

From the struggles against dictatorship to the struggles for democracy: the thinking of Antônio Ivo de Carvalho

Das lutas contra a ditadura às lutas pela democracia: o pensamento de Antônio Ivo de Carvalho

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Introduction

*So comrades, come rally,
And the last fight let us face.
The Internationale!*

(L'Internationale – Pierre de Geyter e Éugene Pottier)

THIS ARTICLE IS A TRIBUTE TO ANTÔNIO IVO DE CARVALHO, social activist, partisan, active member of the Movement for Health Reform (MRS), manager who led the Sergio Arouca National School of Public Health of the Oswaldo Cruz Foundation (ENSP/FIOCRUZ) to a level of international excellence and one of the creators of Fiocruz's Center for Strategic Studies.

The tributes over his unexpected death continue to multiply (<http://informe.ensp.fiocruz.br/noticias/51571> and <https://youtu.be/7kFyvhwM-Bs>, for example) and, in this context, the objective of this work is to highlight his role as an organic intellectual of the health sector and the Unified Health System (SUS).

The following text is a compilation of selected extracts from 11 of his main works that were articulated in order to produce a general sense that guides and allows readers to have contact with the richness of his reflections and proposals. Logically, the reading of each of the reference works will produce the keys necessary for the advancement of the themes and questions mentioned hereinafter.

There is also an utopian and loving desire to always hear his voice, to review his gestures and revisit his argumentative performance, partners we have been for the last 15 years. Anyone who knew him will know that every word reproduced here had a tone of enthusiasm, of desire to change the world, of irritation with inequality and social injustice. Anyone who didn't know him, read knowing that he truly believed in the struggles of the people, dedicated himself to them, was arrested, tortured by the military dictatorship and never felt like a hero, but an equal, with his limits, mistakes and finitude.

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The struggles for health and against the military dictatorship

In the late 1970s, there was a generalized effervescence [...] around the health issue. It was, basically, a struggle for access to health services, then controlled by Inamps (National Institute of Medical Assistance of the Social Security) which, at that time, was already very deteriorated¹.

This effervescence was present 'in the masses', in the population [...] here in Rio de Janeiro, even before Famerj (Federation of Residents' Associations of Rio de Janeiro), there was already this struggle. In Nova Iguaçu, where we were, it was organized as a movement for health. Afterwards, it expanded as a neighborhood movement. In the south and east of São Paulo there was also a strong movement, strongly supported by the left that acted in the Catholic Church¹.

It wasn't a politically elaborate fight, with an ideal of health behind it. It was a struggle to be seen at the health service! People were not served and sometimes reacted with some turmoil!¹

The [Catholic] church played a very important role in mobilizing and organizing these people. Urban social movements were much more present than unions in these struggles. The unions were demanding expansion of rights via health plans. Urban social movements asked for access to a system that did not exist¹.

The PCB (Brazilian Communist Party), within the MDB (Brazilian Democratic Movement), had a strong health movement [...] that was fed by the community medicine process, by people from Montes Claros, Paulínea, Niterói [...] which was based on Alma-Ata and the universalization of primary health actions. This

was the so-called health left. That is where Arouca was¹.

There was also another line in the Party not directly linked to the health sector, which focused on 'popular agitation', the formation of cadres for the popular struggle. And I was on that line. I was, at that time, at Fase (Federation of Organs for Social and Educational Assistance), in Nova Iguaçu. [...] I joined the social movement through the Catholic Church and ended up being much closer to the associative movement in the late 1970s than to the health movement¹.

[...] At Uerj (University of the State of Rio de Janeiro), there were Hésio, Noronha, Reinaldo... creating social medicine. At Ensp (National School of Public Health), there was the Pesis (Program for Socioeconomic Studies in Health), which was where Davizinho [Davi Capistrano Filho] was¹.

I went to Nova Iguaçu associated with the grassroots ecclesial communities. D. Adriano Hipólito was the Bishop there. I would say to him "I am a communist", and he would reply "there are communists who are much more Christian than my Christians!". And D. Adriano was a liberal. On the left was D. Valdir Calheiros, from the diocese of Volta Redonda¹.

We called on the popular movement to put pressure on! I remember that, in the dengue crisis, we articulated with people to go to the streets, close the Dutra [highway]! At that time, I wrote an article for the third issue of 'Saúde em Debate': 'Health and Basic Education: some notes', which saw health not as an end in itself, but as a means of producing class consciousness¹:

That the people involved [in the educational processes] can acquire elements that allow [...] a more critical understanding of reality and [...] strengthening of confidence in their possibility of transforming it².

The Health Reform Movement: from white universalization to the self-reform of the health system and the creation of the SUS

Conceptually, the Sanitary Reform is born from within the big-party [PCB]. Criticism of the wasteful, hospital-centered system, which was going bankrupt with Inamps, comes [...] from the contact of party members and sympathizers [...] with the population's struggles to gain access to the system¹.

And it was in the relationship with urban social movements that the Sanitary Reform was built. [...]. It was not a mass movement, but it was supported and inspired by this spontaneous movement, especially on the outskirts of São Paulo, where people arrived, were not cared for and reacted, protested¹.

There was no party leadership that took the health care personnel and discussed it with them. The party had the sensitivity to listen to its members and supporters and to produce its alliances. [...]. And the party knew how to give these people the opportunity to organize social struggles according to the possibilities they had. This allowed party cadres to enter, for example, in the management of Inamps¹.

In the absence of competent professionals, the government had to absorb the specialists who were cadres of the big-party [...] Aloísio Salles, Temporão, Eleutério, Noronha... It was not an orientation of the party that its specialists entered the State to take it, but the party had the sensitivity to make it possible for the fight to be carried out from within Inamps [...]¹.

At Inamps services, you were only served if you presented a worker ID, but at municipal and state services, no. And these had idle capacity,

while Inamps was overwhelmed [...] and spent a lot accrediting and paying private providers, in a nefarious process that helped to proliferate the 'trambiclinics', which received public funds for services of very low quality or non-existent¹.

In 1979, at a symposium held by the Chamber of Deputies, 'Health and Democracy', Arouca and an entire 'elite' of the Sanitary Reform, which was basically from the big-party, defended a single system, although not called that, based on a concept of health inspired by Alma-Ata and participation¹.

The Conasp (National Social Security Council) plan, in the 1980s, provided for an integration between what was called at the time the 'multiple health systems', from the different spheres of government. It was a networking principle. For this integration, agreements were made, which were manipulated by leftist cadres who worked at Inamps, in order to sign agreements with more advanced thinking municipalities. It was a quick process, which even bypassed the State if it did not want to make the agreement! And then, Inamps began to pay the municipalities for the service. This functioned as a 'white universalization'¹.

[In 1982,] the IHA (Integrated Health Actions) were created [which] had the purpose of occupying the idle capacity of states and municipalities, increasing public service. In the Sarney administration [...] they were succeeded [in 1987] by the Suds (Unified and Decentralized Health System)¹.

This was a self-reform¹. [...] There was [a] significant dispute within the health movement: what is the strategy for building the single system? Would the unification be done by the Ministry of Health or by Inamps¹?

This separated the two main leaders, Arouca and Hésio. Those who were at Inamps, along with Hésio, Temporão, Noronha..., defended

that decentralization should be done through the extinction of Inamps for the states and municipalities, in an incremental process in which the Institute would decentralize its network and its resources¹.

And there was a part of the communist left that was at Fiocruz, at Cebes (Brazilian Center for Health Studies), led by Arouca, who advocated that decentralization be carried out by the Ministry of Health which, at that time, had no power, but had the health programs and a health concept¹.

It was an internal thing, without expression on the outside, but heavy. But that was resolved in the political process. Inamps lost the power to pay the HAAs (Hospital Admission Authorizations), that is, to be a purchaser from the private provider. With the SUS, the HAS/MH (Health Assistance Secretariat of the Ministry of Health) started to issue HAAs, assuming a leading role even before the extinction of Inamps, which occurred, somewhat suddenly, in the Itamar Franco government (1992-1994)¹.

Health Reform as Political and State Reform: democracy, social participation and health councils

Postulating the democratization of access to health-promoting goods and services, but also the democratization of access to power, the health reform agenda has always had in participatory proposals the mark of its concern with the 'functioning mechanisms' of the State and not only with the 'redistributive results' of its policies³.

Hence, the simultaneous use of the slogans 'Democracy is health' and 'Health is democracy', emblem of the Health Reform while also a political reform, in the sense that the universal right to health should be accompanied, even guaranteed, by the right to participate in the power. Health as a strategy for democracy and democracy as a strategy for health³.

The IHA [...] advocated that, when signing agreements between the Union, states and municipalities, there had to be health councils. [...] There, a culture of participation was created, of the presence of representatives of the population in the State's co-management structures¹.

This comes from the local Cuban health system, in which you have to integrate a network, bringing together representatives of the various networks - federal, state and municipal - and the population. Thus, in Niterói, [...] the 'Niterói Project' [with] Gilson Cantarino was created. [...] In Rio de Janeiro, [...] there was a collegiate per program area that was just for the directors and, around it, participation. In Nova Iguaçu, the council was external to the government.

[...] [This] shows that different and, for the time, innovative ways were tried with regard to participation¹ [...], a theme constantly present in the rhetoric and practice of the health movement [...]³.

[...] Both the notion of participation and social control can be discussed from different angles [...], the two terms have different origins and traditions in the field of health [...], they are historically contextualized and relate to different socio-economic-cultural contexts. They correspond [...] to a variety of political-ideological approaches, involving different ways of understanding the State, social groups, State-society relations, the health-disease process and the ways of intervening in it⁴.

In the Eighth [National Health Conference, 1986], the State was the decision-making committee of the bourgeoisie! The [proposal of] participation in the Eighth was also a way of translating the State that came from the dictatorship, which would not be able to guarantee the SUS as universal. External participation [in the councils] is almost a safeguard designed to bring the population into the political struggle. [...] This was softened by redemocratization¹.

The democratization process brings new actors to the scene and raises new questions in the sphere of State-society relations. [...] A new benchmark is designed [...] requalifying participation. [...] The central category is no longer the 'community' or the 'people' and becomes society. The intended participation is no longer that of groups excluded due to dysfunction of the systems (communities) or groups excluded by the logic of the system (marginalized people), but the set of individuals and social groups, whose diversity of interests and projects integrates citizenship and disputes with equal legitimacy for space and service by the state apparatus⁴.

One of the characteristics of this pattern of participation [...] that here is called social participation [...] is its tendency towards institutionalization [...], the process of inclusion in the State's legal-institutional framework of structures that work as direct representations of the society, invested with some level of government responsibilities [...], the explicit and formal presence within the state apparatus of the various social segments in order to make the diversity of interests and projects visible and legitimate⁴.

The Health Councils [in Law nº 8.142/90] are institutional expressions [of this] process of reordering State-society relations, [...] new institutional arrangements designed to provide the State with organizational means to implement universalist social policies, as advocated in the 1988 Constitution⁵.

[...] Institutional innovations can be [considered] [...] an adaptive reform of the institutional design of the State [...] to change the pattern of reception and processing of demands in the health area [...], [instituting] a sectoral agenda 'of public interest', capable of setting the parameters of State action. Its role in the state system of formulating and implementing policies would be to [...] establish or discriminate what is in the public interest [...], [representing] for the various interest groups an arena for thematizing and publicizing of their specific interests³.

Its modernizing impact consists in the veto [...] of the patrimonialist culture typical of the Brazilian State. In place of the hierarchical arrangements typical of patrimonialism, where politics devoid of otherness was based on the unregulated circulation of favors and loyalties, under the empire [...] of private interests, the Councils introduce a pattern of techno-bureaucratic rationality that [marks] the implementation of SUS³.

[...] Permanent structures, of a public character, [are able to] contribute to a reform of the State. [...] Not coming from an occupation of the State by society, nor from a benevolence or concession of the State [...], its performance [...] must be discussed in the context of its democratic effectiveness, that is, its effects on social life and especially on the functioning of the State³.

Ethical and political challenges of public health

[...] Two trends of thought [...] press for the updating of the identity of public health, as a field of knowledge and practice. They emerge from contemporary political, social, cultural and scientific realities, and point to [...] different and alternative developments for the future of public health⁶.

The first [...] concerns the growing weight of economic reason on the epistemic territory of public health [...], the second [...] refers to the growing importance of activities of 'individual' health promotion and prevention of diseases [...], a 'neo-hygienist' public health, obsessed with an ideal of human health, no longer defined by reference to 'external' contaminations, but by reference to a desired perfection or physical purity achievable by biological handling⁶.

In this context [...], both for academic debate and for political dispute, [...] the renewal of public health must [...] preserve what was its historical significance, although not always explicit: the idea of health as a public good [...] clearly rejecting both the role of screen for minimalist health policies, and the institutional and normative expression of the obsession with perfect health⁶.

[This] new pattern of articulation between the biological and the social will certainly have to grant a conceptual and methodological primacy to subjectivity that, however, cannot be restricted either to that of subjects plastered in a structurally defined collective logic, nor to that of subjects that constitute themselves with the elimination of objectivity⁶.

[...] The field of public health is required to undertake and overcome the legacy of the dichotomous, conflicting relationship between objectivity and subjectivity, assuming itself as a field of interaction, intersection of subjects in three territories: [...] social, where the commitment to the equalization of health opportunities, with universality and equity is confirmed; [...] cultural, [in which] is admitted the approximate and constructed character of the categories related to the health-disease binomial, its symbolic dimension and its connections with the human experience of being in the world; and a properly natural, objective, material territory, [in which] a knowing subject understands himself distinct from his 'natural' object, keeping, however, with him, a relationship of intimacy and interaction, of his possible (re)creator⁶.

[This] directly affects the scope and objectives of public health: [...] thinking about a new relationship between the collective and the individual in the field of health [...] is about [...] prolonging human life [...] or also improving its quality? Does it concern collectivities, with their regularities and averages, or does it aim at individuals, with their singularities and differences⁶?

As much as common sense is quick to opt for both, the contemporary health situation shows that conflict situations are increasingly frequent, involving excluding choices and decisions, both in terms of public/collective spaces (resource allocation, legislation, social planning) and in terms of individual daily choices⁶.

With the rise in costs occurring at a faster rate than the extension of health benefits, technological resources tend to be available/accessible to a proportionately smaller number of people, in a context of global increase in demand⁶.

It can be said that, in these choices, the health debate meets the ethical debate: the tension between sacredness and quality of life⁶.

The traditional Principle of the Sacredness of Life, an absolute norm with origins in Christian morality and, in part, in Hippocratic medical ethics, has historically presided, and served as an ideological and ethical framework, to a doctor-centered medicine, aimed at fulfilling 'the of the natural order', having as an absolute duty to preserve life against what is contrary to that order⁶.

The diversity and complexity of modern societies have rendered [this] principle obsolete or insufficient⁶.

O desafio, portanto, é o de equacionar uma nova política [...] capaz de superar os modelos marcados por uma verdade técnica e por uma referência ética unicista [em que] aos indivíduos é reservado o papel de objetos ou meros

coadjuvantes de um enredo 'natural' e a quem cabe apenas cumprir prescrições técnicas e éticas. No seu lugar, deve ser desenvolvida uma visão pluralista em que, preliminarmente, seja respeitada a diversidade de escolhas e vontades, e [na qual] as prescrições sociais decorram de diálogos e contratos intersubjetivos⁶.

For a new health policy: social inequalities and health promotion

Assuming social inequalities as the main obstacle to health and quality of life for all (and the latter as an ethical imperative and a requirement for a stable economy) highlights the need for a broad coalition in favor of a more equitable, effective and efficient policy of public policies that must involve government and society⁷.

[...] From the 1960s onwards, in various parts of the western world, critical thinking [was developed] [...] aimed at revaluing the social and cultural dimensions of the determinants of the health-illness process, going beyond the exclusive focus of fighting the disease only after it has been installed. [...] Although diversified in its conceptual references and in the variety of national health and social profiles, such ideas had their most organized expression in the so-called health promotion movement⁸.

Starting from the positive and expanded concept of health, and focusing on the social process of its production, Health Promotion has shown itself capable of mobilizing [...] the search for the 'autonomy' of individuals and groups (ability to live a free life), and the search for social 'equity' (equitable distribution of this ability between individuals and groups)⁷.

A field under construction and in constant development, it has [...] established itself as a point of convergence for [...] reflections and practices committed to overcoming [...] the biomedicine, which is increasingly a part of the interests of the medical-industrial complex, and responsible⁷.

[...] A critical and expanded approach to Health Promotion points to the need for discussion and improvement of public policies, redistribution of powers and establishment of a new combination of rights and responsibilities in the various spheres of social life, affecting professional relationships /citizens, collectives/people, governments/society, economic/social spheres, as well as sectoral/extra-sectoral ones, among others⁷.

From the point of view of Health Promotion, the socioeconomic determinants of the health-disease process constitute an essential analytical framework, not only for theoretical reflection, but also for the design of public policies, programs and interventions aimed at improving the quality of life [...], thus transcends the health sector and increasingly impacts public policies in general, dialoguing with the diversity of fields, organizations and subjects⁷.

[This] intersectorality for health in public policies, in fact, supposes a supra-sectoral decision, expressive of a pact for health/quality of life as a political decision, to be operationalized at the institutional, programmatic and budgetary levels⁹.

At the institutional level, establishing a locus in the state apparatus, above sectoral agencies (ministries, secretariats, etc.), explicitly in charge of producing and conducting transversal initiatives oriented to the production of health and well-being, through dialogue with the various segments of society and of the state apparatus, as proposed by the National Commission on Social Determinants⁹.

At the programmatic level, taking care so the intersectionality is not sterilized in rhetorical intentions and fragile agreements, and is embodied in concrete programs aimed at specific populations, with their own objectives, management and budgets, submitted to evaluation procedures that allow the dimensioning of their impacts on health and quality of life⁹.

At the budgetary level, to underline that there will be no effective intersectoral programs without the allocation of specific resources; funding these initiatives by adding up budget shares from different bodies induces intersectoral competition, not cooperation⁹.

Health Promotion thus emerges as an opportunity not only to formulate an agenda to expand the SUS, but also to point out a 'new' agenda, requalifying health policy for the new millennium, rescuing the banner of health reform in its dimension of 'social change and combat of social inequalities', necessary for the construction of health and life with dignity⁷.

Futures of SUS, health and Brazil: 2030 agenda and marijuana decriminalization

[...] Developed through a partnership between CEE-Fiocruz and researchers from the Department of Social Sciences, at Ensp, [...] the study 'Perception of Brazilian health experts on the SDGs and the 2030 Agenda' [points out that] the country's potential to achieve any of the 17 SDGs is low, in particular, the eradication of poverty (SDG 1), the reduction of inequalities (SDG 10) and the construction of a culture of peace and justice (SDG 16)¹⁰.

Quality education and poverty eradication, respectively SDGs 4 and 1, are considered the most important to be met by Brazil and also those that will contribute most to the country achieving SDG 3 'health and well-being'¹⁰.

[The Research] presents a list of recommendations distributed in two axes: the first axis is related to what can be called, broadly speaking, 'social policies' - i) reducing poverty; ii) increase the coverage of basic sanitation; iii) reduce the different manifestations of violence; iv) invest in the quality of public roads and highways; and v) expanding control over extraction activities and polluting industries - while the second axis is more directly linked to 'health policy': vi) achieving universal coverage of primary care; vii) expand and qualify prenatal care in primary care; viii) expand 'sexual health and reproductive health' in primary care; and ix) expand the prevention of alcohol abuse¹⁰.

It is noteworthy that, among the recommendations that are perceived as being of 'average' or 'low' importance, are: [...] 'commit and hold automakers responsible' (recommendation for Goal 3.6, which refers to the reduction of deaths and injuries from road accidents); [...] 'legalization of abortion' (recommendation for the fulfillment of Goal 3.1, referring to the reduction of maternal mortality); 'legalize marijuana' and 'decriminalize other drugs' (recommendations for Target 3.5, concerning the prevention of drug abuse), the latter is the only one perceived as being of 'low' importance¹⁰.

[This indicates that] Recent changes in what would constitute a 'sanitary common sense', with the incorporation of progressive values such as environmental protection, consumer rights, gender issues, can perhaps be explained not so much by a 'traditional awareness', but by a subtle combination of democratization of information/knowledge and moral progress⁶.

[Other] Study developed by the Center for Strategic Studies of the Oswaldo Cruz Foundation, [in] 2014 - 'The perception of Brazilians on issues related to the decriminalization of marijuana' - [points out that] the hegemonic agenda so far [...], of the 'war on drugs' [...], that belongs to the political universe of right-wing coalitions, which commonly accompanies propositions against abortion, immigration and policies of positive discrimination [...] has failed. From any point of view that takes into account peace, social justice, public health and even the efficiency of confrontation, its executors are not able to point to any significant gain that can be used as an argument in their favor¹¹.

If the objective is to produce a social scenario in which repression inhibits consumption, [this agenda] is far from being successful, and it coexists daily with pain and suffering. In Brazil, the damage is manifested more incisively in the morbidity and mortality of the most vulnerable populations, notably poor young men, blacks and mulattos, residents of slums and outskirts; in the overcrowding of prison and socio-educational systems, which produce absolutely degrading living conditions; in reinforcing both police repression and its corruption; in the unbridled multiplication of the demand for mental health services; and in the organization of drug trafficking in an economic dynamic that integrates legal, informal and illegal markets, making it an extremely profitable activity, which seeks to infiltrate party and electoral politics¹¹.

[In view of this], there is a need to develop direct dialogues with the population, which admits to being poorly informed. [...] This is directly related to the fact that public education and health services do not represent, by far, the role of information source¹¹.

Now, if the 21st century is that of the 'information society'; whether information and

communication technologies allow the development of social networks that, around the world, have produced powerful social mobilizations; [...] it seems to be clear that, for new democratizing agendas to be successful, they must be able to value and qualify social participation and deliberation, through a communication policy¹¹.

[The aforementioned] research also provides clues for the segments that need to be focused by this communication policy: women, over 45 years old, with low education and income. It should be noted that, in this group, there are mothers who suffer from violence that involves drug trafficking and affects their children¹¹.

Here, two other needs of democratizing agendas become clear: that of listening to and giving voice to women in general, already so attacked by the sexism that dominates Brazilian society; and especially to black women, hurt by the racism that insists on staying in the country. To be a woman, mother and black is to have an accumulation of extremely beautiful and important characteristics for the individual and for the construction of a fairer society. A democratizing agenda must incorporate these people as protagonists¹¹.

Conclusions: it is still necessary to fight, now for democracy!

The political crisis that Brazil has been going through since 2013 brings concrete threats to its already incipient democracy. The open conflict between the powers of the republic, [...] a corollary of the coup that overthrew President Dilma Rousseff, illustrates the radicalization of the political polarization that was established in society¹¹.

[...] Actions of intolerance, violence, prejudice, racism and fascism have disputed the public space with those that seek to promote freedom, coexistence between the different, the advancement of individual and social rights, and the intensification of democratization¹¹.

Reversing a trajectory of growth, investments in social protection and reduction of inequalities and poverty, the country has adopted, since 2016, a political and economic agenda focused on a heavy financial adjustment, the reduction of the inducing role of the State in development and the deregulation of labor relations. Several political actions have been implemented in this sense, the most representative being Constitutional Amendment No. 95, which froze spending on health and education for the next 20 years; the labor reform, which restricted rights historically conquered by Brazilian workers; and the pension reform proposal presented to the national congress in March 2019, in a context in which the President of the Republic considers that the rights enshrined in the 1988 Federal Constitution are responsible for the resurgence of unemployment, poverty and inequality¹⁰.

With regard specifically to the 'health sector' [...] in terms of formulation, [we are still] in the majority. But in terms of policy, implementation, no¹¹!

[...] The difficulties [...] go through historical problems and increase due to the crisis of cooperative federalism that structures the SUS, affecting states and municipalities that face budgetary difficulties, restrict investments, fail to pay salaries of their public servants and deal with the lack of new federal resources as one of the main obstacles to the improvement of SUS¹⁰.

And the SUS, until today, has to dispute [...] the mental universe of organized workers who, from the beginning, have the health plan as an item on the agenda [...] they want access to doctors, not to the health system

[...]. The great victory of the plans is the introduction of this in the agendas of the workers' struggles. [...] This is a distortion that grew in the shadow of the constitutional provision and government policies [...] that let the relations with the private sector slack¹.

Perhaps this explains [...] the 'treatment of kings' that health plan operators have always received, with subsidies and the construction of a political base with the support of the middle class. [...]. This mixture of private interests and the desire of the middle class to have plans is a very powerful obstacle. [...] For those who have some money and pay for the plan, there is a feeling that SUS is something for the poor. And this is due to a feeling that thinks that the poor are worse¹.

On a private plan, if the person wants to have a resonance, they do it. How to do this in the universal SUS? You can only do it when it is really necessary! So, the SUS has to rationalize resources that the plans do not rationalize. Because it is very expensive, funding disappears inside the SUS! And it's not for corruption¹¹!

I defend that the private sector has its place [...], but there are no proposals for an articulation of private and public offers! There is no synergy, a minimum of articulation, between private and public networks! [...] Today, nobody has the courage to propose the end of subsidies to plans, which are scandalous. They are aggressive! [...] I imagine that things would go better if the private sector did not have so many subsidies¹¹!

[In view of this], it is up to those who align themselves to the left, in their different ways and conceptions, to build new democratic agendas capable, on the one hand, of preventing the dismantling of social and protection policies built in the country since 2003, and, on the other hand, advance in identity struggles¹¹.

Democracy requires participation, with or without conscience, through voting. And the act of voting is surrounded by symbolism, it is a sophisticated decision by the voter. This means that, in democracy, there is a refraction of vested interests¹.

Collaborators

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