Readings about developmentalist health and interpretations for the Brazilian health reform and public health

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Abstract

In the Brazilian public health literature, an association has been drawn between the 1970s health reform movement and what has been called developmentalist health. By investigating the discourse of two sanitarians from the developmentalist period – Mario Magalhães da Silveira and Carlos Gentile de Mello – we seek to unpick how their status of "precursors" of the health reform was constructed, analyzing the interfaces between public health, developmentalist thinking, the strategy for the construction of the developmentalist health and the health reform. Without refuting the pioneering nature of the sanitarians' ideas, we argue that the Brazilian Unified Health System, Sistema Único de Saúde, was created not simply in continuation of developmentalist thinking.

Keywords: developmentalism; health reform; public health.

In the public health literature in Brazil, an association has been drawn between the health reform movement of the 1970s and what was called developmentalist health (*sanitarismo desenvolvimentista* in Portuguese) (Luz, 1986; Braga, 2006; Teixeira et al., 1988). We argue that this association was a strategy employed by authors from the 1970s and 1980s to formulate arguments in a context in which practices and theories had to be conceived with an eye to transforming Brazil's health policies and conditions, while at the same time resisting post-1964 authoritarianism.

We analyze the discourse of two sanitarians from the developmentalist period – Mário Magalhães da Silveira and Carlos Gentile de Mello – to identify the precursors of the health reform, which issues were revived in the 1970s and 1980s, and which dilemmas gained visibility. By so doing, we seek to understand how this idea of the precursor was constructed as the argument of developmentalist health was revived.

While our interpretation is historical, it refutes the idea that the political thinking behind these discourses and strategies progressed in any rational or evolutionary way over time. Rather, the marks of time are also marks of relocated inconsistencies and imponderable effects. That is why the authors studied here are not treated as thinking subjects endowed with an expanded consciousness; they are just men of their time who engaged in political thinking and action. At the same time, we acknowledge that at the present moment we are, indeed, interested in making a retrospective judgment, but not so much of the authors, thinkers, and characters involved as of the arguments themselves (Larrosa, 2004).

We begin by presenting the arguments of Mário Magalhães da Silveira and Carlos Gentile de Mello about the issues of health and development. We follow this with a presentation of how, in the authoritarian period, the conception of public health and its interfaces with developmentalist thinking emerged. We then recapitulate how developmentalist health thinking emerged from our reading of authors from the 1970s and 1980s, tracing how the ideas that foreshadowed the health reform took shape in a bid to recognize how the developmentalist, public health, and health reform projects converged and diverged. We conclude by explaining why the construction of the Brazilian Unified Health System (Sistema Único de Saúde, SUS) is not a mere continuation of developmentalist thinking.

Mário Magalhães da Silveira: health and development through the public health route

Mário Magalhães da Silveira (1905-1986) developed his thinking within the area of public health, gaining particular influence as of the mid-1940s and especially after the creation of the Ministry of Health, in 1953. His interest in the relationship between health and economic development made him very much a man of his time: Brazil was undergoing intense transformations in its political, economic, and demographic profile, and around the world considerations about development were at the front of the minds of a great many intellectual figures.[1]

Silveira's basic thesis stemmed from his belief that Brazil was underdeveloped because it had begun its industrialization late. He believed strongly in the precedence of economic development over medicine and public health when it came to their impact on the health of the nation[2] (Silveira, 2005).

As such, his thinking effected a rupture among his contemporary sanitarians, sustaining that the generative power of development lay in economic productivity itself: the impact of this economic growth would mean better living conditions for the people, which in turn would yield improved health conditions. And as a result, the population would grow and life expectancy with it, resulting in improved productivity for the nation as a whole.

Silveira's interpretation was not far from the ideas of virtuous capitalism, whereby the income and benefits derived from economic growth would be redistributed. One prerequisite for capitalist development to be virtuous was to tackle socioeconomic inequalities, since these would stand in the way of the circulation of capital needed for economic growth.

For Silveira, the differences between countries' economic structures – different taxation powers, demographic structures, distributions of occupations amongst the population, per capita income etc. – produced distinct variations in their disease and medical and health requirements, which in turn made it unfeasible to simply replicate a pre-existing medical and health organization.

Accordingly, he advocated the development of a genuinely national development model that put priority on investing in actions that would impact people's living conditions. He was against importing public health models from elsewhere, such as the ones promoted by the Rockefeller Foundation and the Special Public Health Service (Serviço Especial de Saúde Pública, SESP),[3] because they emphasized health spending as a driver for development and promoted national campaigns, operating uniformly across the whole country and allocating resources without prior knowledge of local needs and realities, generating waste rather than improving levels of health (Reis, 2015).

Besides running counter to the beliefs of most Brazilian sanitarians at the time, Silveira's thinking was also incompatible with certain US-sponsored proposals that gained international prestige in the 1960s, targeting investments in health and education.[4] His thinking was influenced not just by pendular developmentalist positions[5] (Lima, Fonseca, Hochman, 2005) and positions formulated by theorists from central countries, like Myrdal and Nurkse (Cepêda, Gumieiro, 2014), but also by Brazilian thinkers like Celso Furtado and Roberto Simonsen, and by institutions devoted to thinking about development in peripheral realities, like the Higher Education Institute for Brazilian Studies (Instituto Superior de Estudos Brasileiros, ISEB) and the Economic Commission for Latin America and the Caribbean (ECLAC). As such, his interpretation had a systemic basis that enabled him to criticize capitalist center-periphery relations and argue that in Brazil, strategies for growth should not mirror those adopted in developed countries or in other underdeveloped realities.

Even while Silveira refuted the idea that health spending should take precedence over investments in general living and working conditions, he still defended a specific way of thinking about health policies. The work of the Ministry of Health could be specific or general. If specific, it would "prepare any national territory in such a way as to provide conditions for man to live and work," improving public health conditions via sanitation, providing the groundwork for settlement policies, and enabling an "expansion of the areas that can be used for agricultural development." It could also be general, providing "indirect assistance for increased production,"

> expanding on a policy for the expansion of health care activities in the inland parts of the country. In this sense, it is of the utmost importance that the Ministry of Health, taking on its legal responsibilities to oversee welfare medical services, seek to coordinate and adjust with the programs of government bodies in order to obtain greater income (Silveira, 2005, p.362).

He wrote this in 1962 in a speech to be given by the former minister of health, Souto Maior, at the 15th Brazilian Hygiene Conference. It therefore postdates the creation of the Ministry of Health and the debate surrounding the bill that created it, which involved issues concerning whether it should take on the health responsibilities of the social welfare system (Hamilton, Fonseca, 2003). Although the above words do not directly reference the legislative debate prior to the creation of the ministry, they make it clear that he would have had the ministry in charge of coordinating and overseeing welfare medicine, too. Interest in coordinating all the health services available did not mean questioning the welfare rationale, but, as the text states, of avoiding "wasting the limited national resources for medical and health care" and the "duplication of services resulting from the multiplicity of bodies with responsibility for similar tasks without any coordination to distribute the tasks and oversee the results" (Silveira, 2005, p.362).

Silveira held two positions when it came to welfare and health policies. First, he believed that economic development boosted the government's capacity to invest in the growth of welfare, which, in turn, would translate into an expansion of medical care. Second, he argued that "health is a good to be purchased" or, "in one word, the health of a national collective depends on the average productivity of the Brazilian population" (Silveira, 2005, p.111). In other words, a society that is productive will earn income – swelling public coffers and household budgets alike – so it can meet its basic and fundamental needs (food, housing, clothing) and even other needs (education, medical care, entertainment), which in the context translated into enjoying good health.

As for the purchase of health care, Silveira's words leave little room for interpretation:

> The improved living conditions of a population, which ultimately translate into the possibility to use more and better goods and services, mean that they will seek to better defend their health and life, using medical and health services on a larger scale. These services, 'whether official or private', under pressure from the demands of the population, will be caused to expand, since the resources for their maintenance resulting from the relative reduction of spending on food (Silveira, 2005, p.115; emphasis added).

Additionally, one of the meanings of public health, according to Silveira, was to take actions through "quality programs," as he explains:

> given the high income elasticity,[6] reflected in the consumption of medical and health services, and development, which always translates into growth of the real per capita income of populations, raising the supply of these services, this is a program of quality (Silveira, 2005, p.74).

As such, increased demand for health services was also expected, which were largely in the hands of the private sector or the welfare sector – both driven by the market economy (Braga, 2006).

If public health actions could leverage health, including as an economic sector, it follows that there was not a parallel relationship between public health and welfare medicine, but a relationship between two mutually complementary political paths, since the expansion of welfare medical services would be motivated by economic progress – supported by public health – which would yield increased productivity, employment, and tax revenues.

Silveira stressed that in view of Brazil's underdeveloped state, its public health policy should be guided by the principle of the cost-effectiveness of actions that were strictly medical and health-related. This meant, by definition, that certain diseases would have to be prioritized over others, meaning universal comprehensive health would not be provided. Moreover, although Silveira did comment on the retirement and pension system, it was entirely with regard to public health that he elaborated all his developmentalist and health-related thinking and policy proposals.

Silveira was an advocate of municipalization, with the "installation of a network of basic public health services under the responsibility of local authorities, with technical and financial assistance from the Union and States" (Silveira, 2005, p.146). He proposed that each municipality should have a medical and public health organization that was compatible with its needs, possibilities, and resources, "not submitting to any prefabricated scheme" (p.143). He argued that the "diversification of systems" was "more convenient" (p.152) and that the aim should be to provide public health services for the whole population. In fact, he refuted the idea of adopting models for health organization and supported a form of universalization that differed from what the country would seek years later. His universalization did not envisage a national system (a set of institutions integrated around common purposes) or a unified system (organized around a normative framework) permeated by standard organizational and doctrinal principles.

Another important aspect of his thinking was the fact that the developmentalism he advocated conceived of the state as having a different role, with the function of economic agent and planner. In other words, even though he did not develop the notion of health as a right, he nonetheless paved the way for the argument that health was a state responsibility and should be enabled through social and economic policies that boosted national development, respecting the country's economic and financial realities.

The civil-military coup of 1964 had a direct impact on Silveira's life. He lost his positions at the Ministry of Health and the National School of Public Health, and it was some time before he found new teaching work, giving courses in epidemiology, statistics, population, health, and development organized by the Guanabara State Medical Association (Associação Médica do Estado da Guanabara, Ameg). Ameg was keen to work with "doctors who fought for the right to health, such as Samuel Pessoa, Mário Vitor de Assis Pacheco, Álvaro de Faria, and Carlos Gentile de Mello. Even in the 1970s, this group from Ameg was involved in the organization of the Medical Revival Movement" (Campos, 2015, p.437). This movement – a key shaper of the health reform movement in the 1970s and 80s – was one of several spaces that Silveira shared with another sanitarian recognized as being developmentalist-minded and a forerunner of the reform: Carlos Gentile de Mello. A man Escorel (2000, p.148-149) describes as "an element of transition, a link between the old group of opponents of liberal ideology in medicine and the renewal movement of the seventies."

Carlos Gentile de Mello: health and development through the welfare medicine route

Carlos Gentile de Mello (1918-1982) graduated in the 1940s and worked in welfare medicine. He also trained in public administration, hospital administration, state planning, and economics. At ISEB, he consolidated the argument that defended a relationship between health and development in coordination with state and nation projects in the political and academic debate of his day.

Mello's trajectory can be divided into periods, based on his output: the first, from 1961 to 1974, when he presented issues related to the organization and administration of hospital services, in dialogue with issues related to the medical class and theses related to the health and development debate; and the second, as of the mid-1970s, when he intensified his critique of the model for the provision of welfare health services, speaking out against privatization and on the role of the state in health.[7]

In the earlier of the two periods, Mello's thinking was on health and the state, understanding the physician as an agent of social transformation and a strategic player in the defense of health. He argued that if these professionals were provided with adequate remuneration and working conditions, they would not wish to work in bulk or based on profit-seeking, because they would be the bearers of an "ethical commitment to the population's health" (Mello, 1964). He believed in what he called institutional medicine, whose existence would depend on a state policy and the country's social and economic development.

Mello's thinking echoes the same set of concerns verbalized by Mário Magalhães da Silveira, calling for state commitment to planning with a view to the population's health and living conditions: "without promoting the economic development of the country, the problem cannot be solved in the specific sector in which they operate" (Mello, 1962, p.40). He also subscribed to the developmentalist thesis whereby health was seen as indirectly affecting production: "Medical care is one of the instruments at society's disposal to improve the population's health, not always the most important, almost always not the most important" (Mello, 24 jun. 1974).

He also shared Silveira's criticism of importing models that did not meet the country's needs and their adoption without planning for the desired effects. He raised this question clearly in the 1960s in his analysis of the performance of the pharmaceutical industry and foreign capital:

> according to the most optimistic estimates, 80% of the pharmaceutical industry is in the hands of foreign companies which make profits, in some cases, of over 250% a year. As this situation puts an excessive burden on medical care, no alternative can be envisaged save state intervention in the pharmaceutical product sector (Mello, 1962, p.36).

Mello also brought up aspects of the logic of welfare medicine that had been beyond the scope of the public health debate. One issue worth mentioning is the understanding of medical practice as an economic activity, a key aspect for understanding the distortions present in the organization of medical practice and services within the scope of welfare medicine (Noronha, 2015). Mello was an important pioneer in defending this position,

which would subsequently become a central issue in the discussions surrounding the health reform.

Working along the same lines, Mello began an effort to trace the various ways public monies could be channeled into health,[8] carrying out various studies into hospital care, health insurance, welfare medicine, and the commercialization and privatization of medical care. These shone a light on the economic and political weight of medical activities, and allowed state regulation to be defended as a way to avoid processes that were perverse for the system and for the health of the population.

For Mello, medical practice should be regulated by expanding institutional medical services, bringing welfare medicine and public health into closer proximity and alignment without reducing benefits. A first step in building institutionalized medicine would be the unification of the institutions. He attacked the wasteful use of social security resources and called for unification to enable economies of scale in the supply of services, enabling improvements to be made in the provision of medical services (Mello, 1962).

His defense of institutionalized medicine did not, however, mean he saw health as a right, but that he envisaged a state-organized health care system that assured workers access to medical care. In other words, he did not discuss those who were not covered by welfare medicine. Like Silveira, he believed that insurance would be enough to guarantee healthcare coverage, assuming that the associated development would generate work for all. Development would accordingly produce inclusion, and the role of the welfare policy would be one of redistribution.

> The moment the new Ministry of Welfare and Social Services announces that it intends to provide universal coverage, protecting the whole Brazilian population, seems opportune to recall these elements of a historical nature, while stressing that from a doctrinal perspective, the health protection and recovery sector should be an instrument of income redistribution (Mello, 9 set. 1974).

Until such a time as there was full inclusion, the state was responsible for planning policies to address the problems that affected the population situated far from the cities in regions lacking medical and health services. Three questions fed into the debate.

The first was the argument around the association between doctors and regional development, indicating the difficulty of retaining medical professionals in locations with poor living conditions and economic standards (Noronha, 2015). The association between the distribution of doctors throughout the country and the distribution of banks was presented as a clear example – "there is an extraordinary analogy between the nominal relationship of municipalities without doctors and without bank branches" (Mello, 1969, p.849) – and referred to the debate about the development policy, with a more comprehensive analysis of the health sector. In the 1960s, Mello reiterated a state of affairs that Silveira had begun to speak about in the 1940s: a period of intense urbanization and industrialization, in which a great number of Brazilian towns did not have "primary" services such as water and sewage.

The second issue had to do with the distribution of doctors throughout the land, including the proposal to attract other professionals, too, in order to guarantee some assistance to the population. Mello advocated the provision of health services by "sub-

professionals," who would be responsible for combatting mass diseases using simple techniques, not unlike the proposals put forward by sanitarians (Mello, 1969).

Finally, there was the question of the training of doctors as a prerogative for concrete changes in medical practice, which should be part of state planning and policymaking. The rationale based on breaking down the services was refuted: "just as the existence of a public health body without welfare activity cannot be justified, neither can welfare bodies be justified without public health activity" (Mello, 1962, p.29-30). He held medical practice and professional training accountable, adopting a criticism similar to Silveira's criticism of sanitarians trained under SESP precepts: the inadequacy of medical schools whose syllabus was geared towards diseases prevalent in developed countries.

His forthright, critical tone reveals how Mello had inherited something of the debate spearheaded by Silveira about "health and development," notwithstanding the differences stemming from their different fields of experience.

The developmentalist proposals for health gained an important platform at the time of the third National Health Conference (1963), whose secretary-general was Mário Magalhães da Silveira.

The conference took place in a context that was favorable for change, when the João Goulart administration was proposing fundamental reforms. The central tenet of the conference was that a general examination of the health situation in Brazil and the definition of health programs adjusted to the needs of the people would contribute to the economic development of the country (Brasil, 1963).

Throughout Brazil's history, five clearly delimited projects have vied for preeminence when it comes to developmentalism: the neoliberal perspective; defenders of a non-nationalist public sector; defenders of the private sector; defenders of a nationalist public sector; and those with a socialist perspective (Bielschowsky, 2004). The developmentalism experienced between the 1950s and early 1960s, with which Silveira and Mello were associated, was of nationalist public sector inspiration. One of its leading exponents was the economist Celso Furtado. Furtado was responsible for the creation, in 1959, of the Department for the Development of the Northeast (SUDENE); director of the development area of ECLAC; devisor of the Three-Year Economic and Social Development Plan; Minister of Planning during the João Goulart administration; and he participated in the construction of the proposal for the fundamental reforms. Mário Magalhães da Silveira worked at SUDENE on Furtado's invitation from 1959 to 1961 (Campos, 2015). But the civil-military coup of 1964 interrupted the political process underway in those years. As a "transition element" (Escorel, 2000), Mello still called for developmentalist proposals until the early 1970s, but by then the ideas were no longer attracting the same interest. The government's approach to health (both public health and welfare medicine) entered a new cycle, and the developmentalist project likewise.

Developmentalism and public health

One important shift in the developmentalist project came about with the onset of authoritarian rule in 1964. With it came a perspective for the strengthening and expansion of the private and non-state public sector as a growth strategy (Singer, 2014).

The developmentalist proposals for health presented at the National Health Conference in 1963, which had stressed state planning of health, were reworked. In 1967, the then minister of health, Leonel Miranda, announced a plan for the "complete privatization of the national system for the protection and recovery of health, a regime for the free choice of doctor and hospital by customers, and direct and immediate compulsory participation of users in covering service costs" (Mello, 1968, p.139). The reaction to the document was immediate and prevented the plan from being implemented as originally envisaged, actions were taken that were in some way consistent with a health model focused on the provision of medical services (Braga, 2006; Almeida, 2006).

It was not just because of the direction implied by the Leonel Miranda Plan, but also because of several other distortions that Mello reinforced his criticisms of the plans for attracting doctors to rural parts without linking them with concrete policies to modify the social and economic state in every region of the country.

In welfare medicine, the expansion of a private model for the provision of health services was consolidated with the unification of the Institutes of Retirement and Pensions (1966). At first, unification seemed to be aligned with the precepts of developmentalist health planning, which indicated the need for a more rational use of social welfare resources; however, the route taken by the National Institute of Social Welfare (Instituto Nacional de Previdência Social, INPS) after six years of unification pointed to the opposite. The agency had overseen the fragmentation and dispersion of its financial resources with "the privatization of medical care, introducing a new component to the functioning of the social security system: profit earned by groups from outside the system." The effects of privatization indicated an "inevitable, proven and significant decline in the qualitative standards of professional medical practice" (Mello, 5-6 ago. 1972).

At that time, tensions between medicine in the service of public interest and private medicine were heightened. Mello unpicked the tangle of ways in which medicine could be privatized, stating categorically that "the right services are, as a general rule, the ones that present the best technical and scientific standards, whatever indicators are used to gauge the technical level of the medical care" (Mello, 28 jan. 1974).

This argument served as an attack on the mechanisms of free choice, either by generating a market-related logic of health service consumption or by creating administrative problems and loss of control of resources per unit of service.[9] The criticism was built around the growth of the private sector within the social security system and not individuals (independent doctors). With his analyses, Mello denounced the state-sponsored commercialization of medicine and the lack of interest in achieving a model that focused on prevention and adequate health care.

Mello began to compare welfare medical spending with public health spending and noted a decline decrease in resources for the latter, making the Ministry of Health's administrative structure obsolete, inoperable, and inefficient, permeated by privatization and a focus on hospital care. He made analyses of what different policy directions could be taken for public health and welfare medicine.

Mello's analyses were also instrumental at a different time during authoritarian rule, when criticism about the political and economic strategy adopted was growing and the

political and social debate was expanding, under pressure from different social movements. It was at this time that the health reform movement began to take on a more consistent identity and proposals.

Pressure for political openness and concern with maintaining the same economic orientation led to a gradual inflection on the part of the government from 1974 onwards, with a strategy of "slow, gradual and safe" relaxation. As far as social demands were concerned, in 1975 it came out with its second National Development Plan, which put emphasis on social matters. One particularly important element in this context was the proposal to create a national health system, along with a bid by the Ministry of Health to create strategies for improved integration (Faria, 1997).

The debate around integration proposals led to political disputes among bureaucratic entities, interest groups, and political agents that involved health and welfare. As Mello put it, "a 'scythe fight in the dark' has started; the scythe, evidently in the hands of the Ministry of Social Security, which has the financial resources" (Mello, 11 ago. 1975; emphasis in original).

There were several obstacles to the national health system, including the absence of a health policy. Criticism was made of the INPS bureaucracy, which blocked integration, maintaining its control of funds for health services – funds that were drained into private institutions.

It was in this context that Mello's developmentalist thinking took a new direction. The thesis that economic development would be accompanied by social development was *sub judice*. The accelerated cycle of economic growth had not been accompanied by an improvement in the population's living standards.[10] The vicious circle of poverty and disease could not be broken merely by investing in areas that promoted economic development, but should constitute a clear policy of social redistribution that involved tackling the dynamics by which certain groups made financial gain.

Mello brought health indicators and worsening living conditions into the debate, and argued that privatized medicine was the main reason for the lack of social development in the health area. In his analyses of group medicine and private insurance in Brazil, he was adamant: "this is a funding model that cannot be generalized; a far cry from universalization" (Mello, 1983, p.78), "far from representing a solution for the financing of medical care, contemplating only the parts of the population with a higher income, increasingly restricted" (p.110). His central argument was based on the state's responsibility for assuring a pattern of development that did not reproduce inequality, but was based on a public rationale and was not subject to market interference. This argument was the closest to the consensus in the health reform movement.

Mello pioneered a whole mode of thinking that inspired sanitarians to migrate from a debate limited to public health toward a debate that included welfare medicine, successfully introducing the dichotomy between the two sectors to the heart the developmentalist debate. He was also behind the call for a bridge between the two sectors and the defense of institutionalized medicine and the right to comprehensive health care, as developmentalist concepts ran their course.

He therefore helped to understand the different political paths in the health area, and thereby the recognition of the actors and interests in the political game that stretched

from the 1970s onward. It should be pointed out, however, that these were not the only arguments developed at that time – a time when what became known as collective health first emerged.

To understand how Mello's thinking converged with the trajectory of the constitution of a new approach to health, we must enter a different sphere of the debate that was taking place at Brazil's universities and drew a connection between medical training and medical practice.

As indicated above, medical training was one target of Mello's analysis, as he perceived the doctor-patient relationship as an important element in sustaining a privatized practice. It was also based on the debate on training that, between 1969 and 1973, the Departments of Preventive Medicine of the State of São Paulo developed a specific analysis of the project for preventive and community medicine, expanding from the more limited focus of the health sciences (Tambellini, 2003). The regional debate drew supporters from the national and international debate, in dialogue with the Pan-American Health Organization and professors from other parts of Latin America, such as Juan Cesar Garcia, Asa Cristina Laurell, and Jaime Breilh.

Criticism of preventive medicine and medical practice marked an important turning point in the debate, with the doctoral theses by Donnangelo (in 1974) and Arouca (in 1976) serving as another contribution towards a break with the prevailing developmentalist interpretation.

Both drew on a Marxist analysis to denounce, in the practice of preventive medicine, what Arouca summarized as a mythified and detheorized model of the social. He lay bare a relationship between science and society based on "circular thinking from a point at which the homogeneity of the categories (biological, economic, social etc.) makes it possible to turn the wheel of social process from any point, in an upward spiral" (Arouca, 2003, p.125). The upward direction of this spiral was synonymous with the progress and economic development sold by the developmentalist theorists.

From this perspective, preventive medicine blurred the social determination of disease by adopting a multicultural interpretation of the natural history of diseases, reducing the social to just one more variable in the explanatory model. Arouca used this approach to explore the fact that preventive medicine would not produce any new knowledge or changes in medical care, let alone any critiques of the social structure, but an ideological movement in which man – in this case, a doctor – was framed as if he were free from constraints and all-powerful in his capacity to establish new social relationships through a preventive attitude; an enticing idea that prevented a recognition of the processes behind the social determination of disease.

Donnangelo's contribution to this debate consisted of making a social and historical interpretation of medicine and viewing the social reproduction of medical practice by discussing the medicalization of exclusion, poverty, and inequality (Schraiber, 2011). By explaining the historical process whereby capitalist labor relations are reformulated and how this affects medical practice, she denounced the gradual replacement of liberal medicine with modes of production that led to the separation of the medical professional from his or her means of work.

According to Donnangelo and Pereira (2011), the effects of this medicine, instrumental in the capitalist relations of production, can be seen clearly in the spheres of the individual therapeutic act and clinical practice, with the expansion of the production of services and the generalization of consumption.

The authors denounced not only community medicine as a means of appeasement and of reproducing the inequalities inherent to capitalist production, but also the actions of the developmentalist state, a prominent agent in the promotion of social policies designed to increase the consumption of specific goods and sectors (e.g., education, housing etc.). These were policies that would not immediately suit the interests of the ruling classes, but would certainly not alter the social and production structure, preserving the existing inequalities.

Arouca's and Donnangelo's contributions built arguments that denounced preventive and community medicine as conservative projects. They did not present a new conceptual framework, but invested in strategies to reorganize medical education and service delivery, respectively, through a rationalizing matrix that was adjusted to the developmentalist rationale of the foreign policy adopted by the world's leading center of economic development, the United States. In this matrix, every project formulation put health as an indicator of bankruptcy and poverty.

These intellectual enterprises, which allowed preventive and community medicine to be critiqued and resignified, along with other critical contributions of the period, formed a set of studies that went beyond the strict field of public health as it had been organized until then.

At the same time that studies offering a clear break with developmentalism were being published, theses from the old sanitarians involved in the development project were being brought back, especially the rejection of reductionism to the biological interpretation of diseases. Their contributions were already building up a sense of "social" and "collective" factors in medicine and health. It was in this melting pot of ideas that these positions coexisted and vied for narratives before they were annulled (Paiva, Teixeira, 2014; Teixeira, Paiva, 2018). In the political field, this dispute operated in the construction of a public health project that was intimately linked with the democratic turn and efforts to combat social inequalities.

Public health, health reform, and the construction of developmentalist health

The spread of criticisms of preventive and community medicine and the upsurge of ideas about social medicine enabled new forms of medical training to be conceived in the 1970s as the social and political debate gained clearer contours. In 1976, the Brazilian Center for Health Studies (Centro Brasileiro de Estudos em Saúde, CEBES) was established, followed in 1978-1979 by the Brazilian Association for Postgraduate Studies in Public Health (Associação Brasileira de Pós-Graduação em Saúde Coletiva, ABRASCO). Both institutions articulated and engaged in the health debate, one focused on political articulation and the other dedicated to academic training.

The debate around the new plans for health, which was already criticizing developmentalism, began to spawn new ideas about a socialist state project. As Teixeira

(1988, p.196) put it, the public health movement "effected a socialist interpretation of the problems brought to light by the crisis of commercialized medicine and its inefficiency."

Costa Filho (1978, p.66) noted the fall of developmentalist conceptions after the economic miracle, stating that "the way development is processed is not alien to those whom it benefits:" in capitalism, development is produced at the cost of the consumption of labor. Even while acknowledging that the destruction of capitalism was not on the agenda, he called for a different theory that might explain the relationships between the health enjoyed by people and the economy, incorporating other concepts, such as social class and structure. As he saw it, public health work should be associated with efforts to transform social relations, which at that time meant strengthening the movement for the return to democracy in the country.

In this sense, democratization attracted a medley of distinct interpretations, which did not all involve defending a socialist project. We would highlight here the contribution made by Fiori (1993, p.35), who denounced the fact that the developmentalist state did not take account of democratic participation "and so never supported the institutionalization of structures that could account for pressures for the expansion of political and social citizenship." This would lead the 1970s health reform movement to point out that developmentalism never served to expand the reach of social protections, just to nurture the growth margins of capital.

In short, although some defended a socializing project, it was generally felt that a socialist perspective was not a viable option in Brazil in the 1970s. In the context of the dictatorship, any proximity to such a project could mean confrontation and loss of political space for the construction of reform (Tambellini, 2003). Therefore, more efforts were put into mediation to consolidate a democratic health policy.

In this context, the return to the developmentalist arguments of the 1950s and 60s seems to have been seen as strategic. In order to push the reform project forward, some former political projects that could be seen as legitimizing the present would have to be brought into play; recouping, as it were, what was conceivable only in a democratic context.

Some of the theses that were present at the time of the third Brazilian Hygiene Conference were taken up and revamped in the light of the debate of the 1970s. Two academic research projects summarize this movement: Madel Luz's doctoral thesis on medical institutions and José Carlos Braga's master's thesis on social policies for public health and welfare medicine. Both studies contributed to the construction of the "category" that would come to be known, from the 1970s on, as developmentalist health, thenceforth announced as deriving from the post-Estado Novo democracy and suited to the socioeconomic transformations of the country (urbanization, industrialization etc.). However, although this developmentalist health propagated in the 1970s evoked the ideas of Silveira, Mello, and others (then recognized as precursors of health reform), it was driven by a narrative aimed at building health reform projects that were not quite what their so-called precursors had conceived.

One element the narratives produced about developmentalist health shared was their immediate characterization as being opposed to campaign-based public health.

According to Braga (2006), traditional public health, with a campaign orientation, was organized around programs that fell short in meeting the real health needs of people, with

their limited financial capacity, and also for their high cost, because of their technical requirements. A centralizing, hierarchical rationale was maintained, and such a level of standardization was recommended that harmful effects of disarticulation with state services were produced. For Braga, developmentalist health had emerged in the 1950s in response to dissatisfactions concerning the campaign approach and proposals to concentrate state resources in developmentalist measures – the idea of investing in industrialization before health.

Luz (1986) also presents an interpretation of this opposition. For her, the developmentalists were opposed to a health campaign approach insofar as they ended up merely tackling mass diseases in focused, standardized sanitation and immunization actions. In contrast, the developmentalists proposed decentralizing services and adopting strategic planning to prevent the dispersion of resources and the repetition and overlapping of activities that should be "integrated" and run by permanent public health services. With the logic of planning, these services should assure "universal medical care," beginning with an expansion of a primary care network.

So it was that the fundamental discursive strategy behind developmentalist health in the 1970s involved consolidating the opposition between supporters of health campaigns and developmentalists. In one fell swoop, this strategy allowed a return to the propositional pillars possible before the 1964 coup and meant progress could be made in developing critical opposition to traditional (campaign-oriented) public health and in proposing fundamental points for what would become the health reform, with emphasis on the defense of unification, integration, and universalization.

What we can see here is an effort to forge new routes forward which, if they did not lead to socialism, should at least lead closer to it, even if this meant making adjustments to the existing capitalist state structure.

Another important dichotomy that developed with the revival of developmentalist ideas was between public health and welfare medicine. This dichotomy was never actually announced by Silveira and was presented by Mello only after the developmentalist theses had run their course. It shook the apparent coherence between the rationale of social security and the expansion of industrial-based capitalism..

Braga (2006, p.52) refers to "two sub-sectors: that of public health and that of welfare medicine," which he saw as jointly composing a national policy, marking the difference between them.

Unlike Braga, Luz does not start with the assumption of a dichotomy between sectors or reduce developmentalist health to an opposition to campaign-oriented health actions. Rather, he builds an analysis of the discourses that contributed to the construction of a general understanding that, within public health, the discourse of the developmentalists was the one that presented wider and more complex criticisms against the performance of SESP, the discourse of health campaigns, and private health care. According to Luz (1986, p.93), the developmentalist discourse for public health denounced the inadequacy of the SESP health units, based as they were on foreign models, failing to take into account the fact that "the health problem is basically the problem of underdevelopment; it is found, etiologically, in economics, not in medicine," since the population's health status depended on "overall labor conditions."

According to Luz, in relation to the welfare model, the developmentalist health position was against the generalized provision of medical care through high-cost, ultra-specialized "private medicine" hospital services. There had been a dispute between nationalization and privatization, which can be seen in the public health area in the recommendations of the 15th Brazilian Congress of Hygiene (1962), which came out against systems of free choice in government and state bodies and in favor of the provision of care through own services.

The question of the organization of services on the national level also prompted a two-sided dispute. While developmental discourse argued for the municipalization of health services – their geographic decentralization and institutional centralization –, part of the discourse from the welfare area called for centralization and unification.

The great value of Luz's interpretation lies in her showing that the discursive disputes were more complex than simply a case of public health *versus* welfare, but that this is how the political projects developed. The entrenchment of this dichotomy between sectors, added to the dichotomy between the pro-campaign and pro-developmentalism camps, served to strengthen the defense of unification, integration, and universalization, which would later be consolidated in the idea of a single, unified health system.

The very concept of comprehensiveness as presented in the 1988 Federal Constitution – "comprehensive care, with priority for preventive action, without detriment to welfare services" (Brasil, 1988) – seems to have developed from the pervasive dichotomy between public health and welfare. This dichotomy was what gave rise to the interpretation of the health reform that made a criticism of the campaign-oriented approach an argument not just for political and administrative decentralization, but also for remedying the fragmentation that existed between individual welfare and care activities – recognized as belonging to the National Institute of Welfare Medical Assistance (Instituto Nacional de Assistência Médica da Previdência Social, INAMPS) – and preventive and mass actions – recognized as typical of the Ministry of Health.

This diagnosis of fragmentation came together with a diagnosis of a dispute between those who favored private medical insurance and those who focused on public health. For Mello, changing this perverse organization meant affirming the universal right to comprehensive care provided by state resources and structure. This is an interesting example of what we understand as the construction of strategic narratives: to be able to call for comprehensive care and the right to health, Mello had to go through a whole mental trajectory that included perceiving the collapse of developmentalism. It was the proposals he built based on this perception that were taken up again to think about the health reform policy, which sustained its legitimacy on the search for its developmentalist precursors.

It is unlikely that the defense of the right to health could have been found in Silveira's writings, at least in these terms. However, the chain of arguments that Mello formulated was robust enough for him to make an argumentative turn: to realize that the rise of private interests in welfare medicine at times of economic growth produced exclusion both from this welfare model and from straitened public health, Mello began to voice the idea that health should be the right of every citizen and assured by the state. This change of emphasis boosted the health reform not only by supporting the organizational guidelines for a health system, but chiefly by sustaining the constitutional principle of the universalization

of the right – perhaps the most revolutionary principle of the period. Once again, it was by extrapolating dichotomies (preventive vs. curative, public health vs. welfare etc.) that diagnoses of problems could be produced that justified new projects for health.

Although Silveira did not develop arguments that envisaged health as a right, he helped propagate another important idea also embraced by Mello, and one that reverberated strongly not so much in the health reform as in the field of public health, with ramifications for the education of health workers. According to Luz (1986), the supporters of developmentalist health were keen to distinguish "health" or "health status" from "sanitary conditions" or "health conditions": the former corresponded to medical needs and the latter to socioeconomic living conditions. This distinction pointed to a way of incorporating the idea conveyed by the World Health Organization that health is more than the absence of illness, and therefore calls for changes in the economic structure. Luz (1986) also highlights in developmentalist health an emphasis on rationality of planning, putting the state back in its role of economic agent and planner. On the one hand, this reinforced the state's legal responsibility in providing for the universalization of health actions; on the other, it allowed for the proposal of a system with a geographically decentralized, institutionally centralized organizational arrangement. Planning and decentralization also seem to have been arguments for the integration of treatment and preventive activities under a single command, encompassing attributes previously allocated to the Ministry of Health and Inamps.

Furthermore, the idea of developmentalist health that each society, depending on its stage of development, has a particular population distribution and composition – from which stems its disease profile and the criticism of campaign-oriented approaches, regarded as failing to link up the health needs of the population and regional economic conditions – reinforced the argument in favor of the political and administrative decentralization of health services to states and municipalities.

Arguably, these explicit intentions of the health reform projects could be extrapolated to an important dilemma that reverberated in the Constituent Assembly: that the way it was possible to conceive of planning and decentralization enabled public services to coexist with "complementary" private establishments. The developmentalist health ideas that survived were the rejection of the system of free choice and the proposal for the institutionalization of all services, including private ones, by submitting to a set of standards that went on to be configured as SUS.

At the height of the reconstruction of the health policy after the civil-military dictatorship, the institutional norms (Federal Constitution of 1988, and Organic Health Laws [law 8.080/1990 and law 8.142/1990]) seemed to have the intention of taming the private sector, which would be complementary, subjecting it to the greater consensus of the right to health under the responsibility of the state.

What's so new about the health reform in the 1970s?

The developmentalist ideas voiced until the early 1960s were not exactly precursors of a project for the universalization of health care; rather, there was an understanding that

individual health was something to be left to the market through the involvement of labor, leaving the state responsible for the health of the people collectively.

In the 1970s, Mello introduced a shift in developmentalist discourse based on a clear perception that economic expansion – the mainstay of the developmentalist model – would not necessarily lead to the improvement of people's living conditions and health. His analyses of the privatization of welfare medicine and the fragmentation of health actions led him to take a different stance *vis-à-vis* the 1960s thinking. From Mello's perspective, the reform in the 1970s and 1980s encompassed a characterization of the health and welfare sectors and deepened the criticism of the privatization of health care by bringing together elements for the defense of an integrated, universal, comprehensive model for the delivery of health services.

What remained of the developmentalist interpretations of the 1950s and 1960s was a criticism of the purely biological nature of health and the understanding of the state's role in assuring living conditions that fostered their good health.

But in the 1970s and 1980s, institutionalized practices in the fields of health and welfare medicine were also maintained unchanged in the health reform project, namely: the incorporation of planning demands; programs combining health worker training with health care delivery, such as in the proposal for preventive medicine; community medicine programs and low-cost primary care; the incorporation of ancillary community workers without professional training. Donnangelo's criticisms were watered down and interpretations of social determination were distorted in analyses of "determinants."

In the conclusion to their study on the "antecedents of the health reform," Teixeira et al. (1988) describe the context of the 1970s and 1980 as "authoritarian/modernizing," explaining that

> there was no rupture with the previous period in terms of the pattern of accumulation that had been seen until then. At the same time, there was no change in the state-dependent and capitalist nature. The change came in the capitalist nature of the regime, namely, in the political, legal, and institutional arrangement that regulated intergovernmental relations and relations between government and civil society (Teixeira et al., 1988).

We conclude that what was achieved with the health reform was not just a straightforward continuation of developmentalist health thinking, because it was not consistent with all the arguments set forth in the 1950s and 1960s. This is because it had to deal with its own contradictions (expressed in the field of public health, especially in the studies by Arouca and Donnangelo), because it underwent a reinterpretation in the 1970s debate (e.g., the studies by Braga and Luz), and because it was shaped by political concessions and adjustments, which at that time involved debates not just in the academic sphere, but by other forms of social movements and organizations (Gerschman, 2004). It was not just a continuation of developmentalist health thinking because the context had changed and the actors, too. Certain ideas that could bolster the political movement in the 1970s and 1980s were brought into the arena, but they were also adapted to the prevailing debate. There was also a compromise that meant structural issues were left to one side, a desire for change that

was postponed but was yet indicated in the introduction of new practices. It was somewhat ambiguous, with criticisms of the structure and promises of new practices, but also envisaged the maintenance of a model that accommodated interests and prevented the construction of the new.

However, it cannot be denied that developmentalist arguments were, indeed, brought into play and so, in this sense, the sanitarians from the 1950s and 1960s could be seen as precursors. We would therefore hazard to say that the scope of developmentalism was perhaps more pragmatic, insofar as it was more easily adaptable to the *modus operandi* of the state in the capitalist political and economic system. The goal was a new form of social life – with health and democracy – but at no point was the idea to change the way politics was done, the way the state operated.

NOTES

[1] There are few studies that make in-depth analyses of the thinking of Mário Magalhães da Silveira, but two stand out: Reis (2015), who revisits Brazilian conceptions about health between 1940 and 1960 to reflect on the relationship between health and development, drawing on Silveira's formulations; and Escorel (2015), who describes Silveira's professional trajectory, taking as a backdrop his critical thinking about the national circumstances and the health policies adopted.

[2] This was in tune with the thinking of Gunnar Myrdal, an economist and sociologist who drew on the thesis of "circular cumulative causation" to design the process of accumulation, whereby "poverty becomes its own cause." He believed that underdevelopment was not immutable, and believed the cycle could be broken through political intervention and planning (Cardoso, 2012). He believed in economic thinking that provided a more general analysis of economic and non-economic factors, tending not to give precedence to health spending.

3 The SESP was created in 1942 in Brazil as an agreement with certain entities from the US government and with the technical and financial sponsorship of the Rockefeller Foundation, an American NGO that developed health agreements with a view to taking actions in the realm of public health training and in the provision of prophylactic services (Muniz, 2013).

[4] The projects linked to Pan-American agreements include the Alliance for Progress (1961), which gave rise to the Charter of Punta del Este, which established investment agreements for development in land reform, housing, health, and education. The Alliance for Progress was the hub from which preventive and community medicine was promoted as a political orientation for different countries (Teixeira et al., 1988).

[5] Hochman (2009) states that under the aegis of developmentalism, despite the recognition of the necessary relationship between health and social protection, on the one hand, and economic development on the other, there tended to be pendular movement between these topics: a dispute over which was a prerequisite for the other. For more on this issue, see Lima, Fonseca, Hochman (2005).

[6] The income elasticity of demand measures the percentage variation in the quantity demanded of a good in response to a percentage variation in consumer income (Fardo, 10 abr. 2012).

[7] Noronha (2015) proposes an analysis of Mello's work, stressing his insistence on the relationship between health and development and the commercialization of medicine.

[8] Carlos Gentile de Mello's 1977 book *Saúde e assistência médica no Brasil* combines a number of Silveira's studies and interventions from 1962 to 1977, enabling his proposed themes and analyses to be identified.

[9] For Mello, payment by "units of service" was an "uncontrollable factor of corruption," since paying a physician for their work would end up inducing the practice of requesting procedures in order to obtain more resources, leading to distortions in the provision of health care (Noronha, 2015).

[10] Authoritarian conservative developmentalism established policies that generated greater social constraints and increased inequality, such as: stagnation and reduction in the real minimum wage, with an associated loss of purchasing power; increased inequality within each income bracket (Milagre..., s.d.); accelerated, unregulated urbanization with extreme poverty (Santos, 1993); rural development with a drain on public resources for reproduction of rural land ownership patterns (Prieto, 2017).

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