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The Brazilian Unified Health System: Thirty Years of Advances and Resistance

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Abstract

In 1988, in the context of the re-democratization of Brazil after an authoritarian period, a new Federal Constitution promoted an institutional rupture in the hitherto valid frameworks of health policy, whose origin and expansion until then had been prioritized by the means of insurance restricted to workers inserted in the formal labor market. The constitution has defined principles and guidelines for a reform informed by a publicist perspective and by a conception of health as the right of everyone and the duty of the state, with the corollary of universalization and equality. For this, the unique health system was created. The chapter aims to describe the construction and evolution of the universal health system of Brazil and its results and perspectives. The construction of the universal system from a segmentation legacy, considering the argument that the previous policies defined constraints for the subsequent institutional development, is portrayed. After that, the evolution of the health system and its results and political, financial, and institutional difficulties, also considering the institutional characteristics derived from Brazilian federative institutions, has been discussed. Finally, the country's current political scenario is presented, which points to a new cycle of social policies, including health policy, in the sense of restricting spending and rights.

Keywords: health system, Brazil, universalization, right of the citizen

1. Introduction

After a long period of more than 20 years of authoritarian military governments, in 1988, as a culmination of the country's re-democratization process, a new Federal Constitution was enacted in Brazil. Through this federal constitution, a new political pact was signed not only for the restoration of the rule of law but for a significant expansion of human rights and citizenship, including social rights. Following a trajectory characterized by the structuring and development of a social protection system predominantly corporate-meritocratic, initiated since the 1930s and excluding vast segments of the population, Brazil was in the right step with the pioneer countries that organized welfare systems more robust. And the constitution laid the groundwork for a significant change in both the form of social intervention of the state and the normative and evaluative principles that guide its actions, pointing to a system of universalist protection based on the concept of the right of citizenship.

Among the constitutional changes, it is worth mentioning the introduction of the concept of social security as a more comprehensive form of protection that expresses the idea of the constitution of a network of protection to the social risks inherent to the life cycle, to the labor trajectory, and to the insufficiency of income. In the Brazilian constitutional definition, security comprises an integrated set of actions aimed at ensuring the rights to health, welfare, and social assistance, based on a set of policies with a universal vocation, in addition to expressing an effort to integrate contributory and noncontributory policies based on a broad and diversified funding base.

Particularly in health, the constitutional provisions promoted an institutional rupture in the hitherto valid frameworks of health policy, particularly in relation to health care, whose origin and expansion until then had been prioritized by the means of insurance restricted to workers inserted in the formal labor market. The constitution, which is very detailed in relation to health policy, has defined principles and guidelines for a reform informed by a publicist perspective and by a conception of health as the right of everyone and the duty of the state, with the corollary of universalization and equality. In the 1990s, the process of implementing legal-institutional changes defined in the constitution began, which involved drastic changes in the organization and breadth of the health system. The implementation process was tortuous and conflicting, initially marked by a political, economic, and ideological context, both national and international, not conducive to expansion of spending and state action. However, despite resistance and obstacles, the health policy designed in the constitution was institutionalized, and a universal health system was implemented, with significant results in relation to access, although it is greatly affected by the diverse political and economic conjunctures in which this process has if given, in addition to suffering the feedback effects of previous policies that worked to build a dual system, made up of a public and a private segment.

The recent period, whose results are not yet defined, seems to signal a new cycle of Brazilian social policies in the opposite direction of the Federal Constitution of 1988, in a context of broad political re-articulation and conservative nuance. A broader process of institutional change is under way that signals the reduction of social policies in a context of strong fiscal adjustment and market valuation, in which policies move away from a constitutional normative idea—rights to be guaranteed by the state—and pass to be seen as costs to be reduced due to a supposed exhaustion of funding capacity.

This chapter aims to describe in an analytical way the construction and evolution of the universal health system of Brazil and its results and perspectives. With these objectives, the next section portrays the construction of the system from a segmentation legacy, considering the argument that the previous policies shaped a certain trajectory and defined constraints for the subsequent institutional development, forging, in fact, a dual system, though formally universal. Section 3 discusses the evolution of the health system and its results and political, financial, and institutional difficulties, adding to the analysis the institutional characteristics derived from the format of the Brazilian federative institutions. Finally, Section 4 aligned some conclusions and points out the trends currently that endanger the Brazilian health system.

2. The construction of the universal health system

Assistance to individual health as a public policy was developed in Brazil incorporated into social security benefits and until the Federal Constitution of 1988 was primarily a benefit linked to the formal work contract, not constituting a public benefit to which the entire population is entitled. Another expression of

this insurance perspective is the dichotomization that was established in health policy until the end of the 1980s, expressed in a functional and institutional differentiation. The Ministry of Health was responsible for the actions of a collective nature in the form of health campaigns and some basic assistance actions of restricted scope. Social Security, in the various institutional formats that it assumed throughout its trajectory, was the responsibility of individual health care, restricted to the insured and their dependents, which left rural workers and those without a formal employment relationship unprotected. The “regulated citizenship,” a conception that expresses the relation between occupation and citizenship, was in force in Brazil, which recognized certain social rights to sectors of urban salaried workers [1]. Among these rights, health care is included, even if secondary to social security benefits.

It was only in the 1960s that there was a substantial expansion of social security health care. This expansion took place largely, particularly in the case of hospital care, through the purchase of services, using the private service network, which developed independently in the public sector [2]. From the 1970s, there was a stagnation in the relative capacity of the public hospital network that remained practically unchanged until the 1990s, which had as counterpart the growth of the importance of the private hospital network¹.

In addition to the purchase of services, another form of articulation between Social Security and the private sector was through the establishment of agreements with companies under which, through a subsidy, the company would assume responsibility for medical care for its employees. In most cases, instead of directly providing the medical services, the company purchased the services of another specialized company, called “group medicine,” “medical company,” or “medical groups,” establishing a triangular agreement between the social security, employer, and medical company. The practice of this covenant favored the expansion of group medicine, restricted to the areas of great concentration of large employer companies, usually located in the more developed regions of the country [4].

Gradually, this form of private health assistance is taking up more space than public assistance in large enterprises on the south/southeast axis—the most developed region of the country—and will be the pillar of the supplementary assistance that will be developed in the following decades.

New forms of inequalities between different strata of workers are introduced in this form of medical care. In general, the agreements were established with large companies, with more specialized labor and higher wages. Medical groups also tend to focus on the more industrialized and urbanized regions. As a consequence, during the 1960s and 1970s, service differentiation would not occur between professional categories but between professional qualifications [5]. Encouraged and legitimized by the public initiative of the agreements, the eminently private forms of health care thereafter developed, which included a great diversity of possibilities of alternative plans and contracts. The different forms of differentiation recreated the particularistic demands of another nature, this time linked to the employment contract and no longer to the professional category.

The counterpart of the option to purchase private health services was the low development of state capacity, mainly for the production of hospital services, which made the public power dependent on the private sector for the expansion of health care. At the same time, the regulatory capacity of the state has not developed, which was strongly captured by private interests. This situation will translate into the prominence of private interests over collective ones, as well as the increase

¹ As of the mid-1970s, the number of private hospital beds already corresponded to more than 70% of the country’s hospital beds [3].

of the expenses of medical care to levels that would end up compromising the governmental financing capacity of the assistance [4].

A legal instrument, established in the 1980s and in force until today, was the tax waiver that started to function as an indirect state incentive for companies to maintain health plans for their employees. As a result, companies obtained legal permission to pass on their employees' health expenses to product prices, computing health-care expenses as operating costs which is therefore subject to deduction of gross income for the purposes of income tax. Through this indirect incentive, the public decision contributed to the expansion of private health care within companies, already properly structured for this since the 1960s and 1970s, when they had direct incentives.

The same incentive was given to the individual option for private health insurance. The tax policy began to allow deductions of the taxable income of the individuals for the purpose of payment of the income tax and, in this way, contributed to the insertion in the private health insurance or even for the use of the liberal medicine (direct disbursement) of people from the highest income strata. From the point of view of the legitimization of public services, the tax break further weakens the public sector, by favoring the exclusion of its coverage from citizens with greater purchasing power, whose behavior, indirectly, is stimulated by tax policy.

In the 1980s, private assistance ceased to be complementary and became supplementary, becoming autonomous in terms of both funding and how to attract clients. There is a significant expansion of the private forms of health care, both by expanding coverage of business health insurances for service sector workers and of the south/southeast axis and by the autonomous commercialization of health plans due to the migration of clients who paid directly service providers for health insurances as a result of aggressive strategies to expand health insurance markets [6, 7]. By the end of the decade, the private sector was consolidated and quite vigorous.

The worsening of the social security financial crisis in the 1980s marked a moment of inflection, with the emergence of proposals for alternative policies for the health system that emphasized the reversal of the model that privileged private service providers through the channeling of social security resources to the public sector. More or more important than the financial crisis of welfare and the incapacity to sustain this model is the coincidence of the crisis with the process of democratization of the country, which puts on the scene other political actors. In a context of political struggle between alternative health policy projects, it will be possible to change the configuration of the medical assistance model, within the scope, however, of the constraints arising from the institutional configuration of health policy then in force, and whose main features were:

- a. The principle of regulated citizenship: health care as a work-related benefit, not as a project of universal and equal inclusion. Parallel to the growth of public health care in a universal sense, the segmentation is recreated through the insertion of some workers in private forms of coverage, favored by public incentives.
- b. The option to purchase private services: public assistance is developed through the expansion of the private service network and the atrophy of governmental capacity, both the provider and regulator.
- c. The development of a set of private institutions such as group medicine, medical cooperatives, health insurer, and self-management systems (assistance managed by the employer).
- d. As one of its consequences, this policy has led to the constitution of a set of institutions and actors and interests. Among the interests constituted, besides

the businessmen of the sector, are the beneficiaries of private health insurances, particularly the employees of the companies and public institutions that administer or contract health insurances. By having access to differentiated assistance, they become their supporters, explicitly or implicitly.

In the midst of the country's democratization process, significant changes were enshrined in the new constitution enacted in 1988. The health reform was the result of a broad and victorious political-ideological movement, called the sanitary movement², which developed since the mid-1970s, in the context of the authoritarian regime and the struggle for the re-democratization of the country. Opposition to the military regime included the struggle to broaden social policies and redefine them toward universal benefits. The discussion of the "democratization of health" was made more intensely via the "sanitary movement," which achieved a high degree of organicity and great political visibility, and played a relevant role in the reformulation of health policy.

The formation of the health policy reform proposal involved the theoretical construction of a model of understanding the social determinants of health and a set of strategic actions aimed at the dissemination of ideas, the articulation of people and organizations, and the occupation of institutional spaces for experimentation of innovative projects as a mechanism to constitute an alternative to the current policy. Of academic origin, the health reform movement managed to articulate a diverse set of actors, such as the medical category, the "popular health movement," bureaucratic segments, and the municipalist movement, made up of the secretaries and municipal health technicians. One of the political strategies was, on the one hand, to act in the parliament as a place for public debate on health and the organization of the movement and, on the other hand, the involvement with elections of deputies, mayors, and councilors who had health on their electoral platforms and were linked to the more general issue of democratization [8]. In the context of dissatisfaction with the authoritarian regime and in the movement to establish a new pact in the country, it was possible to overcome sectoral or corporate goals and interests in affirming an alternative to the health sector, whose main content was universalization and public responsibility, as opposed to the current segmented and hybrid model.

The new constitutional charter indicated a broad reform in current policy, both in its normative principles and in its organizational format, which significantly altered the previous pattern by breaking with the meritocratic character of health care and incorporating it into the idea of right of citizenship, besides breaking with the previous dichotomization between actions of a collective nature and individual actions. This right to health was defined in the constitution comprehensively as follows:

Article 196. Health is the right of all and the duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other damage and universal and equal access to actions and services for their promotion, protection and recovery.

This definition includes two dimensions. Firstly, the understanding of the social determination of health, indicating that social and economic policies should contribute in reducing the risks of becoming ill, so that the right to health is not limited to access to health services but supposes that all must have the opportunity or appropriate conditions to reach their health potential. Secondly, the definition indicates a public policy guideline for guaranteeing health actions and services,

² According to Gerschman, the so-called "sanitary movement" was "a narrow group of intellectuals, physicians and political leaders of the health sector, mostly from the Brazilian Communist Party (PCB), who played a prominent role in opposition to the military regime, as well as a specific political trajectory in the area of health" ([9], p. 41).

guaranteeing universal and equal access to them, expressing a criterion of universal and equal justice in the relationship between the state and citizens.

The focus on the process of implementing the constitutional reform will be equal access to actions and services. In order to give materiality to health policy, the Unified Health System (SUS) was established, defined as the set of public health actions and services provided by federal, state, and municipal public bodies and institutions, since Brazil is a federal state formed by three federative entities with administrative, political, and financial autonomy: the Union, the states (in number of 26), and the municipalities (in number of 5570), besides the federal district constituted by the capital of the country.

The SUS has the following principles: universality of access and gratuity at all levels of health care; equality in care, without any preconceptions or privileges of any kind; the integrality of care, which involves an articulated and continuous set of preventive and curative actions and services, individual and collective; community participation in the process of formulating guidelines and priorities for health policy (by means of health conferences) and in the control and evaluation of actions and services implemented (by means of health councils) at all levels of government; and the political-administrative decentralization, with emphasis on the decentralization of services to the municipalities and the regionalization and hierarchization of the service network.

The SUS funding, defined by the Federal Constitution (FC) of 1988 and amended by the constitutional amendment (CE) in 2000, was defined as the competence of the three federal entities that make up the Brazilian tripartite federation, through resources from its budgets, in addition to including social contributions³.

As a precursor among developing countries, Brazil was thus establishing, at least from the formal point of view, at the end of the 1990s, a public system of universal coverage defined as an obligation of the Brazilian state. Thus, it preceded what was defined in the WHO Resolution 67/81 on December 12, 2012, which reaffirmed “the right of every human being to the enjoyment of the highest attainable standard of physical and mental health, without distinction as to race, religion, political belief, economic or social condition, and the right of everyone to a standard of living adequate for the health and well-being of oneself and one’s family” and recognized “the responsibility of Governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health-care services” [10] and to ensure that all people obtain the health services they need without suffering financial hardship when paying for them.

However, the reform of health policy in the late 1980s, which established the universal and public system, failed to incorporate all citizens into free public health care, since some of them were already tied to private forms of assistance. In the constituent process, two opposing visions of health care, defined as “statistic” and “privatizing,” were made explicit. If the former represented the innovative perspective of the actors that articulated around the reform, the second represented the interests and conceptions forged in the health policy trajectory as feedback effect of the system in force for more than two decades. Only proponents of the ideas of the health movement had more elaborate proposals, the result of a long process of theoretical development and political articulation. The movement was able to use its knowledge as a power resource in the decision-making process and in the definition of alternatives, making its main proposals reinforced by different categories such as the Central Única dos Trabalhadores (Central Office of Workers), trade

³ Social contributions in Brazil refer to a specific type of tax destined exclusively for the costing of social security, some of them for social insure costs and others for noncontributory welfare benefits (health and social assistance).

unions of health professionals, and the Council Federal of Medicine, besides part of the members of the constituent assembly. However, the possibility of an abrupt change in the health system based on the universal and public proposal provoked the mobilization and demonstrated the weight and articulation capacity of both representatives of private institutions (group medicine, medical cooperatives, and insurance companies) and private services providers, united in the defense of the pluralism of the forms of health care and of the “freedom of choice.” These actors have demonstrated significant veto power, and, although they have not been able to overcome the most significant institutional changes, particularly the creation of a public system of universal access, they have ensured the preservation of previously established arrangements related to private health care [4].

The constitutional text reflected the agreements between these different actors, and its ambiguities reflect the adjustment between innovative alternatives and consolidated standards. The result was the juridical-legal conformation of a hybrid and segmented system that, while, on the one hand, consecrates health as a right, guarantees universality of access to health care, increases state responsibility, and defines the constitution of an inclusive system, on the other hand, preserves market freedom and ensures the continuity of private forms of care, regardless of any governmental intervention.

The change was made possible by an exceptional situation of building a new social pact in the process of democratization and in a situation favorable to institutional imbalances, within the framework of which a new legal framework for health was constituted. Within this framework, it was possible to modify the sectoral political arena with the incorporation of new actors who had alternative proposals, which were confronted with those constituted from previous policies. The public health-care crisis, which translated into widespread dissatisfaction, was another factor that favored institutional change, insofar as the health movement knew how to present an alternative to the crisis, place it on the agenda, and obtain political support for it. In this process, an epistemic community was constituted, whose influence was translated into changes in the political process, because it was able to mediate between the crisis and the choices made and to provide a consistent and widely supported proposal. In the democratic transition, a “political window” was opened, so that the problems of the current policy, associated with the broader political process of democratization, converged in such a way as to allow non-hegemonic political forces to decisively influence the formulation of health policy, giving rise, at a specific moment, to the emergence of a policy informed by a publicist ideology and by a conception of health as a right, having as corollary universalization and equality.

The choices defined in the constitution ensured the continuity of the reform with some degree of continuity, in a process of innovation pressed by interests and objectives that had been constituted as a result of previous policies, which limited the possibility of discontinuous changes but at the same time expressed institutional dynamism when defining a reorganization of the public health system.

3. Implementation and evolution of the health system

In the 1990s, the implementation of health reform began, which included, among other things, the transition from a system that was restricted to salaried workers to a universal system; the decentralization of management to autonomous government units from the political-administrative point of view, replacing a highly centralized model; the unification of previously separated structures and activities (collective actions and individual assistance); the expansion of supply and the reorganization of

the health-care model; and the introduction of new management mechanisms that include the participation of society after a long period of restrictions on freedom. This was a major challenge especially for a country with more than 5000 municipalities and deep inequalities between them, both in the capacity to provide services and in socioeconomic conditions and in the health situation and needs [11].

The political conditions for implementing the reform were not very favorable. These include the national and international context marked by the reordering of the role of the state and the state-market relationship in favor of the second and of restriction to universalist policies; the conservative configuration of government coalitions that succeeded the period of democratic transition, in tune with the international environment, which prioritized the processes of adjustment and economic stabilization, accompanied by structural reforms, in the opposite direction to the expansion of government functions and rights enshrined in the constitution; the fragmentation of the health movement and the idealizer of the reform, from the process of democratization, when its heterogeneities and party cleavages were evidenced; the absence of organized support from the main beneficiaries of the SUS, located in the lower social strata; and the fragile and contradictory support of the organized segment of the workers, the majority covered by private health ensures and who did not have immediate interests in a universal system and usually included in their labor agenda the supply of these ensures.

Given the redistributive character of the health reform, broader coalitions would be necessary for its effectiveness, which proved to be very difficult given the political composition of the health arena constituted by different actors and interests configured throughout the health trajectory, as providers of private services, various modalities of health insurance operators, users of private health insurance, etc.

To reach the ultimate goals of the reform, financing was an indispensable resource, involving not only the volume but also the way federal resources were transferred to states and municipalities, since decentralization was made dependent on federal resources. There is a great consensus among analysts and managers in Brazil that financing has been the greatest obstacle to the implementation of the constitutional right to health, but politically the process of its definition has been conflicting, in contexts of restrictive spending policies and lack of definition of sources of financing. After a period of great instability in funding and as a result of pressure from the defense coalition of the SUS, Constitutional Amendment No. 29 was approved in 2000. This amendment defined minimum resources for the financing of public health actions and services in the form of linking budgetary resources of the states and municipalities to health (12 and 15% of their revenues, respectively), and although it established fewer binding rules for the Union, it linked its spending to GDP growth.

Contradictory, in 1998, while discussing the linking of resources to the SUS, the Law 9665 was approved, which regulated private health insurance and plans, and indicated the government's interest in leveraging the growth of the private market. This regulation formalized the duality of the Brazilian health system and politically weakened the proposal of a universal system, although the regulatory process was made independently of national health policy and without even denying or officially redirecting it.

The application of CE 29 has in fact established a sharing between federated entities of health spending and allowed for greater stability in financing, in addition to continuous resource growth, particularly by increasing the expenditures of subnational entities, with a progressive relative decrease in the participation of the Union in the costing of the SUS, although it is still much higher than the expenses of other federated entities (**Table 1**):

	2000	2010	2017
Municipalities	21.7	28.5	31.1
States	18.6	26.4	25.7
Union	59.8	45.1	43.2

Sources: SIOPS/MS [12]; Piola et al., 2018 [13].

Table 1.
Public expenditure on health care by government sphere (%).

However, there is a consensus that resources are insufficient to finance a universal system. In addition to spending relatively little on health (only 6.8% of total public spending and 3.8% of GDP), public health expenditure was US\$439.61 in 2014, corresponding to only 46.4% of total spending in health [14]. Pressures for the expansion of resources destined to SUS permeate the history of the sector. A positive response from the National Congress in this regard was the approval of Law 12,858/2013, which included health in the sharing of resources derived from oil royalties, in a context in which the country celebrated the discovery of oil reserves in the pre-salt layer.

Even within a framework of underfunding considering the characteristic of the universality and integrality of the right to health in Brazil, relevant efforts have been made since the 1990s to make these principles a reality. There was, in fact, the implementation of a universal system with a certain standardization of health policy in a country of continental dimensions. This was favored by federal coordination exercised by the federal government, particularly in the form of incentives and regulation of financial transfers, as well as in the form of federative pacts. The SUS is responsible for the vast majority of health services provided in the country and for the total coverage of approximately 75% of the population, since approximately one quarter of it is a beneficiary of private health insurance. In addition, it serves the total population for certain procedures—cases in which the situation of double coverage of citizens with private coverage is characterized since they do not fail to justify universal public service. These procedures include emergency and emergency care, the use of the Mobile Emergency Care Service (SAMU), blood transfusion, transplants, vaccination programs, some high-cost procedures, and, of course, all actions of a collective nature that affect the population as a whole, such as sanitary and epidemiological surveillance. For example, in 2018, the SUS financed more than 11 million hospitalizations and performed more than 3 billion outpatient care [15].

One of the SUS's guidelines is integral care, with priority for preventive activities. Since the 1990s it has been sought to reorganize the care model, seeking to revert the logic of emergency care, generally focused on hospital care, which had characterized health care until then, but with high cost and low effectiveness. To that end, policies and actions were defined, along with financial incentives from the Union to strengthen primary health care more strongly in the 2000s.

SUS is present throughout the Brazilian territory, including isolated indigenous villages and rural settlements, even with regional and local variations due to diverse financial capacity. The distributive and regulatory role of the federal government is fundamental to allow more homogeneity of assistance. The Brazilian public health system is conceived as a federative pact between three government entities and, based on their articulation and cooperation, aims to guarantee the universality and integrality of health care throughout Brazil. Although there is a sharing of functions, the central government concentrates the authority on decision-making process and in the policy regulation, while subnational governments, particularly municipalities, as federated entities with political autonomy, are responsible for

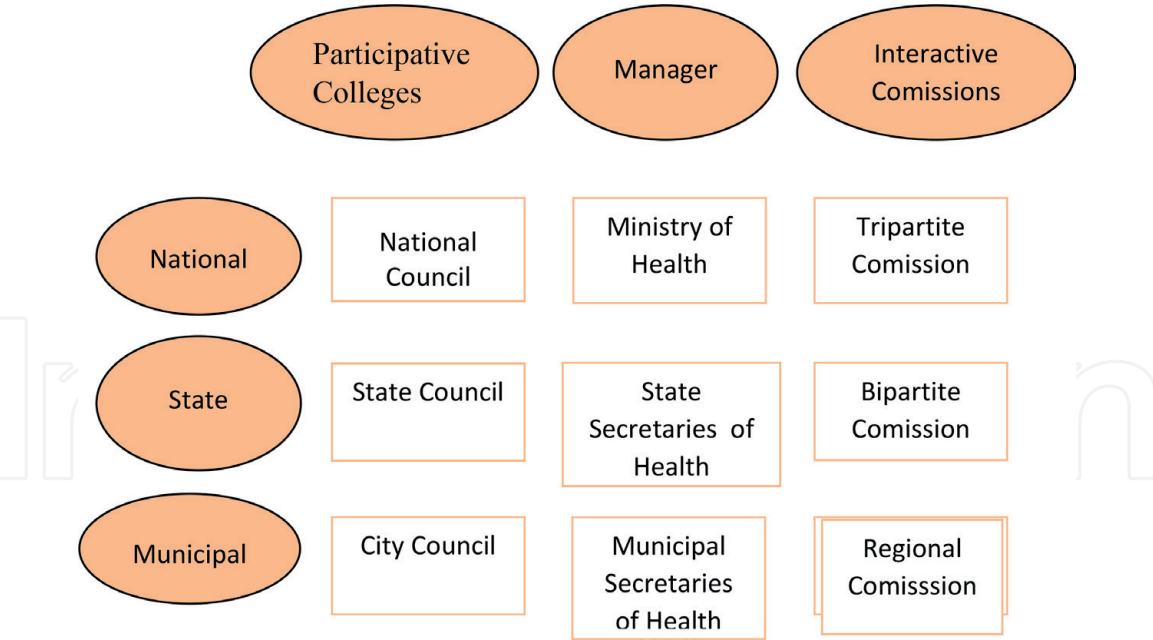


Figure 1.
Institutional and decisional arrangement of SUS. Source: Adapted from Noronha et al., 2008 [16].

policy-making; the states are expected to play the role of coordinating federative pacts between municipalities in their respective jurisdictions and may also be responsible for the provision of more complex services. Institutionalized (tripartite, bipartite regional) committees with normative power aggregate the managers of the different levels of government and are spaces for negotiation and agreement on administrative and financial issues, functioning as federative arenas that articulate the federated entities with shared functions in a national health system organized according to national and binding rules.

It is also worth noting that the participation of society is legally provided by deliberative councils and health conferences, both at the three levels of government. These collegiate instances complete the institutional arrangement of SUS, as illustrated in **Figure 1**.

4. The political turn and the environment of uncertainties: 2015–2019

The materialization of the right to health through the implementation of a universal health system is the result of the post-constitution democratic governments that were challenged to implant SUS, even resistant or facing resistance to the change of status quo. In the 1990s political-institutional advances led toward institutional reorganization, such as the unification of the policy; the construction of the institutional and decision-making framework of the SUS, respecting the federative organization and the social participation guideline; the decentralization and strengthening of municipal health systems; the expansion of actions and services in the national territory; the initial efforts to reorganize the care model with emphasis on primary care; and, at the end of the decade, the definition of new and stable sources of financing. Paradoxically, also at the end of the decade, the regulation of private health plans was formalized, formalizing the dual nature of health care and the cleavage between population covered by private insurance and that covered by the public insurance.

In the twenty-first century, from 2003 to May 2016, Brazil had national governments headed by presidents of the Workers’ Party (PT), whose main brand had focused on social policies and the search for reduction of inequalities through development with inclusion. A set of social and economic policies of the period

had a potential impact on conditions and health status, acting on the first dimension of the right to health defined in FC 1988. The fight against hunger and misery deserved special attention, including income transfer programs and agrarian development policy, besides fight against racism and racial inequalities, constitution of social assistance policy, growth of the social security coverage rate through measures aimed at reducing informal work, implementation of an urban development policy, and recovery of minimum wage values.

However, starting in 2015, one of the country's biggest political and institutional crises begins, with strong repercussions on the future of Brazilian social policies, including health policy. President Dilma Rousseff from the start of her second term in 2015 had the subject of a strong campaign for her removal and the target of an oppositional attack that manifested by the total boycott of her government and the government's capacity. Started by the party that lost the elections (PSDB), the impeachment movement of the newly elected president gained supporters among sectors and more conservative parties, business sectors, and part of the middle class. The signs of an economic crisis and the unraveling of investigations into corruption in the state-owned Petrobras company that reached the political support base of the government provided ammunition for the opposition, strongly supported by the mainstream media, that managed to mobilize significant sectors of the population from the motto of the fight against corruption, leading to the gradual loss of government support and popularity. In the midst of this movement, and articulated to it, the public sphere began to express conservative Government Proposals and restrictions on state action, in clear opposition to the policies developed in the last two decades in the country.

The outcome of this process was the removal of the president, provisionally in May and definitely on August 31, 2016, after a process that observed the constitution in rites and procedures but was quite debatable in its substance to not be able to unambiguously characterize a crime of responsibility of the president, which would provide the constitutional justification for its deposition. Vice-president Michel Temer assumes the government—active articulator of the process of impeachment—with a large majority in the congress and with proposals for deep and structural reforms, both in the economic area and in social and labor policies and in the field of foreign policy. An accelerated process of constitutional change and the deconstruction of the status quo begin under the cloak of severe fiscal adjustment and “modernization,” with a cut in public expenditures, privatizations, and threats to social policies capable of rendering ineffective rights enshrined in the constitution.

Regarding health policy, specifically with regard to its financing, some decisions, on the one hand, indicate restrictions on the financing of the SUS and, on the other hand, signify changes in the principles on which the health system is based. These include:

- a. Establishment of the *new fiscal regime*, which aims to establish, for 20 years, ceilings for primary expenses (excluding interest payments) within the Union, which are limited to the variation of the inflation index as measured by the Extended National Consumer Price Index (IPCA) and based on 2016 expenses; this ceiling mitigates the binding nature of constitutionally defined health expenditures and affects all social policies.
- b. Government Proposals to strengthen and expand private health insurance, justified by the need to “rethink” constitutional rights such as universal access to health, on the grounds that the country is supposed to be unable to support them anymore. These proposals were translated into the creation of an “affordable health insurance” with a lower cost and a list of services lower than the

mandatory minimum established by the National Agency of Supplementary Health (ANS), as well as proposals for changes in the regulation of the supplementary health sector, very favorable to the operators, to the detriment of the users.

- c. Changes in the format of intergovernmental relations, with a reduction in the role of federal coordination by the federal government.

The recent agenda thus points to the underfunding of the SUS, deregulation of the system with reduction of federal coordination, and expansion of the private sector with less regulation. It foresees a new health reform “inside” and without fanfare, which without denying the SUS will make it systemic if it is implemented [17].

It is beyond the scope of this article to analyze the political-institutional crisis in Brazil that began in 2015, but I would like to emphasize here one of its effects which was the intensification of political cleavages, which had many consequences, particularly in the electoral process. Firstly, it prevented the country’s main popular leader from running for the 2018 presidential elections, arrested on charges of corruption that were not proven materially and from a highly questionable legal process both nationally and internationally. Secondly, the crisis allowed the victory of an extreme right-wing politician who proclaimed in discourse the deconstruction for the construction of a new country and that has as economic minister a radical liberal, supported by business sectors that give support to the new government.

The current period may represent the beginning of a new cycle whose contours are delineated, but whose results are still unpredictable. Democracy also seems threatened in one of its foundations which is a guarantee of social rights which has the utopia of greater substantive equality, beyond legal-formal equality, as one of its foundations. It is worth remembering that the concept of social policy has become inseparable from the notion of citizenship, which implies the establishment of a set of rights and duties between the citizen and the state and, fundamentally, the recognition of equality among citizens. It is, therefore, an egalitarian notion that relates to the construction of democracy—a political system based on the assumption of a basic equality among citizens. But even in democratic contexts, social policies tend to be subject to normative controversies involving conceptions of the role of the state and of justice. In the last decades, a great debate about these rights has been experienced in a context of persistent and widespread economic crisis. On one side, there are some interpretations, which emphasize the cost of social policies and consider the maintenance of these rights unsustainable, on the other hand, in different visions, social policies are seen as investment and producers of a more just and sustainable development, especially in countries which have not yet reached adequate levels of development.

In Brazil today, the first vision prevails in the government sphere and the attack against social policies, and the rights they represent are not an isolated event, but are linked to a set of governmental decisions and actions that form a coherent and articulated whole that points to changes in the way the Brazilian state operates, which directly affects social policies. Instead of isolated actions, we have actions that are concatenated with a view to redirect the interventionist or more proactive state standard (both with measures aimed at the development of the economy and at mitigating the perverse effects of the market economy) toward a market society with few state moorings. This would translate not only into more visible processes such as privatizations, sale of public assets, outsourcing, and incentives to market development in areas traditionally attributed to the state, such as health, but in deregulation processes (in various fields). Among these, the reform of labor legislation that has already been implemented is a great example of considerably

reducing state regulation of the relationship between the employer and employee in a situation of great disparity in bargaining power due to high unemployment rates, which in practice allows and accentuates the suspension of guarantees established in previous legislation. This reform tends to increase worker informality and instability, and this outcome, in turn, should have an impact on the very sustainability of social security (which is also the subject of a reform proposal), as more precarious employment ties will have negative effects on the collection of social and pension contributions by workers and companies and, therefore, in the financing part of the social policies in force.

The commemoration of the 30 years of the Brazilian constitution, dubbed as “citizen constitution” for the rights it enshrines, among them the right to health, coexists with an ongoing process of deconstruction or of a larger institutional change in which the association between economic and social development, which was the hallmark of previous governments, loses strength in the current political conjuncture, as well as the proactive role of the state in this regard. Although the developments in this process are not given yet, the current period signals a new cycle of social policies in the opposite direction of the Federal Constitution of 1988.

If the right to health implies a state guarantee of the adoption of public policies that avoid the risk of harm to health, considering all the health determinants, such as healthy environment, income, work, sanitation, food, and education, as well as the guarantee of health services that promote, protect, and recover individual and collective health, the Brazilian future does not seem promising. In all of these areas, there is an institutional deconstruction in Brazil, which includes cutting resources and changing legislation in the sense of social deprotection and market favoring in the context of an exacerbated and authoritarian liberalism. In the case of health, after three decades of building a universal and integral system, it is predicted that the system will be exhausted, even if it is not programmatically denied; it can suffer from a systemic unfeasibility that could lead to its degradation.

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