Between absence from Alma-Ata and Prevsaúde: primary health care in the twilight of the Brazilian dictatorship

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Abstract

Drawing on personal documents from Ernesto Geisel and press reports, this article discusses the background to the decision by Brazil not to take part in the International Conference on Primary Health Care held in Alma-Ata, USSR, in 1978. It is suggested that the Ministry of Health and the Ministry of Foreign Affairs had different views on the importance of the meeting in Kazakhstan, resulting in their submitting conflicting recommendations to the president of Brazil. It also investigates how the precepts consolidated in the Declaration of Alma-Ata were shared among Brazilian health specialists of different ideological persuasions, even to the point of serving as a blueprint for programs devised under the dictatorship, with implications for the development of later initiatives.

Keywords: history of public health; primary health care/history; health policies/history.

> Almost all international conferences are, in my humble opinion, a testament to the paucity of our means before the obstinacy of man to evade the challenge of solidary survival.
> Halfdan Mahler, Pan-American Health Conference, Washington, 1974 (Opas, 1974)

The International Conference on Primary Health Care, held in 1978 at Alma-Ata, USSR, is often referred to as the first step in the spread of primary health care (PHC) initiatives around the world. This is partly true in a number of respects. The conference certainly consolidated some guidelines and put PHC on the international agenda with a view to expanding the coverage of national health services. However, initiatives of a similar ilk had already been tried out in other countries since the late 1960s, often under the label of "basic health services," yielding important results (Newell, 1975).[1] In the Americas, the Pan-American Health Organization (PAHO) had recommended PHC since the early 1970s, or at least similar approaches, such as ones designed to take health services out to rural populations and urban peripheries (Opas, 1972, p.75). A few years later, it is important to note, at the turn of the 1980s, the prescriptive international environment became even more hostile to initiatives oriented to a more complete adoption of the conception of PHC.

However, the importance of that conference – held in the capital of Kazakhstan under the auspices of the World Health Organization (WHO) and the United Nations Children's Fund (Unicef) – is undeniable. Notwithstanding the ambiguity typical of international consensuses, an attempt was made to establish PHC not so much as a model that operated efficiently on a local basis, but as a gateway to health systems and the level around which care should be organized, as called for in the affirmation of the right to health and the comprehensiveness of care. This was the agenda set by WHO, in its most radical terms, and one that should not be underestimated.

Nonetheless, Alma-Ata became a touchstone for authority, even when the hostile institutional environment of the following decades, with neoliberalism and macroeconomic adjustment – and the associated conceptual implications – imposed severe restrictions on the concrete measures underway, which envisaged the provision of care that was effectively universal and comprehensive (Newell, 1988). Like SUS, the Brazilian public health service and *pièce de résistance* of the Brazilian Health Reform.

The organization of the conference, in the context of a period of *détente* between the US and the USSR, the two Cold War superpowers, progressed and suffered setbacks related to the Sino-Soviet conflict,[2] and different conceptions about how to offer health services and the role of the state and private enterprise, among other points of divergence. However, by the end of that complex process, 3,000 delegates representing 134 countries, 64 international organizations, and civil society had reached sufficient consensus to collectively sign the Declaration of Alma-Ata, defining PHC as a central strategy for attaining the goal of Health for All by 2000 (Litsios, 2002; Newell, 1998; Cueto, nov. 2004, p.1865-1968; WHO, 2008, appendix).

However, not every country was represented there. Its fraught, conflictive relationship with the USSR meant that China did not take part. Nor did Brazil, for different reasons.

In fact, the reasons for this latter absence have never been clarified. On at least one occasion, its absence was attributed to a non-existent breakdown in Brazilian-Soviet relations during the military regime (Czapski, Médici, 2011, p.202).[3] At that time, at least one member of the Ministry of Health's core management team heard the minister for Health, Paulo de Almeida Machado, say that the meeting would be unproductive at best, useless at worst, since Brazil already had basic health services, which had been developed well enough by the Public Health Service Foundation (Fundação Serviços de Saúde, Pública, Fsesp).[4]

In this article, we analyze documents from the personal archive of Ernesto Geisel[5] and news stories from the period, previously unexploited for this purpose, to examine fragments of evidence about what went in the corridors of power to make Brazil take this surprising decision. As we shall see, these documents shed new light on the issue and suggest, for example, that the Ministry of Health and the Ministry of Foreign Affairs had different views on the importance and implications of the meeting in Kazakhstan, resulting in their submitting conflicting recommendations to the president of Brazil.

As such, this article brings to light new information on what underpinned this decision by the Brazilian government. It also investigates how the precepts consolidated in the Declaration of Alma-Ata were shared among Brazilian health specialists of different ideological persuasions, even to the point of serving as a blueprint for programs devised under the dictatorship, with implications for the development of later initiatives. Although it is a descriptive text, it contributes to the analysis of the topics in question, drawing on the theoretical contributions of historical institutionalism proposed by Margaret Weir (1992) and the political analyses of John Wells Kingdon (2003).

In the course of the 1970s, at the same time as the international debate around PHC was taking place and plans for the international conference were made, initiatives that were to some extent autonomous were being pursued in some municipalities and particular regions of Brazil with the task of testing out ways of expand the coverage of care on the local level. Meanwhile, on a federal level, more ambitious plans were afoot for programs with a similar purpose in order to model the organization and operation of services of a macro-regional and even national scope.

Basic health services and primary health care on the Pan-American and Brazilian agendas in the 1970s

In 1972, a meeting was held in Santiago, Chile, for the continent's health ministers, where they discussed and finalized the Ten-Year Health Plan for the Americas, succeeding the Alliance for Progress's Ten-Year Health Plan, which had been agreed upon in 1961 at Punta del Este, Uruguay. In Santiago, it was decided that the main objective for the coming decade would be to take health care out to rural regions. To this end, the idea was to gradually offer basic health services, with the longer-term goal of providing care for the entire population, based on the idea of health as a right of individuals and communities. The care on offer, which included lay personnel and community engagement, featured the supply of "elementary" health services, which included emergency, maternal and infant

health, essential health information, and the referral of more complex cases to higher levels of what was now envisaged explicitly as a health care network (Opas, 1972, p.75).

This was the consensus that had been reached by the turn of the decade. A text that consolidated a process whose traces can be identified in Pan-American health throughout the 1960s. By the end of the decade, for example, the upper echelons of the PAHO adopted coverage in rural areas in the form of hierarchized services, and the training of lay personnel as a topic for technical discussion (Opas, 1968, p.4-21, 1969, p.42-47).

A similar and partially connected process took place in WHO, with the crucial involvement of Unicef. Since the 1950s, both organizations had had a joint committee for coordinating their actions and also to overcome conflicts arising from overlaps in their responsibilities concerning maternal and child health. In the first half of the 1970s, under the leadership of Halfdan Mahler at WHO and Henry Labouisse at Unicef, this proximity deepened and the joint committee began sponsoring studies and discussing methods for expanding coverage to different populations, going on to propose the conceptual groundwork for and sharing of the preparation and organization of the International Conference on Primary Health Care at Alma-Ata (Cueto, 2004, p.1864-1865).

Domestically, in mid-1970, Brazil included PHC to its federal health policies in the form of basic services for rural populations in municipalities with up to 20,000 inhabitants, as part of a plan devised and implemented in 1976 called the Program for the Interiorization of Health and Sanitation Actions of the Northeast. The program was soon extended beyond its original regional remit to take in the north of the country, going under the acronym of Piass. Along with the National Health System, created in 1975, Piass was the health branch of the military government's Second National Development Plan, a strategic plan designed to reconstitute its depleted social base now that the so-called economic miracle had run its course (Escorel, 2012, p.333-347).

The entities involved in funding and operating Piass included the Ministry of Health, the National Institute of Social Security (Instituto Nacional de Previdência Social), the Rural Workers' Social Security and Welfare Fund (Fundo de Assistência e Previdência do Trabalhador Rural), the Institute of Food and Nutrition (Instituto de Alimentação e Nutrição), and other agencies and funding sources. The program would be coordinated by a committee chaired by the Ministry of Health, an indication of the complexity of the inter-institutional coordination envisaged (Brasil, 25 ago. 1976, p.11241). A training program, the Program for Strategic Preparation of Health Personnel, was set up to train the workers needed to man this new program, run in cooperation by the Ministry of Health and PAHO. The goals included the mass training of the mid-level personnel – technical staff and health assistants – with particularly ambitious quantitative targets, the creation of ten health care and teaching regions, and the formation in every state of the country of a "system for the development of human resources for health" (Pires-Alves, Paiva, 2006, p.43; Castro, 2008, p.128-134).

One of the pillars of Piass was to mobilize people from local communities to work as assistants and develop low-cost, effective health initiatives to be offered in a network of small health clinics supported by larger units and integrated into the regional health system in order to provide care for the most common diseases, with emphasis on the prevention of

transmissible diseases. Ideally, local communities would take part in the program and the different bodies of the newly created National Health System would work in coordination, albeit answering to different government departments (Brasil, 25 ago. 1976, p.11241; Souza, 1980, p.77-79).

Piass could be considered a large-scale official variant of a set of local initiatives that were being rolled out in different municipalities and regions, based on different ideological configurations and positions by local authorities, state departments of health, civil society organizations, and university outreach programs. The most important of these included the initiatives at Planaltina, in the Federal District, Paulínia and Campinas, in the state of São Paulo, Montes Claros and northern Minas Gerais, Murialdo, in Porto Alegre, Rio Grande do Sul, Londrina, in Paraná, Niterói, in Rio de Janeiro, and Vitória de Santo Antão, in Pernambuco.[6] In other words, a degree of technical and programmatic consensus began to emerge in Brazil's health environment, notwithstanding the different, sometimes conflicting ideological inspirations and orientations around these alternative options for expanding the offer of health services in the country.

The presence of a relatively current and consensual idea in international health about the right to health and thus the public responsibility to meet health needs, alongside a broad consensus around organizational and technical orientations suggest the analysis of the relationships between public philosophy and programmatic ideas as understood by Margaret Weir.

In a study designed to establish the relationships and mutual implications between ideas and values, on the one hand, and interests on the other, Weir (1992) proposes that the ways public policies are made and executed can be analyzed on three interrelated dimensions: the broader level of representations; formulations at an intermediate or sectoral level, where programmatic aspects assume greater importance; and aspects relevant to implementation of policies per se, featuring operational considerations.

It seems clear, as noted in Pires-Alves and Cueto (2017), that the framework of values that underpinned the conception of health as a right and the formulation of primary health care as a strategy for enabling it, in the context of international health, was directly linked to some of the typical debates of the 1970s around the ideas of a potential "new international economic order" – and the social agenda that was gradually incorporated into its essentially economic agenda – and the fulfillment of "basic human needs," a concept that is itself an expression of that expansion of the international agenda. In the sphere of technical and organizational arrangements, focusing here on the second aspect highlighted by Weir, PHC seems to combine – in the form of a programmatic strategy – a critical accumulation of public health, medical training and practice, particularly as of the second half of the twentieth century and especially in the 1960s. If we combine the two levels of analysis, Alma-Ata and PHC were then an attempt, within that broader value framework, to establish precepts and guidelines for the health sector with the power to simultaneously and interconnectedly make both its demands and its solutions legitimate and viable.

Yet any idea of consensus or even convergence should be viewed with some circumspection. In part because of the uncertainty and ambiguity present in the

policymaking processes (Kingdon cited in Gottems et al., 2013, p.512). And also because of the stress that the political dimension of institutionalization as a standard and the concrete implementation of principles and guidelines generally spawns. These concerns apply to health both internationally and domestically, with the specific institutional trajectories of each social formation or local context restricting the potential agency of the actors in the policymaking and implementation processes in the latter case.

These final considerations suggest that we should look forward to the late 1970s and early 1980s to find out more about how the Brazilian health scene developed.

Alma-Ata, 1978: absence of the Brazilian dictatorship

As those national initiatives to expand health care coverage progressed, it is worth looking at how the Brazilian Ministry of Health responded to events on the international scene in the second half of the 1970s, which culminated in the International Conference on Primary Health Care and the Declaration of Alma-Ata, in 1978.

At the time when the National Health System and the program to expand health care coverage to inland parts were being devised, the ideas and initiatives of the director of WHO, Halfdan Mahler, were very well received by Paulo de Almeida Machado, the minister for Health during the Ernesto Geisel administration (1974-1979). According to the minister, emphasis on simple, low-tech solutions, with the deployment of local agents in the community and a hierarchical organization of health units across the country, as championed by WHO, were in tune with the Brazilian government's guidelines in its expansion plan. In the second half of 1977, when Mahler was to make his first visit to Brazil, Almeida Machado described him as perhaps "the most brilliant director of WHO," who had "profound technical knowledge, vast humanistic vision, and indispensable political skill" for conducting pragmatic policies, "preferring simple and economic procedures" of a "social, not elitist nature" (Brasil, 17 ago. 1977). At the time, Almeida Machado suggested that Mahler should meet the president of Brazil, which in fact came about, on the afternoon of September 20, 1977. Escorted by Almeida Machado, Mahler was received by Geisel, in the company of the director-general of PAHO, Hector Acuña. On the same night, Mahler gave a speech at the Ministry of Health. The visit to Geisel and the speech received little attention in the press, with most coverage occurring in the social columns (Diretores..., 21 set. 1977, p.19). As for what was said in the speech, nothing was reported.

This silence about the pronouncement of an international authority who had been received by the president at a time when public health and the medical profession were very much on the public agenda is curious, to say the least.[7] The content of the speech ended up being divulged some months later in *Saúde e Debate*, the journal of the Brazilian Center for Health Studies (Centro Brasileiro de Estudos de *Saúde*, Cebes), which published it in full (Mahler, 1978). But it was only in early 1979, when press censorship was less threatening, that the Agência Estado also addressed it. The piece entitled "Silence about the abuse of medicine in Brazil broken," by Demócrito Moura (3 abr. 1978, p.4), notes that

> the end of a long blockage on information enables [us to] ... better divulge to the public the vehement pronouncement by Halfdan Mahler ... on the abuses and deviations in the practice of medicine. ... A strange blockage has prevented the Brazilian public from having access to the many and forceful denouncements by the world's leading authority on the protection of health.

Mahler's speech was another one given by a speaker known for his impassioned discourse. Not only did he present the general principles then underpinning the proposal for a PHC strategy, but he also referred to the inequalities between countries and within societies as an unacceptable scandal, while also arguing that social change was an imperative for the very survival of the human species. He indicated that social consciousness had a significantly heavier weight than direct medical intervention in improving living conditions and that isolated and repeated therapeutic acts were thus anti-economical. At the same time, obsession with complex technologies was frankly pernicious, he argued (Mahler, 1978, p.28). The distortions in medical training and industrial strategies were producing a legion of "healthy hypochondriacs," in what was a vicious cycle. It was therefore easy to accuse doctors of being alienated and of influencing the people and government authorities about their health needs and the social facilities for the promotion of health. Yet, Mahler went on, this did not prevent physicians from "imperially" prescribing high-tech solutions whose cost-effectiveness was debatable (p.29-30).

Such was the tone of the speech given by the director of the World Health Organization on that September evening in 1977 at the headquarters of the Brazilian Ministry of Health. It is fair to speculate that Mahler's speech was particularly badly received by Almeida Machado and that measures were taken to ensure it did not circulate freely or was even censored. Whatever the case, the differences of opinion between Almeida Machado and the prevailing trends in international health that Mahler championed gradually became more explicit. Machado advocated the organizational separation of public health and the welfare model of medical care established in the National Health System, and was averse to the ideas of integration being bandied in the WHO and PAHO debates. He was equally averse to the ideas of social change associated with combating health-related issues, such as those found in the formulations of Latin American social medicine. Indeed, his hostility even reached the statute of the social sciences in the field of health, a role, it is worth noting, that Mahler valued in his speech (Brasil, 17 ago. 1977).

Almeida Machado's opposition was expressed just as clearly at the sixth National Health Conference, the Brazilian Congress of Hygiene and Public Health, the meeting of health ministers of the Americas, the Pan-American health conferences, and other PAHO events. In dispatches with the Brazilian president, he went so far as to call for the depletion of departments of preventive and social medicine and "communistic" medicine, to borrow his regrettable expression, while at the same time describing what he deemed to be the infiltration of such forms of thinking in medical societies (Brasil, 17 ago. 1977, 3 nov. 1977).

In one dispatch, probably from February or March 1978, he discussed with Geisel Brazil's participation at the International Conference on Primary Health Care, to be held months later in the USSR. According to the minister, the meeting would be eminently political, focusing on the role of health in social change, and would be dominated by socialist

countries, leaving little chance for a Brazilian delegation to make a significant contribution. Swayed by this opinion, the president decided that Brazil would not participate in the event (Brasil, 26 maio 1978).

However, on August 14, 1978, Almeida Machado was taken aback when the president of the Republic issued a decree in which he nominated Machado himself, alongside Aldo Villas Bôas, then the president of the Sesp Foundation, to represent Brazil at the conference (Brasil, 16 ago. 1978). It is possible that the change of position was prompted by actions taken by the Ministry of Foreign Affairs under Antônio Azeredo da Silveira, who was particularly interested in forging relations with Unicef, and Henry Labouisse, director-general of this entity, which had included Labouisse making a trip to Brazil in August during the International Congress of Nutritional Sciences, in Rio de Janeiro (Brasil, 26 maio 1978). As one of the organizers of the conference at Alma-Ata, Unicef must have had some concerns about the imminent absence of Brazil.

Days later, in a dispatch to the president, Almeida Machado set forth why he felt this would put his ministry in a "delicate situation," and listed the barriers that would have to be overcome for a trip to Kazakhstan to be undertaken in such a short space of time. Nonetheless, he reported he was ready and willing to follow whatever direction the president gave him and to draft a Brazilian document for the conference in timely fashion (Brasil, 16 ago. 1978).

As noted earlier, such document was never written and such trip was never taken. The only Brazilian to attend the conference as an official participant was Juljan Czapski, a Polish-born Brazilian from a medical business group, and general secretary of the Brazilian Federation of Hospitals, as representative of the International Federation of Hospitals (Czapski, Médici, 2011, p.202). The non-attendance of any official Brazilian delegate was an anomaly, an aberration. The only other South American country not to send a delegation was Paraguay. All the other dictatorships from the Southern Cone did not find any ideological grounds or logistical hurdles to prevent them from traveling to the USSR (WHO, 1978).

The presence at the conference of a delegate from an international association of private hospitals, representing the interests of private capital in health, is indicative of the mistake of interpreting the meeting from a strictly ideological perspective. The same could be said of the official delegations from some countries in Western Europe and the USA. In the latter country, for example, in public health circles there was even a degree of expectation with regard to the potential ramifications of the conference (Pires-Alves, Cueto, 2017, p.2141-2142). And more so: in the USA since the mid-1960s (Andreopoulos, 1974; White, Willians, Greenberg, 1961), PHC had been on the agenda and regarded by some key segments of society as a concept worthy of discussion and experimentation with the goal of expanding and planning the health protection of US citizens, a perspective that would nonetheless wane in the subsequent decades.

Embracing tradition, inventing novelty

The personal idiosyncrasies and a degree of ideological shortsightedness in Almeida Machado's personal narrative toward the international conference at Alma-Ata stemmed less from his opposition to the strictly technical tenets of PHC or even its operational

architecture than from its potentially political weight, which was heightened on the occasion of Mahler's speech at the ministry. It is also an explicit and somewhat blatant example of the discomfort the minister for health felt toward the movement by health reformers, which would ultimately result in the Brazilian Health Reform.

Efforts were made to build this reformist movement both as a process committed to the struggle for the return to formal democracy and also, promoting it, instituting a renovated health system potentially capable of meeting the population's health needs. The commitment to introduce the new and thereby break with the immediate past was part and parcel of the agenda of those who were engaged in championing it, even if the discourses, the radicalness and the pace of the process of democratization advocated by its many actors varied considerably. Nonetheless, in the context, in terms of doctrines and policies, there was a considerable commitment to the idea of a break with the past.

Under the hegemony of those who formed the core of a nascent collective health, the Brazilian Health Reform was a front. In it, there featured groups who associated the reform of institutions and policies and the adoption of new, efficient, democratic health practices with processes of social change of greater or lesser depth. Also active were those who, while certainly wishing for a return to democratic life, were mostly convinced of the need to find more economic and effective ways of organizing health care without this meaning a call for or desire to transform the pillars of Brazilian society. Obviously, there was also a whole spectrum of modulations between these two positions.

PHC was galvanized at the service of both these extreme positions, and by groups who were not necessarily interested in social or regime change. At one end of the spectrum it was associated with an agenda and a repertoire of solutions that would offer greater possibilities for a democratic experience of health, oriented to social transformation, without disregarding the need for cost-effectiveness and outcomes. This was, to borrow a category proposed by Boaventura de Sousa Santos (2016), what could be called "high-intensity PHC." In other versions, albeit with increasingly limited resources, it was seen as a way of achieving a breadth of efficient primary care coverage that would be able to include marginal population groups that had until then never received health care. At the other extreme, with a more limited, localized orientation, it was "low-intensity PHC," even if it faced major adversities in its implementation.

Their differences aside, these formulations shared a good deal of technical common ground, albeit still disputed, when it came to the organization and functioning of the systems and services. They had much in common with certain critical traditions in public health and in the field of medicine itself. It is fair to say that they also had a degree of elasticity vis-a-vis the two extreme positions, and the sharing of this relative consensus was present in the heart of that conference organized by WHO and Unicef in 1978. After all, by the end of some grueling negotiations, unanimity was reached on the terms of the Declaration of Alma-Ata. These aspects lent the PHC propositions a degree of malleability, enabling it to be configured and reconfigured according to different macro-political orientations, i.e., in diverse national contexts, also an arena of disputes when it came to these very orientations.

In the Brazilian reality, we are therefore before a complex web of ideas and values, on the one hand, and conviction concerning potential solutions, on the other, which, despite being consensual in their more general formulations, had some key points of dispute around ideologies and interests – points especially critical at the time of the decision-making about and objective implementation of the policy.

Prevsaúde: primary health care at the heart of the Brazilian agenda

In late 1979, around a year after the Alma-Ata conference, with Brazil still under military rule, some agencies of the João Batista Figueiredo administration set out to design a National Program of Basic Health Services, which went on to be known as Prevsaúde. The Ministry of Health and the Ministry of Welfare and Social Services, headed by Waldir Arcoverde and Jair Soares, respectively, working with teams from the Ministry of the Interior and the Institute of Applied Economic Research (Instituto de Pesquisa Econômica Aplicada, Ipea), and counting on consultancy from PAHO, set up a working group to devise a project to represent "everything that we had accumulated at that time," according to one of its formulators.[8] In a later statement, Alberto Pellegrini (2005), one of the team members, referred specifically to the work concerning the organizational architecture of the basic health units, their institutional goals, the professionals to work at them, and the organization and funding of the health care network. He felt it was an opportunity to develop a project that was embedded in the "primary health care movement of 1978" (Pellegrini, 2005). In this sense, Prevsaúde was a government proposal to gradually and progressively reorganize the way health services were offered in order to adapt them, according to the text, "to the priority needs of the population and the means available for their support" (Brasil, set. 1980, p.3).

Prevsaúde was only formally divulged in March 1980 at the seventh National Health Conference, where its principles were well received by the different public health stakeholders (Mello, 1981, p.25). The president of the Republic and the ministers of Health, Education, and Welfare all spoke at the conference, as did the director-general of WHO, Halfdan Mahler. The central theme of the conference was the expansion of basic health services, and it explicitly took PHC as a reference for a health system in need of reform (Conferência Nacional..., 1980).

To a large extent, as already indicated, the plan organized a number of "rationalizing" attributes and initiatives in the form of a policy to expand coverage across the nation – initiatives that were more or less established or consensual across different groups in the field of public health. Its observance of the ideas contained in the Declaration of Alma-Ata can be confirmed by observing its operational guidelines. These were: (1) regionalization; (2) universalization of health care; (3) appropriate technology and simplified procedures; (4) intensive use of generalist and ancillary personnel; (5) administrative reorganization, with a focus on inter-institutional integration and decentralization; (6) maximum productivity of services, with a focus on population coverage; (7) comprehensive health actions, understood as actions with a focus on biological, psychic, and social dimensions; (8) community participation in order to influence the community in terms of the planning, execution,

and control of the services provided; and (9) inter-systemic coordination, understood as the need to forge links between the different levels of care in the health system (Brasil, set. 1980, p.3). Beyond this, the debt Prevsaúde owed to the Alma-Ata tradition was explicated in the project description as a strategy for "prioritizing Primary Health Care" (p.4).

In line with what would later be identified as comprehensive primary care, the text contains the characterization of an intended organizational effect of PHC in the way they related to the other levels of care in the health system. In the immediate wake of Alma-Ata, it could be said that Prevsaúde already envisaged primary care as a central "strategy" around which to organize the country's health system. We stress that this orientation was an important point of consensus among its proponents and other actors in the field of public health, even if for some it still fell short. Thus, the idea that the health priorities, the care flows, and the relationships forged between the different actors in a health system should be the object of "rationalizing" effort on the part of the administrators constitutes one of the main discursive cores of which PHC was both an heir and a major advocate.

Conceptually speaking, in the ambit of Prevsaúde, PHC was committed to establishing an integrated set of health services destined to the promotion and recuperation of health and the prevention of disease, with a particular focus on the most prevalent diseases. With universal coverage, services would be provided by "generalist professionals," assistants, and community agents, always under the supervision of professionals. As for the services offered, it was imagined that hospitalization would be available at some mixed-level units, with urgent and emergency services, observation beds, outpatient care, especially in four basic areas: general practice, clinical surgery, gynecology and obstetrics, and pediatrics. Furthermore, dental services and other medical specialties were planned to be adapted to meet local needs (Brasil, set. 1980, p.8).

Alongside the expected focus on medical services, the project also encompassed actions in the field of basic sanitation, improvements to poor housing and general environmental conditions, alongside actions in vocational training with a view to improving both the services provided and the managerial capacity of the health facilities. In other words, the plan envisaged inter-sectoral action.

Another particularly important aspect of Prevsaúde was the creation of a public network of basic units and priority care by the public health units in a bid to combat any idleness in the state's installed capacity. This final proposition galvanized staunch opposition on the part of groups linked to the interests of the network of private accredited hospitals, which were by now well organized in terms of health-related issues and long dependent on transfers of public monies. The Brazilian Federation of Hospitals, for example, an association founded in 1966, which also sent a representative to Alma-Ata, as mentioned earlier, issued a public statement in which it stated that "the document [of Prevsaúde] is highly nationalizing, even if it sometimes attempts to disguise this" (Mello, 1981, p.26).

This position also had supporters among the core group at National Institute of Medical Assistance of the Social Security (Instituto Nacional de Assistência Médica da Previdência Social, Inamps). At the same time that the ministers involved directly in the plan were publicly supporting the new possibilities enabled by Prevsaúde to make the health system more economical and efficient, in his speeches at the seventh National Health Conference

the president of Inamps voiced an opposing view. Hari Valdir Graeff was in favor of creating optional health insurance – also public – for the wealthier of society for the acquisition of priorities, better accommodation, and other privileges, while also vigorously expanding the institute's network of accredited service providers (Mello, 3 jun. 1980). Graeff sent Minister Jair Soares a critical document and, in a highly publicized interview, stated that the project was "nationalizing, with oversized resources and inexplicably attributed the administration of health care in the states to state [health] secretariats." In another statement, he said it would be "incomprehensible to cut private initiative off" from the field of primary care. Jair Soares spoke out against both the leak of this document and the adjective *nationalizing*, reiterating his support for Prevsaúde (Presidente..., 1980, p.15).

This opposition was surely instrumental in ensuring that Prevsaúde never got off the drawing board. Faced with such a strong backlash, as of September 1980 successive new drafts of the plan were published. From then on, Prevsaúde "completely lost its focus," ending up "stillborn," according to Carlos Gentile de Mello (1981, p.26), a health specialist who did not temper his criticism of the enfeeblement of the original plan. Not only were the positions of private health care institutions incorporated, but the potential for social participation in the system's administration was removed. In 1981, the project was shelved.

Final considerations

One inflection, albeit partial and transitory, in the way the health authorities under the dictatorship perceived PHC, according to the terms and context of Alma-Ata, deserves our reflection. Certainly, the change of government in 1979 and thus of the ministers of Health and Welfare, coupled with a change of course toward the relaxing of the regime, heralded a new context less marked by hostility to social issues and even political activism.

Even so, only overwhelming confidence in the technical coherence and systemic rationale underlying the proposals based on the precepts of Alma-Ata, and thus in the experience accumulated in the previous two decades, could justify the official mobilization by the two ministries of a working group that ended up developing and proposing a health system that was largely attuned with that conception. Not even a possible nationalizing bias or the participation of the people seemed politically unfeasible in the eyes of its formulators in that context. It conjures up, as Mello (2010) suggests, the idea of a kind of outpouring of ideas and experiences, which in that context was only possible thanks to the felicitous encounter of a progressive perspective between old traditions and alternative practices and approaches.

The seventh National Health Conference bore indisputable witness to this alignment. The ministers and health specialists involved hailed PHC either as a solution for the rational supply of basic health services to those populations who had access to no care or as a universal solution for a national system under construction. At the same time, a document of a conceptual nature was presented to the participants, setting forth the core aspects of PHC with the aim of allaying fears as to the potentially nationalizing nature of the initiative (Conferência Nacional..., 1980, p.7-29, 249-254).

Nonetheless, in the light of Kingdon's multiple streams framework (Gottems et al., 2013, p.513-515), inevitably spawned of their historical moment, as suggests Weir's (1992, p.191-192) criticism, the trajectory of Prevsaúde may be understood as a combination of events in which a certain convergence of conceptions around the existence of a problem to be addressed (the need to expand access to public health services) and a proposed solution largely underpinned by technical and organization consensus (the rationalizing precepts conceived in the critical trajectory of public health and in the formulation of PHC per se) fell on barren political ground. As such, what seemed to be a window of opportunity to reform the Brazilian health system, opened by the political reconfiguration of a new government in a context of the regime's dwindling social base, in fact revealed itself to be far less auspicious.

Resistance to Prevsaúde came primarily from three sources. First, the ways the expansion and upkeep of the country's private hospitals were sponsored with public monies made this business group well organized and keen to hold its ground and reproduce the economic complex of health (Menicucci, 2007, p.180-181). Second, the consequences of the systemic crisis of capitalism and the economic model adopted in the country deepened the fiscal crisis, affecting the capacity to increase public spending. In this context, the private sector fought tooth and nail to hold onto its share (Oliveira, Teixeira, 1989, p.270-275). A third aspect was that in a context of crisis, envisaging the decentralization of responsibilities and resources would weigh heavily on the national budget and be hard to operate politically, removing considerable spheres of power from the orbit of the Inamps structures, including their ramifications in the states.

Meanwhile, the left-wing handled PHC with care and little enthusiasm (Cebes-Campinas, jan.-mar. 1980, p.14-20). With Prevsaúde, PHC ended up being considered as part of a "technocratic proposal of progressive inspiration" (Oliveira, Teixeira, 1989, p.275). In the proceedings of the first Health Symposium of the Chamber of Deputies, in 1979, PHC was mobilized in the pronouncements of those most directly linked to the official health bodies and international organisms (Abreu e Lima, 1980, p.113-122; Macedo, 1980, p.61-72) and also in the closing remarks (Comissão..., 1980, p.259-262). In the document presented by the Brazilian Center for Health Studies, the newly created entity that was known to be an expression of the new activism for a Brazilian Health Reform, PHC was mentioned only tangentially (Cebes, 1980, p.11-13).

It seems to us important here to note that the discussions and initiatives around primary health care were subject to ebbs and flows of ideas and remained linked to the disputes surrounding the extensive proposals for service coverage, sometimes aligned with the notion of the welfare state and other times with more selective or focal perspectives of politicians. Brazil's political and ideological scenario as of the mid-1980s and especially in the 1990s is evidence that the proposals for the cost-effective organization of the health service and the "low-intensity" variants of PHC chimed with the liberal vocabulary of "fiscal adjustment" and the "minimal state" that orchestrated the conduct and agenda of many actors in the general and health-related political scene.

In the early 1980s, the tensions that ended up casting out Prevsaúde, prompted by the tradition of public health and the guidelines of Alma-Ata, were certainly nourished by

the opposition between public responsibilities and private interests. But they were not limited to this aspect or to its real or imagined left-wing inspirations that so bothered Paulo de Almeida Machado. The budgetary implications and the costs of such a profound institutional reorganization in a context of political instability put boundaries on that initiative, which, it could be said, was the expression of a rationalizing utopia.

What was apparently manifested as a technical and organizational consensus came up against its political limits, even when it was far from reflecting the most radical propositions or greatest "intensity." As ever, PHC was a hot topic. Resolving it depends on our willingness to respond with solidarity to the challenges that have come before and also those of today and the future.

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NOTES

[1] When he was editing a volume on the thirty years of the WHO, Socrates Litsios discussed the transition from the conception of "basic health services" to "primary health care," referring to a study by the organization undertaken in 1972. See WHO (2008, p.117-120) and Williams (1988, p.185-186).

[2] Divisions between Moscow and Beijing over the doctrinal autonomy of China vis-a-vis the USSR and the strategies of the international socialist movement, dating back to the 1950s, were heightened in the 1960s. In 1969, the two countries engaged in armed conflict in the border zone, which came near to becoming a more generalized conflict. These quarrels were only resolved in the 1990s (Mikhailova, 2013, p.316-321).

[3] The confusion over this topic is so great that the prestigious and reliable *Dicionário Histórico-Biográfico de História Contemporânea do Brasil*, published by CPDOC-FGV, records in the entry on Paulo de Almeida Machado, then the minister for Health, that Brazil was in fact present at the meeting. See: http://www.fgv.br/cpdoc/acervo/dicionarios/verbete-biografico/machado-paulo-de-almeida.

[4] This information was supplied by José Carlos Seixas, then the secretary-general of the ministry, in a dialogue described by José Agenor Álvares da Silva (2015, p.44). In a private conversation in a completely different context, José Paranaguá de Santana gathered the same information from Seixas.

[5] The personal archive of Ernesto Geisel is maintained at the archive of Centro de Pesquisa e Documentação de História Contemporânea do Brasil (CPDOC-FGV). It has been digitalized and can be accessed via: https://cpdoc.fgv.br.

[6] It is important to note, for example, that Francisco de Assis Machado was successively responsible for implementing the Health Program for Jequitinhonha Valley, the Montes Claros Project, and later Piass. See Machado (2014, cap.2).

[7] During the Geisel administration, the country faced a serious meningitis epidemic, which became a national topic even with the censorship of the most critical information. Denouncements of the sale in the country of drugs banned in the USA, known as "medical errors," outbreaks of cholera and polio, and strategies to prevent polio, were some of the other topics that had great public repercussions. For more on this, see the large archive of press coverage available at Hemeroteca Digital Brasileira: https://bndigital.bn.gov.br/hemeroteca-digital.

[8] Under the supervision of the secretary-general of the Ministry of Health, Mozart de Abreu e Lima, the Prevsaúde working group was coordinated by Carlyle Guerra de Macedo. Although not completely formalized, it had at least the following members: Marlow Kwitko, Alberto Pellegrini, José Agenor Álvares da Silva, Ricardo Freitas Scotti, Solon Magalhães Vianna; Ana Maria Barata, and Antônio José Guerra. We thank José Agenor and José Paranaguá de Santana for this information.

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