

Brazilian sanitary reform: dilemmas between the instituting and the institutionalized

Reforma sanitária brasileira: dilemas entre o instituinte e o instituído

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Abstract *The article presents the trajectory of social policies in Brazil and identifies, at each stage, the existing social protection model. It affirms that the Federal Constitution of 1988, when it introduced the concept of Social Security and created the National Health Care System, represented a rupture with what came before. The subordination of the principles of justice and social inclusion, which guided the design of this new social protection model, to a liberal and monetarist policy had important impacts in the phase of implementation of the social policies. However, the dilemma that such policies go through and, in particular, the construction of the National Health Care System must be analyzed from a theoretical perspective that encompasses the agreements and disagreements between the three movements that characterize Brazilian Sanitary Reform, which are: subjectivation, constitutionalization and institutionalization.*

Key words *Sanitary reform, Social policy, Citizenship, Right to health, National Health Care System*

Resumo *O artigo apresenta a trajetória das políticas sociais no Brasil e identifica, em cada etapa, o modelo de proteção social vigente. Afirma que a Constituição Federal de 1988, ao introduzir o conceito de Seguridade Social e criar o Sistema Único de Saúde, representou uma ruptura com o modelo tanto de Estado quanto de cidadania anteriores, em resposta à mobilização social que a antecedeu. A subordinação dos princípios de justiça e inclusão social, que orientaram o desenho desse novo padrão de proteção social, a uma política liberal e monetarista, tiveram importantes impactos na fase de implementação das políticas sociais. No entanto, os dilemas que atravessam tais políticas e, em particular, a construção do sistema único de saúde devem ser analisadas sob uma perspectiva teórica que compreende as convergências e divergências entre os três movimentos que caracterizaram a Reforma Sanitária brasileira, quais são: a subjetivação, a constitucionalização e a institucionalização.*

Palavras-chave *Reforma sanitária, Política social, Cidadania, Direito à saúde, Sistema único de saúde*

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Introduction

The themes of State Reform and Social Security were absent from the leftist discourse in Brazil until the 1970s, when changes in political theory and practice introduced themes such as citizenship and democratic institutionalism in the center of political discussions.

These changes were reflected in the strong commitment of the social movements to the fight for the country's democratization and in the centrality taken on by the National Constituent Assembly, in 1977-78, as a privileged public arena for projects that aimed for a new institutionalism.

In this context, the options for the strengthening of public policies and construction of the bases for a Social Welfare State were seen as priorities, unifying the demands of the more progressive sectors. The construction of a Sanitary Reform project was part of the resistance to the dictatorship and its privatization of the Social Security health services and for the construction of a social democratic State.

This democratic reform that came along with the institutionalism projected in the Federal Constitution of 1988 was harshly confronted by the hegemony of liberal discourse, the predominance of economic decisions over politics and over the very constitutional order and, finally, the well articulated propagation of managerial reform of the State.

The failure of liberal reforms, especially where they were above all a way of legitimizing the deconstruction of the national State, is not enough to take the State reform question off the table. It is necessary to take a balance of the impact of liberal reforms on the institutionalism designed in democratic reform, in relation to Social Security and the National Health Care System, and try to assess in a critical and creative way the current demands of a reform that can take up again the principles and directives advocated in democratization, considering the new context where problems which imperil social cohesion have become more severe, and the need to transform constitutional rights into rights being exercised. For this, beyond constitutional rights, there is a need for institutionalized rights, through effective and efficacious public policies. Once again, this goes back to the existence of a permanent reform process, aiming to reach a relationship of forces that ensures change in power distribution, which implies the permanent construction of political subjects, or subjectivation. In other words, it is about confronting the dilemmas between the instituting and the institutionalized in the current course of Brazilian Sanitary Reform.

Trajectory of social protection

Brazilian social policies developed over an 80-year period, creating a type of social protection model that was only changed with the Federal Constitution of 1988. The Brazilian social protection system, up to the end of the 1980s, combined a model of social security in the welfare area, including attention to health, with an assistance model for the population without formal labor ties. Both systems were organized and consolidated between the 1930s and 1940s, as part of the more general process of construction of the modern, interventionist and centralizing state, after the revolution of 1930. The construction of the national State is a never-ending process, in which power relationship in the institutionalism of the administrative apparatus are constantly being drawn, whether it be directed at the implementation of the economic project, or whether it be responsible for the reproduction of the workforce and incorporating the political demands of subordinate groups.

The choice of a certain social policy format, crystallized in the combination of distinct models for different worker segments, indicates the place that each occupies in a certain correlation of forces, as well as the internationally preponderating trends.

The different social protection models can be summarized as follows¹:

In the assistential model actions, of an emergency nature, are directed to the most vulnerable groups of the poor, inspired on a charitable and re-educational perspective, they are organized based on association between voluntary work and public policies, they are structured in a pulverized and discontinuous manner, generating organizations and programs that are often superimposed. Although they permit access to certain goods and services, they do not make up a social rights relationship, as they are compensatory measures that have a stigmatizing effect. For this reason, I call this type of relationship inverted citizenship, where the individual has to prove that he failed in the market to be the object of social protection.

In the social security model, the social protection of the occupational groups establishes a contractual rights relationship, where the benefits are dependent on past contributions and on the individuals' affiliation to those occupational categories that are authorized to operate a security. The highly fragmented organization of the security expresses the conception of the benefits as different privileges for each category, as the result of their capacity to pressure the government. Since social rights are dependent on the insertion of individuals in the

productive structure, Wanderley G. dos Santos² called the relationship a regulated citizenship, regulated by working conditions.

In the period of populist democracy (1946-1963), the expansion of the social security system is part of a political game of benefits exchange by legitimization of governors, benefiting in different ways the groups of workers that have the greatest bargaining power. This phenomenon became known as the massification of privileges and caused the financial and administrative crisis in the social security system to deepen.

The change in direction that the social protection systems and mechanisms takes after the bureaucratic-authoritarian regime was installed in 1964 follows four master lines: the centralization and concentration of power in the hands of the technocracy, with workers removed from the political game and the administration of social policies; the increase of coverage, incorporating, precariously, previously excluded groups, domestic workers, rural and autonomous workers; the creation of funds and social contributions as a mechanism for the programs to fund themselves; the privatization of social services (especially social ones, such as university and secondary education and hospital care).

In the mid-1970s the struggle for the democratization of policies takes on new characteristics and strategies. Whereas before it was confined to universities, clandestine parties and social movements, now it begins to be located in the center of the state itself. At first, based on innovative experiences developed by the opposition town governments elected in 1974; secondly, in the interior of the central organs, responsible for social policies, seeking to take advantage of the financial crisis and the social policies model to introduce transformation elements; in third place, there is a strengthening of the technical capacities of political parties and parliaments, who start making the social problematic a part of their platforms and projects for constructing a democratic society.

Rescuing the social debt becomes the central theme of the democracy agenda, drawing towards it movements of diverse natures. This process intensifies in the 1980s with the rise of a rich emerging social fabric based on the union of the new syndicalism and the urban reivindicatory movements, the construction of a new opposition party front, and the organization of sector movements capable of forming institutional reorganization projects, such as the Sanitary Movement.

All this democratic effervescence was channeled to the National Constituent Assembly works,

which began in 1987. The construction of a democratic institutional order supposed a rearrangement of social policies in response to society's demands for greater social inclusion and equality. Projected for the social policies system as a whole, this demand for inclusion and reduction of inequalities acquired the concrete connotations of affirmation of social rights as a part of citizenship.

The Federal Constitution of 1988 represents a profound transformation in the Brazilian social protection model, consolidating, in greater law, the pressures that had already been felt for more than a decade. A new period is inaugurated, where the model of social security starts to structure the organization and format of Brazilian social protection, in search of the universalization of citizenship. In the social security model there is an attempt to break with the notions of coverage restricted to sectors inserted in the formal market and loosen the connections between contributions and benefits, generating more compassionate and redistributive mechanisms. The benefits start being granted based on needs, based on the principles of social justice, which demands coverage to be extended universally and integrate governmental structures.

The Constitution of 1988 advanced in relation to the previous legal formulations by guaranteeing a set of social rights, expressed in the Social Order Chapter, innovating by declaring the Social Security model "an integrated set of initiatives by the Public Powers and society, destined to ensure rights related to health, social security and social assistance" (Title VIII, Chapter II, Section I, art. 194). The inclusion of providence, health and assistance as parts of Social Security introduces the notion of universal social rights as part of the condition of citizenship, where before, they had been restricted to the population receiving social security.

The new constitutional social policy model is characterized by the universality of coverage, the recognition of social rights, the affirmation of the duty of the state, the subordination of private practices to regulation based on the public relevance of actions and services in these areas, a publicist perspective of government/society co-management, a decentralized organizational arrangement.

The originality of Brazilian Social Security lies in its strong State reform component, in redrawing the relationships between the federal entities and instituting concrete forms of participation and social control, with mechanisms for articulation and agreement between the three levels of government. The organization of the social protection systems should adopt the format of a decentral-

ized, integrated network, with a single political command and a financing fund in each sphere of government, regionalized and arranged in a hierarchy, with deliberative instances that would guarantee the equal participation of organized society in each sphere of government.

Sanitary reform

Sanitary Reform in Brazil is known as the project and the trajectory of constitution and reformulation of a field of knowledge, a political strategy and a process of institutional transformation. Emerging as part of the struggle for democracy, sanitary reform already exceeds three decades, having attained the constitutional guarantee of the universal right to health and the institutional construction of the National Health Care System – UHS.

The theoretical bases that underlie the construction of this sanitary reform project can be found in the revision of the Marxist conception of the State and the elaboration of a critical reading of the collective health field.

The conception of the State in contemporary Marxism begins with the rupture that Gramsci's work introduces; by understanding the State, beyond its repressive function of guardianship of a class society, as performing a fundamental role in the pedagogical function of construction, consolidation and reproduction of the cultural direction of the hegemonic class. The ethical, or civilizing, State corresponds to the elevation of the masses, through public policies, to the cultural level that corresponds to the development of productive forces. Therefore, the State plays a fundamental role in consolidating the advancement of the civilizing process.

The rescue of the State as a strategic battlefield will be emphasized by Poulantzas³, when he affirms that political struggles are not outside the State as an institutional framework but, on the contrary, they are inscribed in this apparatus, thus allowing it to have an organic role in the political struggle, as the unifier of domination. In this conception of the State it is possible to perceive it as more than a set of instruments and institutions, as a strategic field and process, where power nuclei and network cross which, at the same time, articulate themselves and present contradictions and discords in relation to one another. Therefore the constitutive fragmentation of the capitalist State cannot be taken as the inverse of political unity, but rather as its condition of possibility, which ensures its relative autonomy. The State, its policies, its forms, its structures, therefore translate the interests of the dominant class

not in a mechanical way, but through a relationship of forces that turns it into a condensed expression of the developing class struggle.

Offe's concept⁴ of the State's structural selectivity explains how popular demands, even when they enter the administrative apparatus, are deprived of their political content in the ins and outs of state bureaucracy, thus preserving the limits of the accumulation system, even when it is necessary to also contemplate the requirements of power legitimization.

In his last work Poulantzas³ discusses the relationships between the State, power and socialism, based on the need to understand the democratic route to socialism and the construction of a democratic socialism based on a radical transformation of the State, joining the broadening and deepening of the institutions of representative democracy and liberties (conquered by the popular masses) to the development of direct forms of democracy in the base and the proliferation of self-managing foci.

The problem presented is how to develop a democratic path to a democratic socialism – as it considered that democratic institutions are needed for building a democratic socialism – with struggles that are fought both outside and within the State's strategic field, avoiding the risks of mere transformism, that is, the continuous and progressive state transformation that ends up preserving the updated conditions of domination?

As the strategic struggle for power is considered to pass through the State, it is necessary to perform it in this space always needing to differentiate it from the occupation of positions in government leadership and also from progressive reformism, which is no more than state transformation. What differentiates the fight for socialism, even within the State, is its capacity of provoking real ruptures in power relationships, leading it towards the popular masses, which requires it to be permanently joined to the struggles of a broad social movement for the transformation of representative democracy.

The construction of the sanitary reform project was founded on the notion of crisis: a crisis in medical knowledge and practice, a crisis in authoritarianism, a crisis in the sanitary state of the population, a crisis in the health service provider system⁵. The constitution of Collective Health, as a field of knowledge and social practice space, was framed by the construction of a theoretical problematic founded on the relations of health determination by the social structure, with its coordinating concept between theory and social practice

being the organization of medical practice, capable of orienting situational analysis and defining the strategies for each sector's struggle.

Based on the analysis of work processes and the key concept of the social organization of medical practice, such a movement makes a socializing reading of the problematic displayed by the crisis of commercialized medicine, as well as its inefficiency as a way of organizing a health system which is capable of responding to prevailing demands, democratically organized and managed based on rational planning⁵.

The results of this theoretical-political construction indicate the centrality which action with the State would have as a privileged field for intervention and development of the political struggles. However, this same conception can be held responsible for the structuring of a social movement – the sanitary movement – which is organized from different places, such as the University, the health professionals' unions, the popular movements, the National Congress, around a common proposal.

Health begins to be seen as a concrete and complex object, the synthesis of multiple determinations. Arouca's⁶ definition of it includes:

- a field of necessities generated by the health/infirmity phenomenon;
- the production of health services with their technical-material basis, their agents and institutions organized to satisfy needs;
- a scientific space for the circulation and production of commodities (companies, equipment and medication);
- a space of ideological density;
- a class hegemony space, through social policies related to social production;
- to possess a specific technological potency that allows problems to be solved both on the individual and the collective level.

The political question that springs from this theoretical analysis is relative to the conditions necessary for the politicization and democratization of health process. The relationship between democracy and health is suggested by Berlinguer⁷ when he states that both are abstract concepts and, beyond that, ethical-normative orientations. Although it is necessary to recognize the conflicts of interest and the opposition between conservative and reforming forces, both in the case of democracy and in the case of health, such conflicts cannot be reduced to a classist polarization. On the other hand, from the strategic point of view, the struggle for the universalization of health arises as an intrinsic part of the struggle for democracy, as well as the institutionalization of democracy arises as a

condition to guarantee the right to life as a right of citizenship.

The expansionist strategy of a hegemony in formation is consolidated in health through the Sanitary Reform projects, which seek to solidify:

- the political and institutional recognition of the Sanitary Movement as the subject and leader of the reform process;
- the broadening of sanitary conscience so as to allow the active consensus of citizens (users and professionals) in relation to the transforming process in the sector, as well as the social nature of the determinations linked to the illness/health process and the organization of medical care;
- the rescue of health as a public good, although contradictorily limited by the interests generated by the accumulation of capital. Therefore, it is about expressing the public good character of health by consolidating it through legal regulations and an institutional apparatus that aim to guarantee its universalization and equity⁸.

In order to understand the process of Sanitary Reform, the following explanatory hypotheses have been raised⁹:

- the adoption of an amplified conception of health, as resulting from the forms of organization of social production but also as the fruit of everyday popular struggles, both acting in the formation of its historical and singular concretization;
- democracy is a process of recognition of workers as political subject based on their struggles, in a mutual process of auto and hetero-recognition of sociopolitical identities among different subjects;
- the incorporation of sanitary demands through a set of legal and institutional devices, forming distinct citizenships, is at the same time a result of the correlation of existing forces and an active element in the formation of political and social identities;
- Sanitary Reforms almost always emerge in a context of democratization and are associated with the emergence of the popular classes as political subjects, usually in an alliance with sections of the middle class;
- elements of this reforming process are: the generalization of sanitary consciousness; the construction of an analytical paradigm based on the social determination of health and the organization of practices; the development of a new professional ethic; the construction of an arch of political alliances around the defense of the right to health; the creation of instruments of democratic management and social control of the health system;
- the political character of Sanitary Reform will

be given by the nature of the democratic transition experienced in each national context, that is, whether they are agreed transitions or transitions through the collapse of authoritarianism;

- the format and political content of reform will emerge from the confluence of at least some factors such as: the political-ideological character of the coalition that propels the process of democratization and its clashes with the conservative coalition; the articulation of the Sanitary Reform process with the strategies of transition to democracy; the timing of the Reform in relation to the democratization process; the capacity to alter the prevailing political culture towards the universalization of rights and the guarantee of participatory administrative practices;

- the sustainability of the reform process will depend on the capacity to promote effective change at an institutional control level, the quality of services and the efficacy of actions and services, which will guarantee the preservation of social support for reforms;

- the sustainability of the reforming process will depend on the reduction of the financial and political restrictions to the construction of a broad social protection system; on the capacity to deal with the conflicts generated by the reforming process itself; on the bureaucracy's and health professionals' openness to changes;

- the prospects of Sanitary Reform derive from the reforming coalition's capacity to make effective and timely changes in institutional structures so as to prevent the State from filtering the rationalizing aspects of the proposal and destroying its political basis.

To sum up, Brazilian Sanitary Reform had as its starting point the dual character of health, understood as the possibility of seeing it both as a universal value and a subversive nucleus of social structure. As a universal value, it becomes an especially privileged field for the construction of supra-partisan and polyclassist alliances. As a permanently subversive nucleus of the social structure it indicates an always unfinished possibility in a process of social construction of a democratic utopia.

Sanitary reform and national health care – dilemmas between the instituting and the institutionalized

The movement that propelled Brazilian Sanitary Reform embraced the project of counter-hegemonic construction of a new civilizing level, which implies in profound cultural, political and institutional

change capable of making health viable as a public good. The principles that guided this process were:

- an ethical-normative principle that inserts health as part of human rights;

- a scientific principle that understands the social determination of the health/illness process;

- a political principle that assumes health as a universal right inherent to citizens in a democratic society;

- a sanitary principle that understands health protection in an integral way, from promotion, through curative action, to rehabilitation.

However, the construction of the National Health Care System, approved in the Federal Constitution of 1988, occurred in a context where ideological dispute strongly favored the neoliberal project, reorganizing the relations between State and society on distinct bases from those presupposed by the formulators of the UHS.

The liberal orientations that advocated a strong reduction in the State's presence, whether in the economy or in social policies, were taken up again. For this, instruments were used such as the privatization of state companies or even of social services, the reduction of the scope and/or value of social benefits along with greater difficulty of obtaining them, the introduction of market economy mechanisms such as managed competition in the organization of social services, the reduction of the State's provider role with this competency being transferred to civil profit and non-profit organizations.

Still in relation to the state apparatus, there was a dismantling of professional careers and the knowledge-generation nuclei and strategies linked to the national development project, seen as committed to the logic, populist or interventionist, of the previous economic model, seen as responsible for the State's fiscal crisis.

The predominance of the logic of financial capital accumulation resulted in indebted economies of less developed countries becoming net exporters of capital via interest payments on public debt. Public policy began to have as its central objective monetary stabilization, even when this led to abandonment of economic growth as a result of an interest rate policy that promoted an absurd transference of resources from the productive area to the State, by increasing the tax burden and from the State to financial capital, by paying interest on debt and public bonds.

Culturally and socially there was a transformation which accentuated values such as individualism and consumerism, with the elites and upper middle class sectors ever more oriented towards an American consumer society, in detriment of

values such as solidarity, equality and civic participation. The separation between a middle class alienated from the national reality and the marginalized population of globalization was reflected in health by the existence of a system of private insurance and a public system for the poor, but which the insured turn to in several situations.

The fraying of the social fabric with the strong presence of social movements that had begun to flower in previous decades, and the negation of the expectations solidified with the transition to democracy, result in the absence of social integration mechanisms, whether through an increasingly more informal labor market, whether through social protection policies that do not combat exclusion and inequality, marginalizing population sectors in situations of high risk and vulnerability, which are growing in the big cities. The increase and banalization of violence begin to be everyday in big cities, revealing, paradoxically, the incapacity of electoral democracy to generate social cohesion mechanisms.

In the social policy area the corporate model, with limited access and fragmented by occupational sectors, is replaced by a new model based on the individualization of risk. For those who can pay for their social risks there is an explosion of social insurance offer in areas such as health and retirement. This market expansion occurs whether with the State's consent and promotion through subsidies and fiscal cuts, whether with the absence of an effective regulation that can contain the abuses and disrespect to consumer rights. Only after the strengthening of this market would its regulation be promoted in a new and precarious way, allowing insurance holders to also be UHS users, something which ends up functioning as a type of reinsurance for some treatments.

For the poorest population, the principle of risk individualization takes shape in focused protection programs, with benefits in services or income transference that require proof of need and compliance with certain conditions imposed on the beneficiaries. In this way, social policy starts to function as simultaneous mechanisms of promotion and social control, disconnected from the condition of exercising a social right.

In the ideological struggle for the construction of health as a public value there is an important step backwards, where health starts to be seen as a consumer good and, furthermore, as a consumption model characterized by the absence of pain and suffering, the inexhaustible search for pleasure and construction, on the body itself, of an aesthetic standard of beauty to be reached through successive interventions (from tattoos to plastic

surgery, passing through vitamins and anabolic steroids).

Once again, it is a social model that dismisses social bonds, where the other becomes an object and is not a subject that should be more than tolerated, recognized as equal, while different, in a process of communication in the public sphere.

This context in which the Sanitary Reform movement constructs its institutionalization is, therefore, highly unfavorable and full of dilemmas and contradictions to be confronted.

The construction and materialization of the reform project takes place through three processes which, although simultaneous, have distinct rhythms and these differences generate new tensions and some complementarities. These are the processes of subjectivation, constitutionalization and institutionalization.

Subjectivation relates to the construction of political subjects, constitutionalization deals with guaranteeing social rights and institutionalization deals with the institutional apparatus – including the knowledge and practices – that implement health policy.

Touraine¹⁰ designates *as subject the construction of the individual (or group) as actor, through the association of his affirmed freedom with his assumed and reinterpreted life experience. The subject is the transformation effort of a situation lived in free action; it introduces freedom in what appears, firstly, as social determinants and cultural heritage.* He also states that *An individual is a subject who, in his conduct, can associate the desire for freedom with affiliation to a culture and appeal to reason; therefore, a principle of individuality, a principle of particularism and a universalist principle*⁰.

In this sense, the first stage of the struggle for democracy was also that in which the construction of political subjects capable of formulating and conducting the Sanitary Reform process predominated. If in this case political actors assume a social movement character – the sanitary movement in its various expressions – as institutionalization and constitutionalization occur, new subjects emerge in the political scene and even start to predominate in it.

In other words, the reform's success as fruit of the struggles of this political actor, the sanitary movement, will overcome, contradictorily, this character of a movement coming from a civil society critical of the State, towards political actors that are part of a state institutionality, such as municipal and state health secretaries, prosecutors, reforming bureaucracy.

If the hypertrophy of subjectivation can repre-

sent a trend towards either anomic individualization or “communitarianism”, the hypertrophy of constitutionalization results in the judicialization of politics and the hypertrophy of institutionalization leads to the bureaucratization of the social processes.

In the intermediary stage of the reform there was a growing normalization of the decentralization process, with an entanglement of operational norms and mechanisms for transferring financial resources which ended up guaranteeing the central bureaucracy’s preservation of power, even if this brought about the cooling of politics.

However, the strengthening of institutional political actors such as health secretaries generated growing tensions in the exercise of shared power, causing conflicts that were dealt with based on agreement spheres that had been institutionalized, having generated, in the current moment, the Health Pact that includes the important Pact for Life and Management Pact¹¹.

However, the unequal distribution of resources and power among actors tends to always favor the groups of managers and corporate groups, preventing reform ideals from being realized and guaranteeing the centrality of the citizen user.

This is the greatest challenge in the current stage of reform, which involves not only guaranteeing users’ access but also reorienting the bureaucratic and professional logics, which currently organize the system, towards another logic that, seeing the user as central to the health system, guarantees that his rights can be claimed, that reception is humanized and that care is efficacious and resolvable.

Finally, the current phase of UHS implementation is also characterized by the development of a branch of law that became known as sanitary law. This is the consequence of the constitutionalization of the right to health. However, as the law tends to understand the right to health as an individual right and not as a collective right, it acts on the basis of those patients who, as they possess more information and greater resources, are capable to access it when their rights are denied. By meeting these individual demands the law prevents the planning of health actions and, many times, channels scant resources to individual procedures to the detriment of collective actions.

In this sense, it is necessary to take up again the perspective of spreading sanitary consciousness, as the political consciousness of the right to health, since it has been proved that equality is not created by decree, only through law. Besides, it is necessary to overcome the understanding of the right to health as part of consumers’ right and reinsert it in the set of human rights.

In relation to institutionalism, the UHS operated a democratic reform of the State which, in spite of having to confront all the pressures from governments that adopted a distinct reform model which presupposed removing its state provider role, was able to not only maintain itself but also to serve as a model for reorganizing shared management systems in other areas (such as social assistance and public security).

The State reform model contained in the institutionalization of the UHS was sustainable both for having maintained an organic and active reform coalition and also for making the process advance on the basis of existing legislation, that is, what became known as “the challenge of enforcing the law”. In this sense, subjectivation, institutionalization and constitutionalization worked in a synergic and complementary way.

The UHS can be seen as a model of civic republicanism for its capacity to, along with other efforts, permit republican institutions to regain strength, whether by strengthening the Legislative with the increasingly qualified action of the Social Security and Family Commission and with the suprapartisan action of the Parliamentary Health Front; or in the Law, by developing sanitary right and the action and organization of prosecutors who act in health, or in the Executive by introducing a model of co-management and policy networks.

The UHS reorganized the Executive through the following instruments and processes:

- mechanisms for participation and social control represented by the Health Councils, existing in each of the governmental spheres, with equal representation of 50% members of State and 50% members of civil society. The Councils, beyond being social control instruments, external to the State apparatus, must be understood as “state apparatus components, where they function as institutional gears with validity and effects on the filter systems, capable of operating alterations in the standards of demand selectivity¹²”.

- mechanisms that form political will; the Health Conferences, held periodically at all levels of the system and which, with communicative and deliberative interaction, make all social actors interact in a public and communicational sphere that is periodically summoned. Apart from learning and social recognition mechanisms, this strengthens organized society, which participates in the construction of the system’s broader political features, although with no binding character.

- mechanism for shared management, negotiation and agreement between the governmental entities involved in a decentralized health system. The

supposition of distinct interests and institutional chambers for negotiation of these differences and generation of management pacts is one of the great innovations of this innovative federative model which assumes differentiation as reality and equality as a political principle and institutional goal.

A federalism differentiated by the social and regional inequalities that exist in Brazilian society, but equaled by the creation of decentralization, agreement and participation mechanisms that generate new capacities and local powers.

The creation of the UHS and its periodical revision in order to confront internal differences and the constant threats represented by the absence of needed financial resources and the growing presence of the insurance market has been a constant challenge. Although it can be said that with this the objective of constructing a public value has been reached, in such a way that health policy is now more a question of State than of governments, it is certain is that the incapacity of transforming everyday practices that disqualify the user and strip him of his human rights to dignified reception and efficient care are still a challenge for the democratization of health.

The failure to implement an integral healthcare model, changing the predominant curative model into a preventative one, the failure of improvements in the system management to generate corresponding improvements in unit management, the lack of ethical renewal in the professional health systems,

the dependence on raw materials and medications with prices and production costs by large multinational companies that escape national State controls, and many others, are challenges present in the current moment of Sanitary Reform.

However, the current emphasis on legal and institutional aspects ends up neglecting the need to take up again, permanently, the path of construction of the political subjects of reform. The formation of identities, the spreading of sanitary consciousness, and the organization of social coalitions in defense of radical reform is the only way to overcome the current impediments and deepen the democratization of health.

The paradox of Brazilian sanitary reform is that its success, albeit in adverse and partial conditions, by transforming it in public policy, ended up reducing the capacity for rupture, innovation and construction of a new correlation of forces based on organized civil society. In other words, the institutionalized imposed itself on the instituting, reducing the libertarian and transformative character of reform. Observing that the structural iniquity of Brazilian society now passes through the national health care system makes it possible to take up again the fight for egalitarian ideas that oriented the construction of this project. For this purpose, there remains the question of permanent construction of the subject, the one who will be able to again transform the institutionalized into instituting, in order to become institutionalized again.

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