postal Workers' Unions (FINDECT/CTB) aimed to maintain the benefits of the Collective Agreement signed that year. At the time, along with the fight against postal privatization and for the recomposition of salaries, the agenda included disputes about the Postal Saúde (Health) plan. With the company's attempt to change the cost of the plan and its contributory percentages, legal review became inevitable (Minister..., 2019).

In the four months of disputes that ensued over the terms of contracting the Correios health plan, the National Federation of Workers in Postal and Telegraph and Similar Companies (FENTECT/CUT) and the Association of Postal Professionals joined the struggle (ADCAP). In January 2020, before a new unfavorable decision, the unified report of the federations to their representatives announced: "STF cancels the effects of the injunction granted by the TST and postal workers have their greatest historical achievement threatened, the Health Insurance Plan". As a referral, they pointed out the need to build new "fight strategies that culminate in a major strike in defense of our health care plan and against other government attacks" (FENTECT; FINDECT, 2020, p. 1).

The behaviors that demonstrate the interest of organized labor in the commodified universe of care can be observed at different times. To the evidence presented here, one could add studies of events such as the Forum of Supplementary Health, of 2003, and the Permanent National Forum of Workers on Supplementary Health, of 2008 – both articulated by the Chamber of Supplementary Health of ANS together with various union centers (Santos, 2014). In light of this overview, the synthesis that we hope to highlight is the consolidation of the relevance of Brazilian unionism in understanding and overcoming the public and private hybridity of interests that frustrate SUS and in identifying a relevant basis of support in the market of health insurance plans.

As a relevant political determinant in this process – added to institutional conditions, economic circumstances and even employer interests – the study of the corporatist mode of union action offers a more complex picture of the challenges that have prevented an organic and programmatic unity between union members and public health advocates for universalism. The distance between the ideas cultivated by the Sanitary Reform movement and the concrete expectations of the quotidian worker for their union leaders is not strange. Considering the social dynamics that contribute to the development of political ideas, the analysis of corporatism gains even more relevance when considering that the construction of public health rights unavoidably requires the formation of a broad social base of support. Finally, avoiding the naïve attribution of blame toward labor organizations, it is only with careful investigation of the social practices that led to the construction and cultivation of corporatist values within the Brazilian labor movement that it will be possible to identify ways to overcome the challenges posed for the inauguration of a renewed era of struggles for SUS.

## Final considerations

The formation of a public health unionism presupposes a health movement sensitive to the demands of workers. As we sought to present, the progress historically achieved through the corporatist language of rights is a platform that orients civic expectations towards the demands of the employed. The origins of the universal health reform movement, including studies such as those by Giovanni Berlinguer (1978), situated this challenge by pointing out that mobilizing organized workers was a necessary condition for achieving broader health awareness. Thirty years after the

creation of SUS, the degree of penetration and consolidation of the ideas of the universal health reform movement in the labor environs has yet a lot way to go. The horizontal diffusion of the universal language of health with respect to labor relations is perhaps a political challenge that is best placed on movements and parties within the Brazilian left in general.

In the current situation with the new coronavirus pandemic, the legitimization of the universal health program surrounding SUS may present an opportunity for reorganizing the agenda of a great variety of social movements. Perhaps it could even be said that the universalist aims of the Sanitary Reform movement will find the corporatist culture of rights in a historically unprecedented precarious position: on the one hand, the health insurance sector has failed to offer a feasible solution to the problems that arose with the pandemic; on the other hand, the pandemic has accentuated the employment crisis and the recently-enfeebled nature of collective bargaining powers due to the deconstruction of the legislated model of labor relations. As a consequence of this situation, the commodification of health and the corporatist model of rights may be opened up to a potential and progressive delegitimization.

Based on this understanding, accelerated political efforts to increase employment flexibility in the country – such as outsourcing, temporary work, part-time work, cooperatives, interns and the false self-employed hired as a legal entity – could directly impact the dynamics of supplementary health. The discourse around the so-called "popular health plans" in 2017, and the expansion of "false collective plans", as mentioned above, suggest a phenomenon of adaptation to changes in the composition of the country's job market, particularly with respect to the precariousness of employment contracts. Another key that makes this context of public-private reconfigurations in health more complex is the financial merger of large economic entities in the investment sector controlled by international capital. The disruptive potential of this shift for the causal chain connecting health entrepreneurship and union action we have presented is undeniable and certainly warrants further investigation. In this regard, it is noteworthy that the ongoing decline in employment indicators has not affected the net profit margins of the main companies in the sector – not even in the pandemic.

In this work, our goal was to elucidate the foundational roll of union behavior for understanding the commodification of health. In order to do so, it was necessary to investigate the perceived inconsistencies between PNAD and ANS records to recognize the centrality of collective negotiations in the contracting of health plans. With this development, we seek to enrich the dialogue with the field of collective health, drawing attention to the need to recognize that the corporatism present in labor culture must be understood as a political determinant driving the public and private hybridity of interests that impede the aims of SUS.

It is true that labor's corporatist underpinnings do not exhaustively encapsulate the experience of union struggles for workers' health – nor should this argument be interpreted as the singular causal driver of the proliferation of health plans bought through the private insurance market. Since the 1980s, interest in building SUS has also constituted a substantive part of union discourse. The natural link between unions and the public system appears, for example, in the efforts made to implement the National Policy on Occupational Health and the National Network for Comprehensive Occupational Health Care, which have effectively contributed to the institutional development of SUS, as evident in the national expansion of Reference Centers in Workers' Health. However, despite the weight of this important political advancement, the scope of this analysis is limited to the deconstruction of the relationship between union activity and the process of commodification of workers' health.

In our understanding, the struggles of the employed for the rights of citizenship must be informed by a universal public health awareness to realize the principal historical aspirations for a democratic SUS. In the organic cross-section between the Brazilian public health tradition and the democratic spirit of popular labor struggles lies, without a doubt, the possibility of a renewed chapter of struggles for SUS.

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**Authors' contribution**

Teodoro and Csapo performed the design, writing and data analysis.

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