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Debates

Would the Brazilian Collective Health be prepared to pandemic times?

Pandemic, Brazilian National Health System (SUS) and Collective Health: com-positions and openings for worlds-others

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Pandemia, Sistema Brasileño de Salud (SUS) y Salud Colectiva: com-posiciones y aperturas hacia otros mundos (resumen: p. 15)

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The objective of this essay is to produce memories and to question networks, plots, dissensions and tensions that are arising in Brazil in light of the Covid-19 pandemic. The text is composed of five plateaux that attempt to make visible and to enunciate a dialogue with the production of new socialisation realities in the current context. Rather than offering ideas to be reproduced, we built paths of thought that we hope may affect and trigger new encounters and thoughts. Thus, we intend to enable the disruption of the pre-pandemic world, which no longer exists, and the opening for the construction of a 'world other', in which life in its multiplicity is the common for all, and a general equivalent for any ethical position in health.

Keywords: Collective Health. Health public policies. Covid-19. Brazilian National Health System. Primary Health Care.

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Overview

As a brief guide for the reader, we would like to say that we wrote this article as a composition of text-plateaus, which can be read in direct order or go in leaps – as in Cortázar's Hopscotch. We tried to break apart with an analogical, sequenced writing, and opted for a kind of (dis) order indicated from the premise that each plateau has in it a consistency and a singularity of its own, even if crossed by the other plateaus.

This idea is inspired by the production of Deleuze and Guattari, in the material A Thousand Plateaus[1], where they try through their writing to avoid something that seems very natural to us: thinking as an image that represents flashes of reality, and sequential accumulative linear reasoning.

This aesthetic of writing, more than offering ideas to be reproduced, has the intention to affect and produce new encounters, thoughts and, hopefully, the becoming of worlds-others[2].

Plateau pandemic and us

At this moment, there are several statements that hit us daily because of the new coronavirus and the pandemic situation we are in:

"When this situation is over, we will see each other again...". "After the Pandemic, life will go back to normal..". "Soon, soon, after the mass vaccination, we will see each other again...". "I can't wait until this is over so I can get back to my life...".

Within these always-collective enunciations, we miss others that announce that this situation does not exist, that deny the very existence of the pandemic and its harmful effects on individual and collective lives. It escapes from us that many continued to live their lives as usual, not adopting changes to avoid the spread of the virus.

We could say that there are those who do this because they don't believe that the pandemic exists, and those who, in order to minimally maintain their material living conditions, need to get around to work.

There is also a certain difficulty in perceiving how much negationism dwells in these enunciations, not only because they deny the pandemic, but because they cannot imagine that in the post-pandemic there will no longer exist a world that looks like the one we knew before, to which we can return.

Likewise, to think that strategies in the health field can be based only on a narrow version of science, or that mass vaccination can return us to the previous world, is, without a doubt, denialism of another kind.

We are already living the post-pandemic at the time of writing this article, and there is no "yesterday's world" to which we can go back. A world that, by the way, was not interesting at all, because if we look at what was happening in Brazil before this health crisis (and the other crises triggered by it), we will see a country torn down by severe social inequalities - in access to health, education, culture.

The killing of black people by various forms of violence has always been a disgrace. The extermination of native peoples was incessant. The destruction of lives by environmental contamination and destruction was already incalculable.

To return to this pre-pandemic world is not interesting at all, it is simply to accept that the worst of the past is better than the present, which is not supported by the wishes of those who continue to be the main vulnerable groups excluded from decent lives.

The pandemic laid bare the various tensions constitutive of our civilizational process, built over the last centuries and centered on the production of disposable lives in the context of the prevailing capitalism. It has crudely exposed the game of necropower and necropolitics as contemporary biopolitics, valuing in capitalistic fashion the lives that should and should not, or even need not, live.

This civilizing process brings to the fore how much the State exists and does not exist[3] as something that emerges in national contexts, to the extent that the interplay of interests and governance over the state "techno-bureaucracies" of large corporations becomes evident, calling into question the very notion of nation and the existence of a national state. This opens a key problem for paradigms that work with social law in concrete national societies, based on Eurocentric conceptions of political theory that have been built in the last centuries about the State, society and governments.

Who, by living what we are living, can say that, at the end of the pandemic, we will be able to go back to the way we were? Who dares to guarantee that we will be able to give up these current ways of building our relationships, amplified by the real life of the virtual, of the communicative at a distance, of the games of affection for other logics of encounters and presences? Who feels comfortable in understanding the state-society relationship in the most classical molds of political theories? Who can guarantee that we are no longer in another world, still capitalistic and exploitative of the lives of others, and not in a 'world-other'[2]? These are key questions so that we can imagine that much of what we have built as competence to act and live, in the world we used to live in, is no longer producing such effective effects.

The Brazilian Collective Health (CH) may say it, by not being able to get out of its hard references of state science[4] and its conceptions of already inapplicable political theories. Before that, it is worthwhile to look at this governing machine that is being manufactured according to the capitalistic logic and not to the logic of producing a different world, in which lives in their differences would be the central patrimony of the wealth that we could have.

Regarding this plateau as well as on the others, the big questions are located around the construction of a dialog with the production of new realities of socialization in the context of the pandemic, based on the key notion that there is no going back to the world of before and that we are facing the possibility of dissolution of the previous governmental paradigm in a '*non-res publica*' and non national state. Still, how much these new realities are poorly perceived, or denied, or do not even constitute relevant issues for many ways of thinking that are instituted in various social groups in Brazil.

The pandemic has shattered worlds. We live the coexistence of new worlds, those of the pandemic and those of the post-pandemic. The future is already installed in the present and is being forged now, in the radical disputes about which worlds we want to produce.

Ailton Krenak[5] provokes us by bringing to the scene these times that limit our capacity for invention, creation, existence, and freedom. It urges us to broaden our horizons - not the prospective ones, but the existential ones. Our perspective is not the one of a new normal in another world, resuming old routines and facing new challenges, but alternatively, reflecting and building a "world-other", here and now.

It seems pertinent to us to understand this moment of crisis as a 'temporal window of opportunity' to decipher the actions that have been taken to govern in neoliberal capitalist societies. This would be, therefore, one of those rare moments in history when processes, disputes, and power plays with very distinct meanings become explicit: on one side, the forces that point to the valuation of some lives to the detriment of others, as we indicated before; on the other side, re-existences, which wage their bets on new forms of organization of the social machinery capable of displacing discriminatory interests in the construction of social policies and actions in which all lives are worth being viable and socially supported.

In this direction, toiling for the construction of the Brazilian National Health System (SUS) exposes in an exemplary way, the complex process of struggles that occupy the daily life of social groups, especially those who suffer the effects of exclusion, prejudice, and necropolitical actions. Especially now, considering that there is the emergence of new realities that challenge the specific bet in favor of the institutionalization of a universalist SUS that constitutes a network of social protection to lives in all its forms of expression and without any discrimination, within the more formal frameworks of what is understood by governmental entities in terms of accountability and effectiveness in this field of social policy.

It seems to us that the pandemic has created, ironically and in the midst of unacceptable mortality, great challenges in the direction of equating the experiences that we have lived through, in the search for the construction and consolidation of the constitutional landmarks that provide the central guidelines for the societal fabrication of health care, at this moment in which we dispute a world-other that is very different from the previous world. The king is naked, and the future is in the present, and it depends on what we do now.

Plateau SUS in production - experiments and detours

We propose to point out two folds that affect the relations of forces we are experiencing in order to understand the current SUS conjuncture.

A first fold concerns the Brazilian Constitution that, by defining health as a universal right and a duty of the State, guaranteed through social and economic policies, but without explicitly providing a concrete direction for an eminently public SUS, has created a gap that the private sector has exploited, within legality and in their own interests, as a fold that directs the SUS toward a precarious "universal coverage".

The second fold relates directly to the first plateau, which is the entry of transnational health care projects to operate in so-called national territories. This issue reveals the lack of governability in the formulation of public policies, since many of the health model projects that we operate continue to be international projects that submit Brazil to

certain globalizing packages. Thus, by avoiding to define the proposal of an eminently public SUS, these forces in dispute occupied this fissure and revealed the fragility of the idea of a National State governing public policies.

The implementation and expansion of the SUS allowed Brazil to move from a rationale where few had access to health services to a rationale of full and universal access. However, if this scenario of extending citizenship rights to the entire population represented a substantial and unprecedented advance in the history of Brazil, it did not happen without disputes and it still remains inconclusive.

The international debate on different conceptions of universality in health, polarized in the proposals of universal system versus universal health coverage, has become more acute in recent years[6]. The dispute between health as a right and its exploitation as a business took on a new dimension since the emergence of the proposal for universal coverage led by the Rockefeller Foundation, with the participation of other foundations representing international capital and with the endorsement of the World Health Organization (WHO).

This proposal promises to give all people access to health care, but in a differentiated way according to their purchasing power: the richest would have access to more and better services, while the middle and lower income people would have access to a "basic package".

Universal health systems are a legacy of the Welfare States, where the needs and social protection in people's lives become the responsibility of the State, even in capitalist contexts and even because of them. In Brazil, this concept has been adopted, but the different interests historically in dispute imply a continuous boycott of the SUS, expressed for example in its insufficient financing.

The concept of universality has been emptied of its primary meaning of a universal right to health in favor of strengthening the private sector in the provision of health insurance and services[7] and the term itself is a clear attempt to confuse and capture subjectivities through semantic deviations[8].

In contrast, universal systems consider health as a result of a set of other essential subsystems, such as education, housing, work, etc. There is compelling evidence that tax-funded public universal systems, organized in the territories with the Primary Health Care Network (PHCN) in interaction with other health services and multiprofessional teamwork, have better health indicators and lower spending[6].

It is necessary to remember that since the 1988 Constituent Assembly, the tension of conservative parliamentary sectors articulated in the so-called "the big middle", a caucus of parliamentarians from different political parties who do not have a specific ideological orientation and benefit from support for the government in office, allowed them to maintain their particular interests, barring advances in the national scenario. In health, political forces represented by health plans, benefit managers, and large private hospital networks are increasingly stronger in the relationship with the federal powers. Thus, more than private sector, we refer to privatizing forces that have been progressively capturing more public resources from the SUS to provide services, often of dubious quality.

Another strategy has been the transfer to the private sector of the management and organization of health services, for example by opening legal structures such as the Civil Society Organizations of Public Interest[9] and, later, of the Social

Health Organizations[10]. Since then, the changes in the legislation that make health management more flexible through outsourcing have not stopped expanding in the management of hospitals, Basic Health Units, Emergency Care Units, Psychosocial Care Centers, Specialized Rehabilitation Centers, etc.

The interests of annihilating the SUS as a universal, integral, and quality system intend a low-quality public system, intended only for those who cannot pay and, in any case, will not bring profit to the health care markets[7]. Not surprisingly, Brazilian healthcare billionaires have seen record growth in their fortunes in 2020, through IPO's and the greed of foreign capital[11].

Undoubtedly, we have come a long way in implementing a public health system based on the concept of Social Security. But this model in Brazil ended up being characterized as a hybrid system, which combines rights derived from and dependent on labor (social security) with universal rights (health) and selective rights (assistance). The advances of the SUS are undeniable, but anti-universal SUS actions persist, even within non-authoritarian governments, even implying the denial of constitutional rights.

The pandemic deepens the debate about the market-state, exposing the backstage of these described scenarios. This new world institutional order that is proposed brings the imperative of the place of governance of transnational corporations. This reality is produced not only in the visible relations of forces, but also in the molecular domains, those that affect the processes of subjectivation, not necessarily within the machinery of the State, in an extremely conservative logic and authoritarian production in the government of lives.

The notions of Nation and National State are being completely dismantled and such structures, which were presuppositions for the SUS, are ceasing to exist, which amplifies the threats to the construction of the SUS as a State policy at the service of anyone's life.

Plateau experiences and experiments in the production of care

If the pandemic opened a "temporal window of opportunities" so that policies and governments could justify the choice for an increasingly close - if not promiscuous - relationship between the state and the private sector, the market-state as a new institutional order also produces effects in the daily life of health production networks.

Thus, the pandemic and its novel health risk served as justification for the re-centralization of health care in spaces such as hospitals and triage centers for Covid-19, organized by guidelines such as the Ministry of Health's fast-tracks. At the same time, the PHCN teams have been led to withdraw into their units to, at most, perform Covid-19 triage, attend to priority groups, certain emergencies, and some remote services - which, by the way, are quite compromised in territories lacking internet and telephone signal.

We observed an emptying of collective modes of production of health care, which can only exist within the possibility of encounters and the intensive presence of teams in the territories where people live. Simultaneously, we saw an expressive return of biomedical knowledge and its hard and soft-hard technologies: protocols, routines, diagnostics,

therapies, and drugs, in almost daily updates, sometimes based on new studies with scientific recognition, sometimes based on commercial interests linked to a negationism project.

The pandemic, in this way, allowed conservative and authoritarian narratives in healthcare to find fertile ground to circulate. While these narratives have always coexisted with the more caring and user-centered practices, they previously tended to occupy a marginal place in settings like the PHCN.

We saw doctors prescribing treatments without any scientific evidence of benefits, or even with evidence of risks; mental health teams reverting to discussing electroconvulsive therapy; PHCN teams withdrawing from the continuity of general preventive actions, prenatal care, care for health users with chronic or acute non- Covid-19 conditions, and dental treatment; and the drastic reduction of health home visits.

We can state that the pandemic is presently demobilizing networks of protection and social control, and creates a favorable environment for decision-making processes to take place in an authoritarian and centralized manner, without accountability, justified by health urgency. This impoverishment of support networks has acted in two directions: users have become more vulnerable to services, and many teams have weakened their power to act.

We are witnessing an emptied and de-powered PHCN in facing the pandemic, despite having built over the past 25 years a highly capillary network, with deep knowledge of local contexts and with consistent and irrefutable experiences in the field of proximity health care.

Vaccination against Covid-19, based in the executive and planning capacity of PHCN, despite having served to revalue to some extent this space, tends to be limited to technical-procedural actions, which corroborates the impoverishment of PHCN as a space for invention and production of possibilities. Still, the vaccination against Covid-19 in Brazil today, so uncoordinated at the national level, would be even more difficult without this PHCN.

The communities, stunned, receive contradictory calls: on one hand, to adopt measures of social distancing, wearing masks and hand hygiene; on the other, to deny the pandemic, refuse vaccination and believe, mainly through fake news, in ineffective treatments. Such tensions surround the PHCN teams, already discredited in their role within the health emergency, in a vicious cycle that intensifies their disappearance and all the consequences for their users-citizens.

Meanwhile, care in the territory remains blocked, interrupted. The PHCN finds itself in a trench. And the exception has been the lines of flight opened here and there, by teams that resist and tear these imprisoning bonds, sometimes swimming against the current.

However, this focus exclusively on increasing hospital and intensive care, hospital beds and specialized screening centers is extremely limited[12], the lack of capillary monitoring releases community transmission, culminating in queues to access hospital care. These bets seem to us to be an exercise on futility: high mortality rates coexist with expressive numbers of recovered people, but that frequently evolve with important sequels. Exhausted health workers, living with the consequences of Covid-19 and mental suffering.

The care for other health demands, for example, in specialized care, is suspended or extremely limited to avoid the proliferation of the virus. In 2020, it was suggested that this situation would be temporary, and that in the short or medium term the situation would be under control and the routines would be resumed, an expectation that has not materialized either. The federal government's bet on collective immunity, with the relativization - if not the denial - of the importance of non-pharmacological measures, added to the delay in acquiring sufficient vaccines, resulted in a slow immunization and allowed both the pandemic to advance in Brazilian territory and the emergence and dissemination of new variants of the virus, including two "Brazilian" strains, Gamma and Zeta, a sad feat matched only by the USA and India, and at least one variant that has just arrived with the America Soccer Cup[13].

In addition to Covid-19 case triages, a recent publication in Nature Science on the resilience of health systems in managing the pandemic[14], with lessons from 28 countries, reinforces what other authors and institutions have been stressing since the beginning of the health crisis: community-based approaches and primary health care are crucial strategies for better responses to the pandemic, with ongoing coordinated and person-centered care strengthened by the incorporation of community health resources.

Such a mischaracterization of the PHCN had been underway for some time, perhaps since its inception in Brazil, a process that today is added to the de-funding of health care, the deconstruction of training and development policies for health workers, and the low capacity for care management in health care networks.

The pandemic amplifies the fact that populations are deeply vulnerable in their existences by the neoliberal way of building societal policies and impoverishing lives, and now without being able to rely on proximity health care, or led to fear them as potential places of contamination.

The absence of the PHCN in the leading role, and of other effective actions by the State in defense of vulnerable lives, displaced the singular relations of care in resistance, whether by a community leadership or by self-management for survival. They are new common ways of organizing life, which do not necessarily pass through the state machinery. We understand these relationships as part of the intricate mesh of value-forces that have always disputed projects within the BN and the health system in Brazil[15].

If we look at the value-forces that over the decades have shaped the Brazilian PHCN - work, clinical-care, governing oneself and the other, territory, care pathways, and teamwork - we see that in each time and place more or less caring arrangements are formed, more or less open to processes of subjectivation for the production of life[15].

At this moment, in a pandemic scenario concomitant with the advance of the dismantling of social policies in Brazil, we are witnessing a violent revolt in such value-forces. New control urgencies of the living work in act, the recrudescence of a historical disproportion between the clinic and its procedures in face of the caregiving relationships, with a tendency to a greater disciplinarization of the bodies and not always in the sense of the effective pandemic control, besides the withdrawal of the teams from the territories with their shadowing, while in the health services and teams in general, including the PHCN, there is a reinforcement in the centrality of certain professions and specialties in relation to others.

Plateau Collective Health - re-emerging and re-existing to "hold up the heavens"

The new global panorama poses to the CH new questions and demands for analysis, as a field of knowledge and practice that has been forging our health system since the 1970s. In fact, since pre-SUS times, CH points to a system in which private interests, in all its dimensions, should be subsumed by public health needs[16].

The CH is a Brazilian invention, and, even though the specific narratives about its constitution[17-19] are not exactly coincidental, it had an innovative/institutional character in relation to what existed at that time in Brazil[18] and globally, as a space for critical analysis of biomedicine and the relationship between health and society[19].

Thus, CH sought to decolonize the European tradition of public health and what was produced from North American preventive and social medicine, with its characteristics and technologies for the surveillance and control of the production of bodies, in order to produce other movements in the field of health.

CH will then dispute this field, especially from the 1960s and with the struggles for democratization, associating health and democracy as mutual constitutivity. It was an attempt to serve, as a state machine, the interests of some societal groups, and to build the health field as a productive machine that feeds on the notion that the life of anyone and everyone is the greatest wealth in this country.

By this pretension, the CH field even proposed to counteract the long necropolitical history present in the country, permeated with lives that are immune and many that are not immune. Immune to the operation of legal, political, societal rules, and to the recognition that a certain life has rights and others do not.

It is evident that the CH field has been a space to debate and points out paths for the construction of the SUS, with the perspective of improving the health of Brazilians. In spite of the inventions of the CH in the field of knowledge and social control, there is still a way of operating in which traditional ways and values persist and capture the networks of thinking, learning, and knowing, blocking the processes of creation[20].

The generation of the first militants for the Brazilian health reform did not care where knowledge came from, epistemologically speaking, because any knowledge that pointed towards the construction of a democratic society would be valid. This changes the place of knowledge, because differences are taken advantage of, enrichment and complementation are produced, and not the fractioning of knowledge or the rigid institution of schools of thought.

This process, however, never overcame the constitutive tension about which "collective" is this that adjectives "health". Since the 1970s/80s, some of us[21,16] pointed out that, under the mantle of "collective", public health has always taken "population" as its object of action, as a generic that does not contemplate several other dimensions that cross through it. CH points to population segments that would mark profoundly unequal Brazilian social groups in terms of economic, racial, and cultural characteristics, among many others. From the perspective of "collective" we can bring into play how the field was forged around COM-positions of interests coming from the most varied

origins. This constitutive recognition is not of exclusive places, for they can reach compromise with each other in different ways, which would give CH varied modeling, from the place of a nomadic and inventive science to that of a state and repetitive science.

In this mosaic of models, the challenges are many, given the history of the various aspect at stake when organizing a universal system, the multiplicity of needs of the various social groups in Brazil, all the disputes, forces, and tensions in the field, and, currently, the pandemic of Covid-19.

In order to let the potency of the CH to emerge and participate in the construction of worlds-others, it is necessary to confront its fragilities and constitutivity aspects. It is necessary to re-exist as a powerhouse for the production of projects and proposals, both to confront the pandemic from the territories where proximity care can be found, in the places where people produce their existences, and to look and think of a post-Covid-19 scenario, from today, that places health in other level of compromise with various other sectors.

We are certainly in an important moment of problematization of the CH field, which must position itself as a war machine in defense of life for all, especially of the bodies that are considered only nakedly alive, less valid, disposable, invisible, and that with the pandemic are being made unviable.

The CH movement can produce this world-other from this desiring machine. To do so, it is fundamental to rescue its capacity to produce lines of flight to break through walls and to recover its capacity for inventiveness, to leave the frame as a state machine and occupy the leading role, within new compromises for the world of care. Out of any biomedicalizing trap, in the production of possibilities to collectively constitute ways to link the production of more life in lives with a priori actions centered in the networks of existences of others, and not of oneself. Opening up to be decentered from oneself may give with inventiveness and collective implication, in the here and now of what is already another post-pandemic world.

It is key to avoid returning to the pre-pandemic world, with those familiar challenges of defending the SUS, in which old discussions, impregnated with sanitary-ism, are not enough for us to face the new problems. In this sense, it means to rediscover its logic of nomadic science and to abandon the currently dominant normalizing logic. Pay more attention and learn from the Original Peoples about respect and integration with all forms of life. In the cosmic vision of these peoples, at certain moments there is a pressure from the sky over the Earth, putting humanity at risk and, when this occurs, it is necessary to make a stop, a ritual to ascend to heaven, that is, to expand the collective/existential horizons[22].

The pandemic puts humanity in check and increases the visibility of the health risks of the Earth as Gaia, and all its beings. We need another ritual to expand our horizons and produce worlds with policies and practices that take into account what is set in Brazil and in the world, that intensify the lives and the powers to exist, a radical shift, to assume that we have much more non-knowledge than knowledge, and produce cracks in the plans, knowledge, devices, and subjectivations that frame and territorialize the CH. How will we produce another world, how will we hold up the heaven, if we remain deeply captured by pre-pandemic experiences and worlds that no longer exist?

Plateau - What to do with our imaginary for world other

It doesn't seem possible to us to just reactivate our militancy in the battlefronts for the universal right to health, giving voice to the mottos that have been moving us for decades. We are facing a new scenario, unprecedented and full of new challenges and pitfalls, and we need to be with all senses alert to this dizzying outbreak.

Krenak writes: "Gaia, the living organism that is the Planet, may be saying to us: You are not listening to me, are you? I will turn off some of you to see if you understand what I am saying"[23] What warnings are we not hearing, coming from the communities, the streets, the users-citizens, and the health workers?

The fact that we have, as a pessimistic offer to face the pandemic, a hardened and centralized biomedical model and a weakened PHCN, is it not a warning of the obsolescence of the ways of thinking about health and operating politics and management? Why is it so easy to "lose" our hardly built PHCN? Accepting this reflective path, we could ask ourselves if in some way the Brazilian sanitary movement - involuntarily and even if from its historically minority place, but not always popular - could have facilitated the crystallization of this reality experienced today by PHCN. If so, recognizing this, even though it strikes us at the core of our militant implication, may be a necessary inflection at this moment when we need to build worlds-others.

Perhaps we have neglected, in our "welfare models", the necessary empowerment of collective machines that want to produce life that are not state machines, but that have consistent mechanisms to demand to the State. Perhaps the political character that we have always attributed to the construction of the SUS still lacks a trans valuation of what we consider politics, which is not restricted to the rights guaranteed by the State, but which also may move through the construction of existences and friendships, of life as a work of art by collective agency action.

Perhaps we can conclude that to enunciate community leading role, only enunciating its construction from inside the state machine, is to leave it at the mercy of capitalistic subjectivations that inevitably cross both workers (of care and management) and users/citizens, tending to produce more individualism and less collective life, despite the existence of supposedly emancipatory care guidelines and flows.

Covid-19 must be seen as a profound de-constructor, which unceasingly disassociates our certainties. And the war machines outside the state machines are the ones that pose us the ultimate challenge, looking at the offerings of Krenak, Deleuze, Guattari, Foucault, and many others: to break away with health as a state apparatus that destroys the desiring machines that the various collectives create for themselves. And through this, to enable the opening for the construction of a world-other, in which life in its multiplicity is the common ground for all and the only general equivalent for any ethical position in health care.

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Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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O objetivo deste ensaio é produzir memórias e problematizar uma série de redes, tramas, disputas e tensões que estão sendo operadas no país diante da pandemia da Covid-19. O texto está constituído por cinco platôs que buscam dar visibilidade e dizibilidade para um diálogo com a produção de novas realidades de socialização no contexto atual. Mais do que ofertar ideias para serem reproduzidas, construímos linhas de pensamento com as quais esperamos afetar e, assim, disparar novos encontros e pensamentos. Com isso, possibilitar a disruptura do mundo pré-pandemia, que não mais existe, e a abertura para a construção de um "mundo outro", no qual a vida em sua multiplicidade é o comum de todes, e um equivalente geral para qualquer posicionamento ético no agir em saúde.

Palavras-chave: Saúde Coletiva. Políticas públicas de saúde. Covid-19. Sistema Único de Saúde. Atenção Básica à Saúde.

El objetivo de este ensayo es producir memorias y problematizar una serie de redes, tramas, disputas y tensiones que se están operando en el país ante la pandemia de Covid-19. El texto está constituido por cinco escenarios que buscan proporcionar visibilidad y capacidad de expresión para un diálogo con la producción de nuevas realidades de socialización en el contexto actual. Más que ofrecer ideas para reproducción, construimos líneas de pensamiento con las que esperamos afectar y, de tal forma, disparar nuevos encuentros y pensamiento. De esa forma, posibilitar la disrupción del mundo pre-pandemia que no existe más y la apertura para la construcción de "otro mundo", en el cual la vida en su multiplicidad es el común para todos y un equivalente general para cualquier posicionamiento ético en la actuación en salud.

Palabras clave: Salud Colectiva. Políticas públicas de salud. Covid-19. Sistema Brasileño de Salud. Atención Básica.