Origins of Successful Health Sector Reform: Public Health Professionals and Institutional Opportunities in Brazil

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1 Introduction

This article examines the origins of the Brazilian health sector reforms that have led to universal and free access to integrated healthcare, provided in a decentralised manner. For many experts in the field of health sector reform, the Unified Health System (Sistema Único de Saúde, SUS) that emerged in the late-1980s and 1990s is a success story. Understanding the origins of this success is the goal of this article.

The key changes in the Brazilian health sector, the article argues, took place in the early 1980s, at the end of the military regime, and were the product of an intense and particular form of interaction between actors in society and in the state.[1] Conditions favourable to the reforms emerged to the extent that, on the one hand, there were health professionals organised in the *Sanitarista* movement (the public health movement), which opted for a reformist strategy within state institutions and, on the other, the military regime invested in expanding social rights that made the health sector permeable to different, if not antagonistic, views.

The combination of these factors enabled, at the time of the financial crisis of 1981, reformist measures to be adopted and gradually implemented in the entire country, despite the private medical sector's opposing interests. The policies adopted represented more than an administrative rationalisation inclination or merely a series of programme efforts of limited reach. Such policies

constituted an original reform at odds with their time: they did not privatise the sector or turn it entirely over to the state. They began to decentralise services and universalise full access while maintaining the private sector as a service provider. This occurred even before there was any major consensus on public sector reforms.

This interpretation contrasts to the most recurrent one in the literature on health sector reforms in Brazil which has narrated its trajectory as being marked both by the connection between the sector's reform project and democratisation of society and the state, and by the ensuing criticism to the authoritarian regime established by the military from 1964 to 1984. In this view, the military's centralised, exclusionary, hospital-centric and institutionally fragmented model, whose main service provider was the private medical sector, was replaced by a decentralised and participative system with free access to integrated care called SUS. The SUS was established by the Constitution of 1988, which accentuated the country's re-democratisation and is perceived as the sector's turning point.

The article presents, in the first section, the main actors that made up the sector's settings in the 1970s: the military regime and its techno-bureaucracy, the private medical sector and the *Sanitarista* movement. With this description as a backdrop, the second section focuses on the process of reforms that introduced the sector's turning point in the early 1980s.

2 Actors, their proposals and their roles: affinities despite differences

This section analyses the health sector's national trajectory in the late 1970s, focusing on actions and proposals of actors that were capable of influencing sectoral policymaking: the techno-bureaucratic state, the private medical sector and the *Sanitarista* movement. Unlike the arguments of specialised literature, this assessment reveals that the health model implemented by the military represented considerable achievements and that the sector's institutions were opened to reformist-minded professionals. The *Sanitarista* movement was able to gradually penetrate public institutions, acquiring experience and rallying its members around a single proposal.

2.1 Military government, techno-bureaucracy and the private medical sector

The military were in power in Brazil during 1964–84 and they established an authoritarian regime that restricted political rights. This assumed creating a bi-partisan system and maintaining elections: direct for most municipalities and indirect for president, state governments and key state capitals. Regarding social rights, however, there was expansion (Carvalho 2007). Although health had not become a universal right, a series of health sector measures increased its coverage. They also fostered basic care programmes and integrated public health services to the federal system. This interpretation contradicts a consensus found in the sector's literature. Such consensus tends to describe the military regime's health model as centralised, exclusionary, institutionally fragmented and hospital-centric, with the private sector as the main provider of hospital-based medical care (Noronha and Levcovitz 1994; Barros *et al.* 1996; Cohn 2003; Saddi 2004; Cohn and Elias 2005).

This consensus is found in most literature from the 1990s on the advances and retreats of the SUS. It can be explained by those authors' commitment to the health reform project as inseparable from the project of democratising Brazilian society. These projects are expressed in the famous motto 'Health and Democracy'. Assessed in this perspective, such a standing could not be granted to the changes and reforms made by the military regime, which had restricted the rules of the democratic game and strongly oppressed opposition.

Thus, where the literature reads *exclusion* – i.e. a population divided into social security contributors entitled to hospital-based medical care and non-contributors – there were actually several categories progressively included in that care's coverage: in 1971 rural workers were incorporated into medical care benefits; in 1972, domestic employees; in 1973, autonomous workers; in 1974, invalids and people over the age of 70 and, in 1975, rural employers. Although the literature does not ignore this expansion, it is rarely demonstrated in actual figures. These demonstrate undeniable advances: between 1968–78, the number of insured contributors practically tripled (from 7,763,058 to 21,166,088) (Possas 1980: 276). At the end of the 1970s, social security's medical care covered 80 per cent of the economically active population (Bahia 2005: 427, 431). If we consider 1960 (before the military regime), when there were 4,058,000 insured, growth was quintupled in 1975. Coverage expansion can also be expressed in the total of benefited people, when including contributors' dependents: in 1977, 55 million people out of 113,208,500 inhabitants in the country (Possas 1980: 276).

The literature's emphasis on institutional fragmentation ensues from the division of health service responsibilities in two separate groups. On the one hand, collective health services (prevention and care of collective reach, which were provided by the Health Ministry (Ministério da Saúde, MS), together with State and Municipal Health Secretariats. On the other hand, individual hospital-based medical care services, connected to the Ministry of Social Security and Services (Ministério de Previdência e Assistência Social, MPAS).[2] Such division was undoubtedly complicated in terms of healthcare. It must be stressed however, that in 1967 it replaced a pulverised system of institutions in charge of medical care benefits – the Retirement and Pension Institutes (Institutos de Aposentadoria e Pensões)[3] – which grouped workers by professional category and acted independently. The military regime managed to unify the institutes into a single organ, the National Institute for Social Security (Instituto Nacional de Previdência Social, INPS), and made benefits uniform in 1977.

Hospital-based medical care, covering social security contributors, was developed with the *private medical sector as the state's main supplier,* which continued the trend prior to the military regime (Cohn 2003: 44). Historical data series on the amount of hospital beds reveal that there was already a majority of private beds

in 1950: 59.9 per cent, vs. 46.1 per cent public beds (Possas 1980: 309). The military regime expanded the amount of private beds in only 14 per cent. The most significant change was the increase in the for-profit medical sector, which eventually occupied more space than the traditional philanthropic sector.

The model's logic was sustainable and profitable for private businesses: the number of private hospital facilities grew with cheap public funding and the sector ensured social security contracts by articulating with bureaucratic segments. In 1960 only 14.4 per cent of private beds were for-profit; in 1975 they had reached 45.2 per cent (Possas 1980: 309). In political–institutional terms, the for-profit medical sector's growth reflected the articulation between social security's bureaucratic segments and representatives of industrial–medical conglomerates' interests (Cordeiro 1991: 33). These included the Brazilian Federation of Hospitals (Federação Brasileira de Hospitais, FBH), the Brazilian Association of Hospitals (Associação Brasileira de Hospitais, ABH), the National Federation of Health Facilities and Services (Federação Nacional de Estabelecimentos e Serviços de Saúde, FENAESS), state unions of hospitals, the Brazilian Association of Group Medicine (Associação Brasileira de Medicina de Grupo, ABRAMGE) and the Brazilian Medical Association (Associação Médica Brasileira, AMB), together with less evident representatives of pharmaceuticals, dentistry, medical and hospital equipment and other suppliers.

A staggering proportion of health resources, approximately 85 per cent, was concentrated in the MPAS, which is in charge of hospital-based medical attention. This concentration provided grounds to describe the model as *hospital-centric* – i.e. one that promotes more treatment than prevention and uses hospitals as the main service facility. Such emphasis eclipsed the actions of the Health Ministry, in which alternative interests were able to flourish. Its meagre portion of resources left this latter ministry in the sidelines, and thus more open to the trends of community medicine and an administrative rationalisation approach. These trends were aligned with the approach of international health organisations and alternative to the emphasis on hospital-based medical care.

Sanitarista doctors, who occupied management positions within the Health Ministry, had relative freedom in staffing their teams and initiated coverage-increasing programmes, especially in rural areas. This was enabled by the II National Development Plan of 1975, which put social issues at its core and led to massive investments. One example that illustrates this is the 35.7 per cent increase in the Health Ministry budget in 1974–5 (Almeida and Oliveira 1979: 5 in Escorel 1998: 58). This social approach also occupied institutional spaces in the V and VI National Health Conferences (Conferências Nacionais de Saúde) – spaces for technical and governmental discussion, respectively held in 1975 and 1977 – in which medical-*Sanitarista* attention was the main agenda (Escorel 1998).

To sum up, the military regime considerably increased hospital-based medical care coverage in the health sector on one hand and, on the other, encompassed different healthcare models in its institutions, albeit with unequal weight and resources. This last trend will be evidenced by the actual implementation of alternative programmes to hospital-based medical care in the section on the *Sanitarista* movement.

2.2 *Sanitarista* movement
The *Sanitarista* movement in Brazil is a collective actor that established itself throughout the 1970s, from the Preventive Medicine Departments. It gradually encompassed several healthcare professionals – union-organised doctors, academia and the medical student movement – forming a movement of doctors and intellectuals of liberal, socialist and communist backgrounds (Escorel *et al.* 2005: 68; see also Escorel 1998: 193; Barros 2002: 23). Until 1979, guided by medical–social ideals and defined by acute criticism to the military regime's health model, the movement acted in some projects and programmes of limited scope, but which nonetheless allowed accumulating experience and gathering members. These actions were part of the choice for reformist action in public health institutions, which intensified in the early 1980s.

The movement grew and strengthened around certain spaces and institutions. The first important common space for these actors was the Community Health Studies Week (Semana de Estudos Sobre Saúde Comunitária), held annually since 1975. This studies week was not targeted for repression by the military regime and thus enabled discussion and debate. As from 1979, the actions of new institutions for research, debate and dissemination of the

proposals became stronger. Among these was the Brazilian Centre of Health Studies (Centro Brasileiro de Estudos da Saúde, CEBES), established in 1976. CEBES played a key role in disseminating proposals and promoting debates through its journal *Saúde em Debate* (Debating Health). By opening regional nuclei throughout Brazil, CEBES became notably capillary. The Brasília nucleus, for instance, worked closely with congressmen, which led, among others, to the National Health Policy Symposia (Simpósios da Política Nacional de Saúde), wherein the movement presented and debated its reform proposals. Among more academic spaces, there were the Brazilian Post-graduate Associations for Collective Health (Associação Brasileira de Pós-graduação em Saúde Coletiva, ABRASCO), which was founded in 1979 and was an important partner of CEBES, and the Social Medicine Institute (Instituto da Medicina Social) at the State University of Rio de Janeiro. In addition, the medical union movement, by renewing its representation entities, became very active in organising the category (Lima *et al.* 2005; Escorel 1998; Cordeiro 1991; Cohn 1989).

The choice for reformist action within state institutions driven by the military regime was not the only trend in the *Sanitarista* movement, but it grew in importance when social issues were prioritised in 1975, as aforementioned. The military regime created new institutions and programmes, but lacked adequate personnel to fill these new spaces, which opened doors for professionals committed to a health project contrary to the existing one (Escorel *et al.* 2005: 66). A mutually reinforcing relationship was formed: progressive-minded bureaucracy took over government proposals in order to advance their own, which contradicted the main model, while the regime itself took advantage of the development of progressive proposals, whether for its own legitimisation or to implement administrative rationalisation measures (Arretche 2005: 291; Escorel 1998: 182).

The *Sanitarista* movement was able to put in practice some of its key proposals – such as universalisation, accessibility, decentralisation, comprehensiveness and community participation (Escorel 1998: 133) – in three projects developed in the 1970s: the Service Unit Location Plan (Plano de Localização de Unidade de Serviços, PLUS), the Integrated System for Providing Health Services in North Minas Gerais (Sistema Integrado de Prestação de Serviços de

Saúde no Norte de Minas Gerais) and the Interiorisation of Healthcare and Sanitation Programme (Programa de Interiorização de Ações de Saúde e Saneamento, PIASS). The localisation plan was created in 1975 to develop health plans for metropolitan regions and was conceived in a context of social security marked by administrative modernisation and rationalisation-minded planning. Due to the lack of adequate personnel in social security, the assembled technical team was comprised of professionals from several areas of the state bureaucracy connected by a common ideal of social medicine. The 'PLUS group', with ample resources and recognition in different states, generated strong opposition in the VI National Health Conference (1977), leading to the plan's interruption in April 1979 and to the group's dispersal. The plan is mentioned here due to it being the first common experience for reform-minded professionals within social security medical care and as an example that alternative planning within social security was possible (Escorel 1998: 135–42).

The Integrated System for Providing Health Services in North Minas Gerais began in 1971 and ended in 1978, and was the first experience that demonstrated the *Sanitarista* movement's principles put into practice. The project proposed to integrate all health actions, both prevention and treatment, in a hierarchal structure, introducing the principle of community participation. This project was important to the *Sanitarista* movement because it gathered members, promoted discussions and was academically investigated. Despite great mobilisation by reformist sectors, the project was reduced to a primary attention system due to private sector pressure, but it was an important local experience for the *Sanitarista* movement's next project, PIASS.

The 1976, PIASS illustrates the change in trends towards the social–medical approach and demonstrates the movement's growing capacity of influencing sectoral policy. PIASS is considered the most representative example of affinity between the *Sanitarista* movement and techno-bureaucracy. For the institutions in charge, the programme simplified services and care, reducing costs (Bodstein and Fonseca 1989). From the *Sanitarista* movement's perspective, the programme integrated prevention and treatment and encouraged popular participation, enabling a 'major increase in the supply of basic ambulatory services to populations entirely excluded

from access to social facilities, especially in the Northeast' (Noronha and Levcovitz 1994: 79). Although the initial proposal was to offer access to all service levels and only a network of mini-facilities focused on primary care was feasible in the end, the programme achieved high coverage rates: 56 per cent of the population in the states in which it was implemented (Escorel 1998: 168).

PIASS represented a strengthening of the public health sector as the State Health Secretariats were put in charge of its management and implementation. Moreover, in 1979 it obtained funding from the federal agency in charge of hospital-based medical care and the refuge of private interests, the National Institute of Medical Care and Social Security (Instituto Nacional de Assistência Médica e Previdência Social, INAMPS).

3 The health sector's pre-constitutional turning point

In 1981 a financial crisis surfaced in the social security system that funded health, revealing the collapse of such funding model.[4] In order to interfere, the military regime, through the President of the Republic, established the National Council of Social Security Health Administration (Conselho Nacional de Administração da Saúde Previdenciária, CONASP), comprised of representatives of the main sectoral actors: private health sector, techno-bureaucracy and reformists (Cordeiro 1991). The Council prepared the Reorientation Plan for Healthcare within Social Security (Plano de Reorientação da Assistência à Saúde no Âmbito da Previdência Social). Known as the CONASP Plan, it acknowledged the distortions in the INAMPS health organisation model and set forth 17 administrative rationalisation measures aiming at remedying the situation by reducing costs (Gallo 1988: 77; Barros 2002: 20; Cordeiro 1991: 31). One example of such measures was to reformulate relations with private providers contracted by INAMPS by means of the Social Security Hospital-based Medical Care System (Sistema de Assistência Médico-Hospitalar da Previdência Social). The system no longer compensated surgical-medical procedures by the sum of fragmented medical actions performed in a given patient, which left ample room for corruption, but by the pre-established average value of the procedure as a whole.

The CONASP Plan's most important and lasting measure, however, were the Integrated Health

Actions (Ações Integradas de Saúde, AIS), which most revealingly expressed the *Sanitarista* movement's proposals. In 1983, the AIS announced no less than an overall change to healthcare, with principles of universal access, decentralisation, community participation, regionalisation and hierarchisation of actions and greater participation of public providers (Fleury 1991: 78; Escorel *et al.* 2005: 75). In practice, the AIS constituted transferring INAMPS monies to other federative levels, thus reanimating or creating local health services, especially at the basic care level. The new system also promoted integration between the actions of public providers by creating inter-institutional committees at the local, regional, state and federal levels.

Implementation of the AIS was enabled by the 1982 election outcomes in municipal and state governments, which brought to power parties opposing the military government in several parts of the country. This led the *Sanitarista* movement to intensify its strategy of occupying spaces in public institutions. In 1983, for instance, several of its members were tied up in public administration tasks, so that the movement's main journal, *Saúde em Debate*, was not published (Gallo 1988: 77). In 1983–4, the AIS governmental contracts (*convênios*) were signed with 15 states and 112 municipalities, among which were two very important ones: São Paulo and Rio de Janeiro (Paim 1986: 168; Fleury 1991).

The AIS had already demonstrated the *Sanitarista* movement's capacity to influence sectoral policy, but their staggering growth occurred in the democratic transition government that succeeded the military regime in 1985. For the health sector, the new government's policy was prepared in the V National Health Policy Symposium, based on CEBES documents and reinforcing the AIS strategy. In this phase, representatives from the *Sanitarista* movement took on key positions in the institutions in charge of health policy in the country. This led to an increase in implementation – in 1986 the number of municipalities involved grew to 2,215 – and to deepening the actions' guiding principles (Cohn and Elias 2005: 63; Escorel 1998: 185; Brasil, in Noronha and Levcovitz 1994: 88; Pimenta 1993: 28).

The AIS were replaced in 1987 by an even more daunting proposal for financial and political decentralisation within INAMPS. The Unified and Decentralised Health System (Sistema Unificado e

Descentralizado de Saúde – SUDS) was created by presidential decree in 1987, based on the INAMPS president's proposal – an office then held by a representative of the *Sanitarista* movement, Hésio Cordeiro. This was a proposal of national scope and reach, which directives reinforced the principles of change: decentralisation and, more specifically, municipalisation of health services; universal and equal access to health services; comprehensive care; regionalisation and integration of services and the development of collegiate institutions (Lima *et al.* 2005: 79; Noronha and Levcovitz 1994: 88). With SUDS, public sector participation in INAMPS expenditure grew from 25.8 per cent in 1981 (considering public services, university hospitals and INAMPS' own network of facilities) to 45.2 per cent in 1987, while the private sector's participation in contracts and governmental contracts (*convênios*) fell from 64.3 per cent to 40 per cent in the same years (Cordeiro 1991: 106).[5]

In 1988, when the Constitution was enacted, the Brazilian health sector had already undergone a long path of reforms that universalised free access to healthcare and decentralised services to states and municipalities, albeit maintaining the private sector as one of the service providers. It is important to highlight that reformist changes were processed within the institution in charge of hospital-based medical care (unlike the projects of the 1970s under the Health Ministry). It must also be stressed that they were supported by the *Sanitarista* movement, which had a clear proposal and acted in state institutions at all three federative levels, despite ideological differences with these governments. In this way, a specific reform design occurred, contemplating the sector's relevant actors' projects and interests in its arena. This happened without applying international prescriptions that consisted, at that time, of privatisation or cutting public expenditure.

4 Conclusion

The health sector's trajectory in Brazil, presented in this article, indicates that the sector's turning point towards a universalising reform occurred in the first half of the 1980s. The AIS caused a first reformist shock – which pre-neoliberal nature must be highlighted, since there was not yet a broad international consensus on how to promote reform in public sectors (except for privatisation and cutting public expenditure). The AIS also altered the sector's

path towards what would be confirmed by the Constitution of 1988.

The factors that conditioned the turning point are clarified when we shift its position in time, contradicting the literature's predominant emphasis. The article has sought to argue that the reforms of that period resulted from a special setting of actors in the sector's political arena, from their proposals and forms of interaction. The military regime, undergoing a tricky process towards democratisation, chose social policies as its priority, at the expense of civil and political rights. In the health sector, this trend allowed proximity between several actors with diverse and often divergent interests: an administrative-rationalising techno-bureaucracy, a private medical sector reinforcing its role as service provider to the state and the *Sanitarista* movement with its radical proposal of *Sanitária* Reform.

The *Sanitarista* movement, with a clear reform proposal, had defined the strategy of occupying spaces within public institutions. With the 1981 financial crisis dictating the need for changes, the movement's local or at best regional actions were able to become national programmes, thus implementing and applying its principles in the entire country.

The *Sanitária* Reform was consolidated by the 1988 Constitution. The successful implementation of the SUS throughout the 1990s, despite national and international barriers, is a process that requires specific analysis. It is safe to conclude, however, that its feasibility was at least in part due to the outcomes of the 1980s' reforms. The AIS and SUDS had initiated service decentralisation and regionalisation, reanimating the sector at the municipal and state levels. At the same time, public providers became more valued and this led to institutionalising governmental actors such as municipal and state health secretaries who played an important role in defending SUS in the last decade of the twentieth century.

Lastly, a relevant aspect in the Brazilian experience is that the reforms contemplated interests of key societal actors in the political arena. On the one hand, they ensured universal access to healthcare and established user participation (advocated by the *Sanitarista* movement). On the other, the private sector was maintained as a complementary provider of public

services. Although such design did not fully accommodate each party's demands, it placed these actors on the same side, as partners. Both defended issues that were essential to the sector – among

which, for instance, funding health in face of the state's budget restrictions and fiscal adjustments in the 1990s – thus perpetuating implementation of the reforms.

Notes
1 The article adopts a polity-centred approach, which emphasises process-tracing from the perspective of actors that are capable of influencing policy, examining the way they act and interact as well as their interests and proposals. For the main components of this approach see Houtzager (2004).
2 MPAS allotted its resources to four areas: administration, health, assistance and social security. From 1978 onwards, new agencies were created, each in charge of one of these areas.
3 The Institutes encompassed the main urban professional categories in the country, such as maritime, commerce, banking, industrial, transportation and freight workers, and workers in railways and public services.
4 Social security's negative balance was due to its benefits extending to greater amounts of the population without ensuring new funding

mechanisms. The system was supported mainly by salaried urban workers and their payrolls, which resource was drastically reduced in the economic recession of that period. The social security deficit was also attributed to resources being siphoned off for infrastructure construction (Arretche 2005: 291). On the other hand, there was lack of expenditure control with hospital-based medical care.
5 SUDS lasted until 1990, i.e. until enactment of the Organic Health Law (Lei Orgânica de Saúde, LOS). Throughout its existence, it faced resistance from the private sector and from the INAMPS bureaucracy, especially when representatives of the *Sanitarista* movement were removed from managing positions in MPAS and INAMPS. Continuity of the SUDS was ensured by engagement and pressure from municipal and state health secretaries (Escorel 1998: 94; Noronha and Levcovitz 1994: 94).

References
Arretche, Marta (2005) 'A Política da Política de Saúde no Brasil' ['The Politics of Health Policy in Brazil'], in Nísia Trinidade Lima, Silvia Gerschman, Flavio Coelho Edler and Julio Manuel Suárez (eds), *Saúde e Democracia: História e Perspectivas do SUS [Health and Democracy: SUS History and Perspectives]*, Rio de Janeiro: Fiocruz
Bahia, Ligia (2005) 'O SUS e os Desafios da Universalização do Direito à Saúde: Tensões e Padrões de Convivência Entre o Público e o Privado no Sistema de Saúde Brasileiro' ['SUS and the Challenges of Universalising the Right to Health: Tensions and Interactions Between Public and Private Arenas in the Brazilian Health System'], in Nísia Trinidade Lima, Silvia Gerschman, Flavio Coelho Edler and Julio Manuel Suárez (eds), *Saúde e Democracia: História e Perspectivas do SUS [Health and Democracy: SUS History and Perspectives]*, Rio de Janeiro: Fiocruz
Barros, Maria Elizabeth (2002) 'Financiamento do Sistema de Saúde no Brasil: Marco Legal e Comportamento do Gasto' ['Financing the Brazilian Health System: Legal Framework and Expenditure Behaviour'], *Projeto de Desenvolvimento de Sistemas*

e Serviços de Saúde [Health Systems and Services Development Project] 4, Brasília: Pan-American Health Organization, Health Care Secretariat and Health Ministry
Barros, Maria Elizabeth; Piola, Sergio Francisco and Vianna, Solon Magalhães (1996) 'Implementando a Reforma Sanitária' ['Implementing the Sanitária Reform'], 'Processo de Descentralização' ['Decentralisation Process'], 'Desafios na Gestão' ['Challenges in Management'], *Política de Saúde no Brasil: Diagnóstico e Perspectivas [Health Policy in Brazil: Diagnosis and Perspectives]*, Brasília: Instituto de Pesquísa Economica Aplicada (Institute of Applied Economic Research, IPEA)
Bodstein, Regina Cele de A. and Fonseca, Cristina M. Oliveira (1989) 'Desafio da Reforma Sanitária: Consolidação de uma Estrutura Permanente de Serviços Básicos de Saúde' ['Challenge in the Sanitária Reform: Consolidating a Permanent Structure for Basic Health Services'], in N.R. Costa, M.C.S. Minayo, C.L. Ramosand and E.N. Stotz (eds), *Demandas Populares, Políticas Públicas e Saúde [Popular Demands, Public Policies and Health]*, Rio de Janeiro: Vozes and ABRASCO

Carvalho, José Murilo de (2007) *Cidadania no Brasil – O Longo Caminho [Citizenship in Brazil – A Long Way]*, Rio de Janeiro: Civilização Brasileira

Cohn, Amelia (2003) 'A Saúde na Previdência Social e na Seguridade Social: Antigos Estigmas e Novos Desafios' ['Health in Social Security and in Social Welfare: Old Prejudices and New Challenges'], in A. Cohn and M.P. Elias (eds), *Saúde no Brasil: Políticas e Organização de Serviços [Health in Brazil: Service Organization and Policies]*, 5th edn, São Paulo: Cortez

Cohn, Amelia (1989) 'Caminhos da Reforma Sanitária' ['Paths of the Sanitária Reform'], *Lua Nova* 19: 123–40

Cohn, Amelia and Elias, Paulo Eduardo Mangeon (eds) (2005) *Descentralização e Saúde no Estado de São Paulo. As Articulações Entre as Esferas do Governo [Decentralisation and Health in the State of São Paulo. Articulation Among Government Spheres]*, São Paulo: Centro de Estudos de Cultura Contemporânea (Center for Contemporary Culture Studies, CEDEC)

Cordeiro, Hésio (1991) *Sistema Único de Saúde [Unified Health System]*, Rio de Janeiro: Ayuri

Escorel, Sarah (1998) *Reviravolta na Saúde: Origem e Articulação do Movimento Sanitário [Shake-up in Health: Origin and Articulation of the Sanitário Movement]*, Rio de Janeiro: Fiocruz

Escorel, Sarah; Nascimento, Dilene Raimundo do and Edler, Flavio Coelho (2005) 'As Origens da Reforma Sanitária' ['Origins of the Sanitária Reform'], in Nísia Trinidade Lima, Silvia Gerschman, Flavio Coelho Edler and Julio Manuel Suárez (eds), *Saúde e Democracia: História e Perspectivas do SUS [Health and Democracy: SUS History and Perspectives]*, Rio de Janeiro: Fiocruz

Fleury, Sonia (1991) 'Avaliação Comparativa das Ações Integradas de Saúde' ['Comparative Evaluation of the Integrated Health Actions'], *Saúde em Debate [Debating Health]* 3, February

Gallo, Edmundo (1988) 'Da Reforma ao Reformismo: o CEBES e o "Movimento Sanitário", da Ditadura à "Nova República"' ['From Reform to Reformism: CEBES and the "Sanitário Movement", from Dictatorship to the "New Republic"'], *Saúde em Debate [Debating Health]* 7, October

Houtzager, Peter (2004) 'Além da Sociedade Civil e do Estado: Autoridade Política, Instituições e Mobilização Popular' ['Beyond Civil Society and the State: Political Authority, Institutions and Popular Mobilisation'], in *Os Ultimos Cidadãos: Conflito e Modernização no Brasil Rural (1964–1995) [The Last Citizens: Conflict and Modernization in Rural Brazil (1964–1995)]*, São Paulo: Globo

Lima, Nísia Trinidade; Fonseca, Cristina M.O. and Hochman, Gilberto (2005) 'A Saúde na Construção do Estado Nacional no Brasil: Reforma Sanitária em Perspectiva Histórica' ['The Role of Health in Building the National State in Brazil: The Sanitária Reform in a Historical Perspective'], in Nísia Trinidade Lima, Silvia Gerschman, Flavio Coelho Edler and Julio Manuel Suárez (eds), *Saúde e Democracia: História e Perspectivas do SUS [Health and Democracy: SUS History and Perspectives]*, Rio de Janeiro: Fiocruz

Noronha, José Carvalho and Levcovitz, Eduardo (1994) 'AIS-SUDS-SUS: os Caminhos do Direito à Saúde' ['AIS-SUDS-SUS: Paths to the Right to Health'], in Reinaldo Guimarães and Ricardo A.W. Tavares (eds), *Saúde e Sociedade no Brasil: Anos 80 [Health and Society in Brazil: The 80s]*, Rio de Janeiro: Relume-Dumará

Paim, Jairnilson Silva (1986) 'Ações Integradas de Saúde (AIS): Por que não Dois Passos Atrás?' ['Integrated Health Actions (AIS): Why Not Two Steps Backward?'], *Cadernos de Saúde Pública [Reports in Public Health]* 2.2, April/June

Pimenta, Aparecida Linhares (1993) 'O SUS e a Municipalização à luz da Experiência Concreta' ('SUS and Municipalisation in Light of Concrete Experiences'), *Saúde e Sociedade [Health and Society]* 2.1: 25–40

Possas, Cristina de Albuquerque (1980) 'Saúde, Medicina e Trabalho no Brasil: Uma Antropofagia do Capitalismo Selvagem' ['Health, Medicine and Work in Brazil: An Anthropophagy of Savage Capitalism'], MSc thesis, Social Anthropology Department, IFCH, State University of Campinas

Saddi, F. (2004) 'Estado, Sociedade e Descentralização da Política Pública de Saúde no México (1982–2000) e no Brasil (1985–1998): Construindo um Novo Domínio Público em Contextos de Dupla Transição' ['State, Society and Decentralising Public Health Policy in Mexico (1982–2000) and in Brazil (1985–1998): Building a New Public Domain in Double Transition Contexts'], Doctoral dissertation, Department of Sociology, School of Philosophy, Letters and Human Sciences of the University of São Paulo