The Fate of Primary Health Care in Brazil

Carlyle G. de Macêdo and Cesar A. de B. Vieira[1]

International organisations are promoting primary health care (PHC) as the main strategy for tackling health problems around the world [WHO/UNICEF 1978; IBRD 1980], and many developing countries have adopted health care policies in line with that strategy. The results, however, have not always matched the optimistic forecasts expressed in international documents [Djukanovic and Mach 1975]. A recent study by the UNICEF/WHO joint committee on health policy [1981] identified obstacles which have hindered the full implementation of PHC in several countries. Such obstacles are similar to those which undermine the success of redistributive policies in general throughout the Third World.

According to the PHC approach, the promotion of health should be based on action in the socioeconomic sphere as well as in the health care sector itself. The former aims to counteract the causes of ill health and to make the development process itself more likely to contribute to improving people's health. The latter tries to make the existing health services more equitable and effective in relation to the needs of the population. Although all this sounds eminently reasonable in theory, PHC turns out to be problematic in practice, because many of the policies may not be viable in political terms. It may be impossible for PHC to be adopted realistically as an immediate target, so that it comes to be seen as only a possible — almost utopian — outcome of political processes which must be worked through over the long term.

The purpose of this article is to analyse the Brazilian experience with respect to PHC in the recent past. As will be seen, it is an experience characterised by little success, and on top of this it has focused almost exclusively on the health care aspects of PHC. Despite these limitations, the case of Brazil is worth discussing, not only within the country in the context of planning future national strategies, but also as a contribution to the international debate on the subject. Before explaining the sequence of PHC events in the country, a brief account is given of the current health and health care situation. The paper then describes a new PHC programme that the government has recently failed to adopt. Finally, the main lessons to be learnt from this failure are discussed to provide a basis for future attempts to promote alternative policies in the health sector.

The Health Problems and their Socioeconomic Determinants[2]

The Brazilian population has experienced a remarkable improvement in its health status: by 1980, life expectancy at birth was 61.3 years for men and 65.5 years for women, a 50 per cent increase in comparison with 1940. Nevertheless, countries like Argentina, Chile, or Venezuela, appear to be enjoying better health than Brazil, although they have reached only comparable stages of socioeconomic development. In addition, within the country, inequalities in mortality and morbidity rates by social class or region have widened in recent years. There has also been a rising incidence of chronic diseases, whose control demands increasing quantities of health care resources. At the same time, other causes of illness and death — notably infectious diseases — still persist at high levels, although they could be prevented by using the resources available in the country.

Such an epidemiological situation is related closely to the socioeconomic changes that have been taking place in Brazil since the 1950s. The share of agriculture in the gross domestic product (GDP) has halved to 10 per cent, while that of industry has increased from 25 to 37 per cent. There has been a corresponding massive shift of the economically active population from the rural to the urban areas. If the current trends persist, about 80 per cent of the population (some 160-170 mn people) will be living in towns larger than 10,000 by the end of the century, and about 50 per cent will be concentrated in 10 metropolitan regions.

[1] The authors are indebted to their colleagues in the Pan-American Health Organisation's manpower development group in Brasília, with whom they have shared work and had discussions on many of the points raised in this paper.

[2] Data presented in this section and the following one are extracted from Acordo MS-MEC-MPAS/OPS [1982].

The growth of employment in the cities, however, is lagging behind the urbanisation rate and this has produced vast masses of unemployed people earning their subsistence from the 'black' economy. The rural population is actually declining in absolute terms, and large sections of the peasantry have been turned into a rural proletariat, whose aspirations and demands are influenced by those prevailing in the cities. Urbanisation is also said to be responsible for a declining fertility rate and a slower demographic growth in Brazil, which mean that the population is gradually getting older in composition. This trend, together with the urban concentration, pollution, and a prevailing working environment which is often detrimental to health, is helping to produce a rising incidence of chronic and degenerative diseases, accidents, and violent deaths.

Despite the extraordinary economic growth of the last 15 years, poor housing, lack of sanitation, and inadequate dietary intake persist and explain the continuing high incidence of infectious diseases and the elevated infant mortality rates. Appalling living conditions are widespread, particularly in the *favelas*[3] around the bigger cities. In 1980 public water supplies covered 75 per cent of the urban population, but the percentage provided with a proper sewage disposal system was only 55 per cent; the situation in the rural areas is much worse.

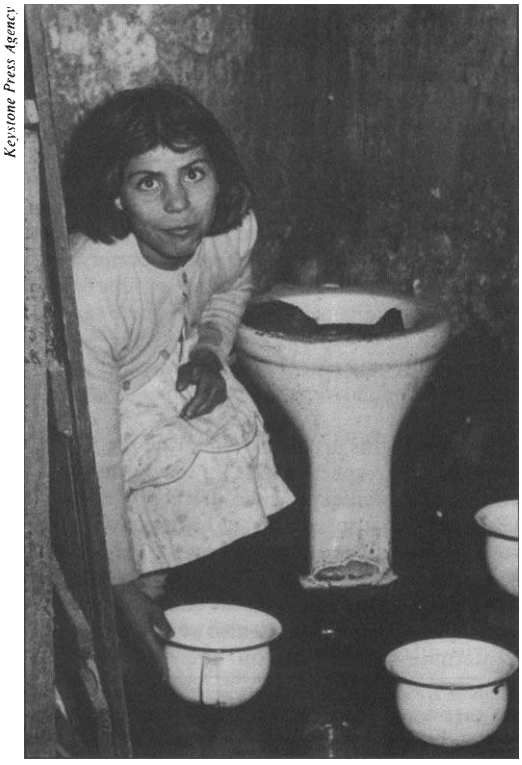
The nutritional status of low income groups is unsatisfactory and may worsen in the near future, due to the current trend of income concentration. Overall two-thirds of the economically active population earn less than the equivalent of £114[4] monthly, (approximately two minimum wages), but this proportion varies from 90 per cent in the Northeastern state of Maranhâo to 48 per cent in Brasilia, the federal capital. At present the poorest 50 per cent of the population gets only 14.5 per cent of the national income, while the share of the richest 10 per cent is 48.5 per cent. The corresponding figures for 1960 were 17.4 per cent and 39.6 per cent respectively.

A reduction in such social inequalities over this period would have required a different type of national development, which would have been less favourable to the middle and upper classes who were the major beneficiaries of the rapid growth between 1968 and 1973. Distributive economic policies of that sort were incompatible, however, with the political framework created by the post-1964 regime. It was only in the late 1970s when — under the impact of the economic recession — the living standards of the privileged classes began to decline as well, that the social unrest arising from the critical condition of the masses led the government to soften its socioeconomic policies.

In fact, some of the criticisms arising at this point referred specifically to the negative health implications of the growth strategies pursued thus far. Other criticisms related to the unsatisfactory performance of the so-called 'national health system', which was far from being effective in handling the people's health problems. A brief review of what was going wrong with that system is thus important in reconstructing the scene within which the disputes about PHC were to take place.

The Health Care System

The word 'system' is used here only to designate the complex set of public and private agencies that deal with health care in Brazil and not at all to indicate that they function in a rationally integrated manner. Nevertheless, Brazil, like other Latin American countries, has attained a reasonable level of domestic capacity in health care. The national ratios of one doctor and four hospital beds per 1,000 people, the existence of 76 medical schools, and a yearly market turnover of £1,125 mn in pharmaceuticals, illustrate the far greater availability of health care resources than exists in most of the developing world. This rather special resource situation has evolved along



Keystone Press Agency

[3] Brazilian word for shanty towns.

[4] £1 = Cr 414 at the time of writing; later in February 1983 the *cruzeiro* was devalued by 30 per cent.

with two dominant characteristics in health care provision: public funding and private production of services.

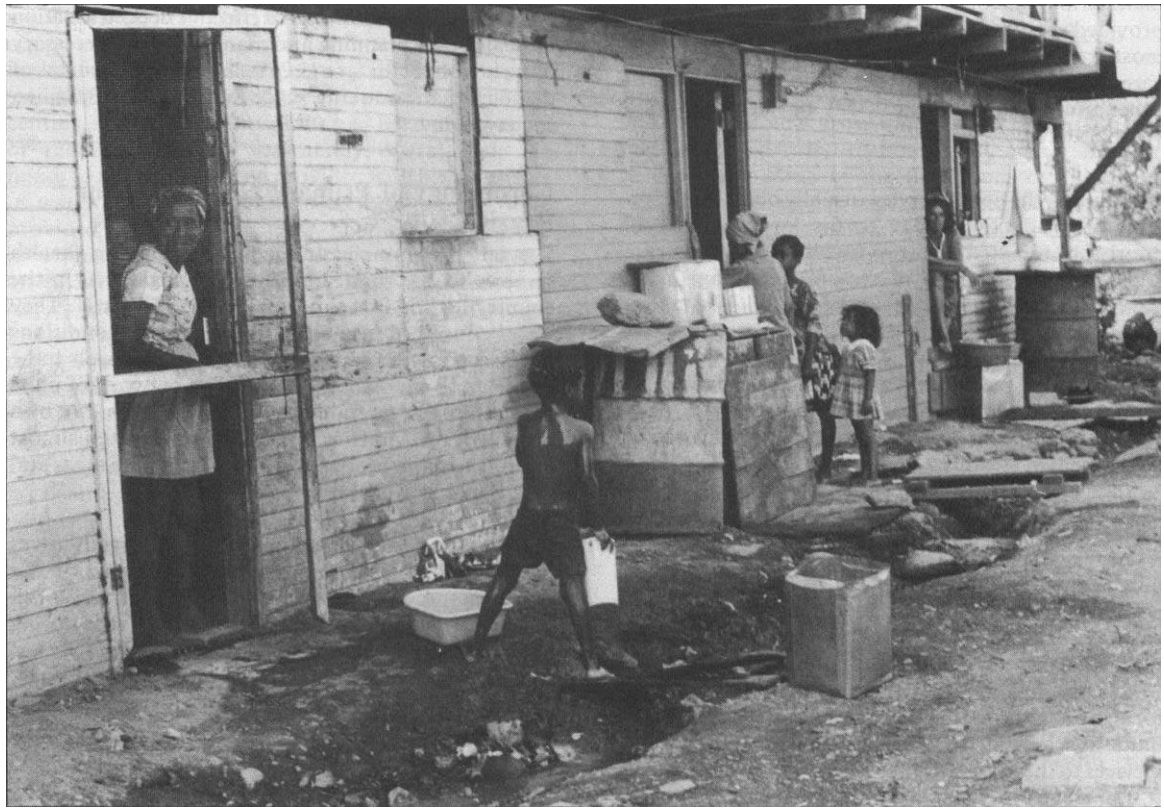
The overall expenditure on health care in 1982 is estimated to be £4,870 mn — £39 per head or 3.2 per cent of GDP — of which 71.5 per cent came from public funds. INAMPS,[5] the social security agency for medical care, was responsible for 37 per cent of health sector funds, making it the main single source of finance. Other public sources included the federal (6.8 per cent, mainly the Ministry of Health), state (20.4 per cent) and municipal (7.3 per cent) budgets. The major private source (16.5 per cent of sectoral expenditure) was individual households in their expenses on personal health care, followed by employers' schemes (6.3 per cent), private insurance (2.9 per cent), trade unions (2.1 per cent), and voluntary agencies (0.7 per cent).

INAMPS' resources are allocated both to the purchase of services from private providers and to subsidising the services partially funded by the three levels of government, the employers' schemes and the trade unions. This gives INAMPS, with its thrust towards curative care, the capacity to influence the allocation of most of the sectoral budget. As the Ministry of Health and the state departments of health have faced a chronic shortage of funds, they have increasingly resorted to INAMPS as a source of financial help, and public health centres have thus become deeply engaged in curative care, to the detriment of their original preventive aims.

With regard to the production of services, the private sector controls 75 per cent of the almost half a million hospital beds available in the country. One-third of this total is scattered among small units (less than 100 beds each), which account however for 77 per cent of the hospitals. Private services provide about a half of the outpatient care, two-thirds of the laboratory tests, X-rays, and specialised treatments, and 90 per cent of the hospital care, financed by INAMPS. In 1981, 71 per cent of the latter's budget went to the private sector in payment for medical services; the rest of the budget was spent on services provided either by INAMPS' own units (mainly for outpatients) or by federal, state, and municipal hospitals and health centres.

[5] Instituto Nacional da Assistência Médica da Previdência Social.

Carlos Reyes



Despite the extraordinary economic growth of the last 15 years, poor housing, lack of sanitation, and inadequate dietary intake persist in Brazil.

Small hospitals and individual doctors (practising on their own account or contracted by INAMPS, or often both) constitute the most frequent forms of medical care organisation in the private sector. Medical care enterprises, however, have grown very rapidly since they first appeared in the early 1960s. They usually care for employees of big corporations through employer-sponsored schemes subsidised by INAMPS. In addition to increasing their share in the health care market, their economic dynamism has forced the private sector as a whole to operate increasingly on strict capitalist lines. This has created a growing contingent of salaried professionals who — especially in the case of the doctors — are suffering a sharp decline in status and income relative to an earlier era of more common liberal practice. Health workers, particularly doctors, are thus becoming increasingly angry about their situation, to the point where their unions now constitute a powerful source of pressure in favour of changing the health care system.

The poor performance of this system relative to the health needs of the country is well known. One-third of the population lacks regular access to health services, which are either inadequate or are maldistributed, socially and regionally. The services provided are often over-sophisticated in relation to the most frequent causes of illness and death. Curative care takes up about 90 per cent of the sector's expenditure, leaving insufficient resources for preventive activities.

In addition, the health services usually operate at a low level of productivity, due to the large number of poorly-coordinated agencies involved in health care and the ineffectiveness of sectoral planning; many government units are in fact underutilised. Wastage of resources often coexists with shortages elsewhere, such that health units are not properly equipped and staffed. More recently, health care costs have risen very quickly, seemingly out of control, and the social benefit in return for each *cruzeiro* spent in the sector has decreased steadily.

The search for solutions to these problems constitutes a serious challenge to the country. First, there is the quantitative problem of widening the system's coverage. The mere maintenance of the current level of coverage, allowing for population growth up to the year 2000, would require an annual investment of £1,275 mn, ie about 10 per cent of the gross capital formation in the national economy as a whole. This is quite apart from the investments needed to extend services to the population not properly covered today. It is obvious that the financing of such investments — and the new current costs they imply — will demand, not just a large quantity of additional funds, but also a much better coordination between the public and private sectors.

Services must also be better adapted to the prevailing health needs, both in terms of the technical inputs of care and — still more important — of the social modes of organising care, the sectoral 'productive processes'. It is necessary to select those processes that are most conducive to the provision of health care according to the criteria of equity, cost-effectiveness, acceptability and feasibility. In addition, these processes should give the country the chance of promoting its own capacity for innovating and controlling the technologies it needs.

Health care must thus be placed under wider social control. Most of the existing problems result from the fact that the interests of the consumer elites, and of the producers of health care services and goods, have prevailed over those of the vast majority of the people. The latter have scarcely had a say either in policy making or in controlling the operation of the health care sector. The present degree of political and bureaucratic centralisation obstructs the formulation and implementation of alternative health policies appropriate to the different social and regional conditions of the country. An effective decentralisation of health care planning and management is necessary if the health sector is to keep in line with the process of democratisation taking place in the rest of Brazilian society today.

Chronology of Primary Health Care in Brazil[6]

Special programmes aimed at extending health services to the rural areas were implemented in the country for the first time during World War II. They were conceived as being part of the conditions necessary for the exploitation of raw materials to be exported to the Allied Powers. The network of units then set up has operated to the present time, run by a branch of the Ministry of Health and devoted almost entirely to caring for people living in remote areas and on the country's frontiers.

State departments of health have also taken initiatives of that sort, like the pioneering case of Piaui in the Northeast. A network of health centres and of local, district, and regional hospitals was established during the late 1960s, and came to account for 90 per cent of the hospital beds, and almost all the institutional primary care, in the state.

From the early 1970s two different approaches to health care extension were developed. The first, led by

[6] This chronology is based on the work of Vieira [1978], IBRD [1979], Guimarães [1982], and Ministério da Saúde [1982].

agencies like the World Bank supporting integrated rural development projects in the Northeast, consisted of the provision of preventive care through health auxiliaries cooperating closely with other extension workers. In this case there was no major concern with other levels of care. The second approach originated within the health care sector itself and was an attempt to spread basic health services — already existing in the cities — to the rural areas. The Ministry of Health, INAMPS, the US Agency for International Development, and the Pan-American Health Organisation (PAHO), supported state health departments to develop 'regional health systems', like those of Montes Claros and Caruaru, in the states of Minas Gerais and Pernambuco respectively.

Based on the experience gained from the 'regional systems', the federal government initiated in 1976 a large programme — PIASS[7] — that was to cover all Northeastern towns and villages of up to 20,000 people with 'statewide projects' for basic health and sanitation services. PIASS was to incorporate the health components of the rural development projects being implemented throughout the region. In 1979 PIASS was turned into a national programme, incorporating the health sectoral and extra-sectoral activities related to PHC already taking place in other regions of the country. Even taking this into account, the achievements of PIASS are quite impressive. By the early 1980s about 4,800 health posts, 4,300 health centres, and 310 rural hospitals had been constructed or rebuilt, and were reasonably operational. Six hundred villages had been provided with basic systems of water supply and nearly 80,000 households were provided with latrines. The operation of PIASS involved 30,000 village health workers and health attendants, 7,800 health technicians, 13,500 doctors, nurses and other professionals, and a £340 mn annual budget for current costs. The programme's health services were said to be accessible to 60 mn people, while 1.6 mn people were covered by its water supply and sanitation systems.

There were, however, wide variations in the quality of the health care. While in some states all health posts performed routine immunisations, in others few did so. Most of the health centres offered medical care, but only a few performed outreach work at community or household levels. Preventive services were rarely delivered by rural hospitals. Although an overall evaluation has not been undertaken, there is evidence to suggest that PIASS services were generally unsatisfactory qualitatively, and they won little public acceptance.

Official reports have claimed that the problems of PIASS resulted from the speed of its implementation, which did not allow enough time for the proper establishment of health posts and centres, the adequate training of the staff, and the sorting out of the funding arrangements among the health agencies involved. At local level, politicians had distorted the programme for electoral purposes; rural health workers, including doctors, staffing the units were not really committed to the objectives of PIASS; and so on. Arguments like these became so prevalent that one could be excused for thinking such problems might not be aberrations but the normal outcome of a programme like PIASS in the Brazilian context.

This attempt at a PHC-type of approach was thus only partially successful, to the extent that it extended some services to areas where they were not available before. Since its sphere of operation was limited to the periphery of the health sector, it did not influence the definition of priorities or the pattern of resource allocation in the sector as a whole. Equally serious was the fact that the PHC programmes reinforced the dominance of health professionals and the manipulative practices of politicians, and very little was achieved in terms of substantive participation by the population.

PREVSAÚDE[8]: Was PHC about to Leap Forward?

It was in the wake of these problems experienced by PIASS that a new programme — PREVSAÚDE — was formulated from 1979 onwards. Besides attempting to overcome some of the limitations of PIASS in practice, two main new objectives were set. First, basic health services and sanitation were to be extended to benefit the entire population, in both the rural and urban areas. Second, the public sector — the federal, state, and municipal health organisations — was to be integrated to rationalise the provision of services and to raise the productivity of the resources allocated by government agencies to health care. The provision of care would be regionalised. Emphasis would be given to appropriate technology, to the wide use of general practitioners and auxiliary personnel, and to community participation in the planning, implementation and control of the services.

PREVSAÚDE's activities were to be organised on three levels (see Figure 1). The primary level would be constituted by basic care provided by health auxiliaries, and by primary medical care in the fields of general practice, paediatrics, gynaecology and obstetrics, and dentistry. This level was expected to cope with about 80 per cent of the demand for health care, and would be the entry to the whole health care system. The secondary and tertiary levels would

[7] *Programa de Interiorização das Ações de Saúde e Saneamento.*

[8] *Programa Nacional de Serviços Básicos de Saúde.* Most of this section is based on PREVSAÚDE [1980].

attend to patients referred to them from the primary level, as well as dealing directly with high-risk patients needing specialist care.

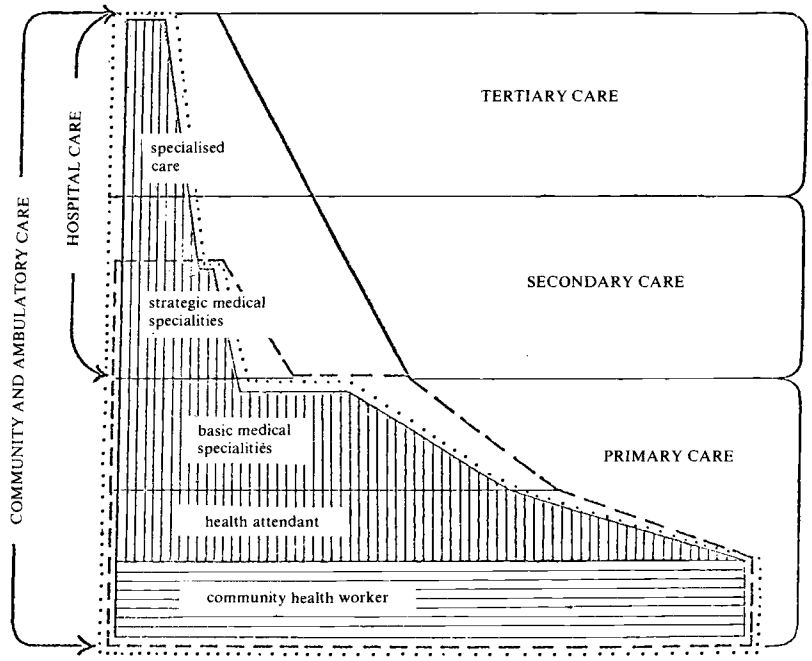
Different types of health units would take part in PREVSAÚDE's network, including health posts and centres, outpatient clinics, and local hospitals. They would be integrated to allow for the referral of patients, and the provision of technical, managerial and supervisory support. As in the case of PIASS, it was also suggested that the units should be linked to each other to make up health care modules, established in relation to defined target populations.

In quantitative terms PREVSAÚDE had very ambitious goals. It would build or renovate a large number of health posts, medical and dental surgeries, rural hospitals, and emergency units, so that the availability of these facilities would almost treble during the 1981-86 planning period. The network would be sufficient to provide for two outpatient visits per head per year, and attain a satisfactory population coverage in terms of hospital care, dental care, nutritional aid, basic immunisation, water supply and sanitation, and communicable disease control. Over 300,000 health service workers were to be trained (or retrained) and deployed. Community-based workers were to be taught the basic principles of health care, so they could become one of the means by which communities could participate in the programme.

The proposed investments for PREVSAÚDE between 1981 and 1986 were estimated to be some £1,650 mn. Operating costs over the whole development phase were calculated at £6,900 mn and the full operating costs after 1986 would reach £1,400 mn yearly. The latter amount was about 30 per cent of the country's total expenditure on health care (or about 40 per cent of the public sector budget for health). Eighty per cent of the total investment was to come from government (mainly federal) funds, while external sources like the World Bank would provide the rest in the form of credit and grants. Current costs would be financed exclusively from domestic sources, mainly the federal government. Given the shortage of funds for the current expenditures of most health authorities, the implementation of PREVSAÚDE would have required a substantial shift in public sector resource allocation.

Figure 1

PREVSAÚDE in the context of the Brazilian national health system



Source: PREVSAÚDE 1980

The Rise and Fall of a Good Idea

PREVSAÚDE never left the drawing board. It was conceived initially by a group of health planners in the federal government and PAHO. Most of them had close relations to — and much enthusiasm for — the earlier experience of PIASS. A preliminary draft of PREVSAÚDE was put forward for the consideration of different interest groups in the sector. This lengthened the 'gestation period' of the proposal which, instead of being nourished by these groups, was purged of its more controversial aspects, and finally aborted. Why that happened is an important question to be answered: it is necessary to learn from past mistakes in order to adopt better strategies in the future. A conclusive answer would require an investigation into many points that are still unclear, a task that is impossible within the limits of the present work. Instead some explanatory hypotheses with fair degrees of plausibility are discussed.

First it should be borne in mind that, in comparison with some radical PHC initiatives in the Third World, PREVSAÚDE was only a modernising, reforming proposal. It is true that it had a generally redistributive orientation and made some proposals in the areas of food policy, housing and sanitation. Nevertheless it was fundamentally a proposal for health care reform and it focused exclusively on the public segment of the sector. As far as the more crucial determinants of health were concerned — like working conditions, income distribution, or ultimately political participation — PREVSAÚDE was especially cautious, if not completely silent.

It would thus be incorrect to conclude that the proposal failed because it conflicted directly with the dominant interests in the country or even within the health care sector itself. As mentioned earlier, Brazil was going through a period of political 'opening up' when the proposal appeared, and movements for similar demands were succeeding at that time. The regime was trying to adopt a neo-populist face, and was searching for legitimacy and new social bases. An expression of this was seen during the opening session of the 7th national health conference in March 1980. Addressing the audience in the presence of the President and several Ministers, Halfdan Mahler, the Director-General of WHO, pushed the Brazilian Government into a corner by asking about its commitment to the 10 points stated in the Alma Ata Declaration. The government did not leave the challenge unanswered: eloquent speeches by the President and his Ministers reaffirmed the government's pledge to make PHC a reality in Brazil [Ministério da Saúde 1980].

That conference was a clear expression of support for the ideas of PREVSAÚDE, which was to be launched a few months later. The 400 participants comprised mainly top-ranking civil servants from federal, state and local governments, and also university teachers, private sector representatives, professional leaders, and politicians. To most of the technocrats present PREVSAÚDE was appealing because it strengthened the position of the public sector in the health care system and thus enlarged their share of power *vis-à-vis* the private sector. There were, however, good reasons to expect resistance to PREVSAÚDE by some INAMPS professionals, as indeed transpired. Many of them were related closely to the private sector, in which they often held part-time appointments. Also the integration of the government agencies in the health sector would have undermined the sectoral leadership that INAMPS had enjoyed thus far. So one of the possible explanations for PREVSAÚDE's difficulties was that it became mixed up in the rivalry among technocrats for hegemony in the health sector [Nicz 1982].

However, the main source of opposition to PREVSAÚDE came from the private providers, although their opposition was not total. They did not object to the programme as such, but rather to specific components of it that might have affected the share of the private sector in INAMPS funds. Uncertainty as to whether additional government funding would in fact be forthcoming led private providers to fear that resources presently allocated to purchasing their services would be shifted to financing the public network of basic health services. Representatives of the private sector thus came to criticise what they called PREVSAÚDE's 'nationalising' — or 'socialising' — character. Despite the more liberal political climate prevailing at that time, labels like these were still damaging in the Brazil of the early 1980s [*O Globo* 1980, *Jornal de Brasília* 1980].

Since their opposition to PREVSAÚDE was based on specific points, private producers did not react against the programme in a cohesive way from the beginning. However, the planners who were pushing the proposal did not at first perceive that lack of cohesion. By the time they recognised that various interests were at stake, the chance was lost for deepening the rifts among the different groups, or for making provisional alliances with some of them against others. This weakness of strategy for promoting PREVSAÚDE allowed its opponents to unite and ultimately changed the balance of forces against the proposal.

What then were the different producer interests? It is possible to identify four main interest groups, each of which can be sub-divided further. The first group was the doctors who were defending, through their powerful medical association, the AMB,[9] the situation of the semi-independent practitioners contracted by

[9] Associação Médica Brasileira.

INAMPS on a fee-for-services basis. These practitioners rejected the programme because a greater participation of the public sector in outpatient care could have been financially catastrophic for them. These doctors were still very influential, although they were already in a minority in the profession. There was in fact an increasing number of doctors, particularly new graduates, who at the time were demanding jobs that could have been given to them through PREVSAÚDE. However, the programme's supporters did not attempt an alliance with the unemployed doctors, perhaps because the latter were not considered to be a group strong enough to counterbalance the opposition of other doctors to the proposal [*Folha de S. Paulo* 1980].

The second interest group comprised the private hospital owners represented by their federation, the FBH.[10] It seems unlikely that they felt any threat from the 6,000 new beds PREVSAÚDE intended to set up in rural hospitals. It is also improbable that they were concerned that better outpatient care might reduce the demand for hospital care: the reverse was much more likely to occur, namely, that the growth in ambulatory care would bring about a substantial increase in the number of patients referred to hospitals. Moreover, FBH personnel were closely related to top members of the government and they had little reason to fear that their interests would be threatened, at least in the short run. Yet they were apprehensive about PREVSAÚDE, and this possibly derived from the fact that the full implementation of the programme might endanger the growth and maintenance of the network of private hospitals in the long term; the conditions would be created for more radical changes to occur in the sector, like the complete nationalisation of the health care system [*O Globo* 1980].

Even among hospital owners, however, there were grounds for different reactions to PREVSAÚDE. Owners of small local hospitals and managers of community hospitals were less inclined to reject the programme, in which they were to participate on a subsidised basis; but their political strength was insufficient to counteract the opposition from the capitalist owners of the medium and large hospitals.

The third producer faction consisted of the group medical enterprises that provided services for the employers' schemes subsidised by INAMPS. These enterprises ought not, in principle, to have feared PREVSAÚDE for at least three reasons: first, because they cared for the employees of the big corporations, the elite of the Brazilian working class, who were to be among the last groups to be covered by the programme; second, because they themselves were trying to rationalise health care in a manner quite similar to that sponsored by the proposal; and third, because PREVSAÚDE could have weakened the market position of the private doctors and hospitals, thus creating new opportunities for the enterprises to expand their share of the medical care market.

However, they also had reasons for being unenthusiastic about a programme that could come to mean a virtual government monopoly of outpatient care. ABRAMGE,[11] the enterprises' representative organisation, argued this possibility at the time. Another circumstance may also have led ABRAMGE to oppose PREVSAÚDE. Young doctors who were supporting the proposal in the medical union movement were often employees of the medical enterprises, and in the course of labour disputes they would voice opinions in favour of nationalisation, an association of political views that could have hardened the attitude of the medical enterprises against PREVSAÚDE [*Visão* 1980].

The last interest group involved the producers of drugs and of medical equipment and supplies. What mattered to them was growth of sales, be this through the state system or the private sector. Even if the government had intended to take over the health care sector, it would only have affected the production of health services and not that of supplies (though PREVSAÚDE did state some policy principles regarding pharmaceuticals). Thus this producer group did not take sides in the PREVSAÚDE controversy.

Although PREVSAÚDE was nothing more than a logical development of PIASS, it could be argued that its failure was due, at least partly, to its over-ambitious objectives in the Brazilian context. Thus at the time PREVSAÚDE was proposed, there was no active public or political interest in such a programme. The attitudes of the health care authorities and institutions, and the balance of power in the sector, were such as to create an environment that was hostile to the thrust of the programme.

Nevertheless, there was also a failure of political strategy. Despite the non-conducive atmosphere of the health arena, the proposal never managed to break out of that sector to involve other social groups in the discussion. The latter took place only in specialist health circles and there was no attempt to mobilise precisely those whom the programme was expected to benefit, the poorer strata of the population. Ironically, the proposal in favour of popular participation in health was managed in a notably non-participatory way [*Estado de Minas* 1980], and neither the population nor their representative organisations recognised it as something that they should support actively.

[10] Federação Brasileira de Hospitais.

[11] Associação Brasileira de Medicina de Grupo.

In this connection it is worth mentioning that, during the first national conference of the labour movement in 1981 — after the hard political years of the 1970s — the trade unionists attending agreed that a crucial question for them was the social control of health care. Yet while they criticised the private sector, they rejected the idea of nationalisation until such time as they had been granted the right to participate in health policy making [Comissão Nacional Pró-Cut 1981]. The lessons of such an attitude were not grasped by the promoters of PREVSAÚDE, and the wider social support that might have counterbalanced the sectoral opposition to the programme never materialised.

It would be wrong to state that none of PREVSAÚDE's proposals has been put into practice; some of them have been implemented in the process of INAMPS trying to rationalise its own health care provision. In the meantime the PIASS network continues to function, not without its usual problems. And the same crisis situation of the Brazilian health care system persists, sometimes more, sometimes less, acutely. It is doubtful if radical changes can be postponed indefinitely [CONASP 1982].[12]

PREVSAÚDE: Was it only a Failure or also a Rich Learning Experience?

From the standpoint of practical achievement, PREVSAÚDE was a complete failure. However, a whole generation of Brazilian health planners — senior and junior — has had the chance to learn two important, related lessons from the experience.

The first is, once again, the necessity to put health in its proper multisectoral perspective, which is so much wider than the narrow framework of the health care sector that has dominated the discussion in the country so far. Many health care professionals — even well meaning ones — have fallen into the trap of 'medicalising' health, which masks the continuing socioeconomic determinants of health and disease; and they have thereby contributed to brainwashing the population into believing that health care is a sufficient condition for achieving health. In future health policy must not be limited to health care organisation, which is only one focus of the former. It must be clarified how, and to what extent, the socioeconomic determinants of illness will be dealt with in the social and economic spheres. Health care services will then appear as just one of the measures that must be adopted to promote, protect and restore health.

It may be difficult for those who earn their living by dispensing medical care to accept such an argument, but a critical evaluation of the limits and scope of health care is absolutely essential. Countries that have managed to undertake radical changes in their health systems have often done so without the help of their health care professionals, if not actually in face of their opposition.

At the same time it must be recognised that society as a whole has not yet adopted this sort of critical thinking; it remains fixated on the traditional myths about medicine and health. A critical view of the limits of health care technology has been gaining ground only recently, and has arisen — paradoxically — from within medicine itself. Broadening the perspective of the health sector should thus be a social process rather than a technocratic exercise or a corporate institutional arrangement, and society must develop its own critical faculty in relation to health questions. Promoting popular evaluation of health problems and policies may well become a new important field of work for professionals who want to break away from the constraints of conventional medical analyses.

Following this point, the second lesson from the PREVSAÚDE experience relates to the process by which reform will take place in the health sector. The fate of the proposal seems to have put an end to the idea that drawing up a rational blueprint is a sufficient means for changing the face of reality. Planning can only have limited power to solve the problems of the provision of health services and the organisation of the health sector. This is even more the case when the planning does not take into account the economic and political interests that are at stake in the health care arena, and idealises what is likely to be achieved by state intervention in a situation such as that prevailing in Brazil.

PREVSAÚDE completely failed to come to grips with the politics of health and health care. It succumbed to the technocratic temptation to try to change reality in a voluntaristic and messianic way, and it attempted —unwittingly — to substitute for those popular forces that are so much more capable of waging an effective struggle for social change. Because the programme was not submitted for wider social scrutiny and support, PREVSAÚDE was never validated by the political forces that could have translated the proposal into a reality.

The health situation in Brazil has reached a point where technique alone can contribute little towards finding solutions to the crucial questions that are still unresolved. The recognition of this fact, and the democratisation of the health debate, must be top priorities if society is to exercise control over the causes of its health problems and over the health care system.

[12] Conselho Consultivo da Adminstração da Saúde Previdenciária.

References

Acordo MS-MEC-MPAS/OPS, 1982, 'Programa de investigação em serviços de saúde — termos de referencia', mimeo, Brasília

Comissão Nacional Pró-Cut, 1981, *I CONCLAT*, São Paulo

CONASP, 1982, *Plano de Reorientação da Assistência à Saúde no Ambito da Previdência Social*, MPAS, Brasília

Djukanovic, V. and E. P. Mach (eds), 1975, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, WHO, Geneva

Estado de Minas, 1980, 'Sindicato dos médicos de minas vê contradições no PREVSAÚDE, 7 October

Folha de S. Paulo, 1980, 'Médicos Paulistas criticam PREVSAÚDE', 26 October

Guimarães, C., 1982, 'Situação assistencial Brasileira' in E. L. Gonçalves (ed), *Administração de Saúde no Brasil*, Pioneira, São Paulo, pp 103-37

IBRD, 1979, *Brazil: Human Resources Special Report*, World Bank, Washington
—1980, *Health: Sector Policy Paper*, World Bank, Washington

Jornal de Brasília, 1980, 'Jair Soares defende o PREVSAÚDE', 1 August

Ministério da Saúde, 1980, *Anais da 7a Conferência Nacional de Saúde*, CD/MS, Brasília
—1982, 'Relatório de avaliação do PIASS', Brasília, mimeo

Nicz, L. F., 1982, 'Previdência social no Brasil' in E. L. Gonçalves (ed), op cit, pp 163-96

O Globo, 1980, 'Hospitais privados dizem que PREVSAÚDE estatiza', 23 September

PREVSAÚDE, 1980, *Ante-Projeto*, MS-MPAS-MINTER-SEPLAN, Brasília

UNICEF/WHO joint committee on health policy, 1981, *National Decision-making for Primary Health Care*, WHO, Geneva

Vieira, C. A. B., 1978, 'Extensão de cobertura no Brasil: crise e reforma do sistema de saúde' in ABEN, *Anais do XXX Congresso Brasileiro de Enfermagem*, Belém, pp 37-60

Visão, 1980, 'Saúde estatizada', 29 September

WHO/UNICEF, 1978, *Alma Ata 1978. Primary Health Care*, WHO, Geneva