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OPINION ARTICLE

# The Unified Health System and Workers' Health in Brazil

## *O Sistema Único de Saúde e a Saúde do Trabalhador no Brasil*

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**ABSTRACT** The implementation of the Unified Health System (SUS) over the past three decades calls for a critical analysis from several perspectives. This article aims to revisit some aspects of Brazilian health policies, discussing the current situation and the importance of the SUS for developing Workers' Health (WH). This opinion piece analyzes the main political facts related to the SUS and WH. The findings indicate that the SUS has not been consolidated as a universal health system, and we can identify privatization at the phenomenological level and the financialization of health at the structural level. The expansion of public services was accompanied by the growth of the private sector, especially intermediary companies. The government escalated the counter-reform of the Brazilian Health Reform (RSB), turning the SUS into a simulacrum, compromising the universalization and expansion of public services. The creation of the Frente pela Vida signals an opportunity to resume the RSB again through the socio-community route, especially after the rapprochement of workers' representative organizations with the health movement. In conclusion, since politics is the biggest challenge facing the SUS, social struggles are antidotes to setbacks and reconstitute the RSB.

**KEYWORDS** Health care reform. Unified Health System. Health policies. Occupational health policy.

**RESUMO** *A implementação do Sistema Único de Saúde (SUS) nas últimas três décadas enseja uma análise crítica em diversas perspectivas. O artigo pretende revisitar alguns aspectos das políticas de saúde no Brasil, discutindo a situação atual e a importância do SUS para o desenvolvimento da área de Saúde do Trabalhador (ST). Trata-se de um artigo de opinião que contemplou a análise dos principais fatos políticos relacionados com o SUS e a ST. Os resultados demonstram que o SUS não foi consolidado como um sistema de saúde universal, sendo possível identificar a privatização no plano fenomênico e a financeirização da saúde no plano estrutural. A expansão da oferta de serviços públicos foi acompanhada do crescimento do setor privado, especialmente, de empresas de intermediação. O governo aprofundou a contrarreforma da Reforma Sanitária Brasileira (RSB), tornando o SUS um simulacro, comprometendo a universalização e a expansão de serviços públicos. A criação da Frente pela Vida sinaliza uma oportunidade para a retomada da RSB, por meio da via sociocomunitária, principalmente após a reaproximação de entidades representativas dos trabalhadores com o movimento sanitário. Conclui-se que, sendo político o maior desafio do SUS, as lutas sociais são antídotos contra retrocessos e reconstituintes da RSB.*

**PALAVRAS-CHAVE** *Reforma dos serviços de saúde. Sistema Único de Saúde. Políticas de saúde. Política de saúde do trabalhador.*

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## Introduction

Workers' Health (WH) should, in theory, be of interest to all individuals who need to work to live and, more extensively, to society and the State when they consider the human right to health. In its relationship with health, work can be examined from a negative and positive perspective. In the first case, we find the diseases and accidents identified since Hippocrates and systematized in 1700 in the work of Bernardino Ramazzini[1], or the worker's exploitation and alienation, analyzed by capitalism critics. Thus, harm (illness, disability, distress, accidents, and discomfort) and risks caused by work or lack thereof, such as unemployment, can be considered. However, labor's positive aspects have also been highlighted:

> Labor is central to determining the well-being and health of people and communities, contributing to the construction of the subjectivity and social identity of individuals, their survival, and personal fulfillment[2(327)].

In Brazil, the use of slave labor until the end of the 19th century postponed the occupational health issue, so that health care for the working class, with demands for the control of unhealthy working conditions, financial support, and the reduction of working hours, especially for women and children[3] only appeared with the first factories at the turn of the 20th century and strikes from 1917 onwards.

Some studies point to the development of Brazilian health policies in a trifurcated fashion: institutionalized public health, social security-based medical care, and so-called 'occupational medicine'[4]. Later, proposals such as Occupational Health (OH) and Workers' Health (WH) emerged.

Brazilian authors systematized specific differences between these expressions based on conceptual, epistemological, and historical reflections. In the case of WH, they sometimes address it as a movement linked to the Brazilian Health Reform (RSB) and the implementation of the Unified Health System (SUS), and sometimes as a field of knowledge and practices linked to Collective Health (CH), highlighting specific international influences[2,3].

This theoretical-conceptual, professional, and practical development is therefore associated with the formation of Latin American Social Medicine[5], particularly social or critical Epidemiology[6,7], which developed into social sciences, the RSB project, and the SUS[8] in Brazil. In the case of CH, its origins include the emphasis on the labor category and the work process concept, enabling theorizations about the social determination of diseases and concrete investigations[9].

The RSB, in turn, benefited from the aforementioned concepts in constructing its theoretical foundations and facilitated the inclusion of WH in the political and institutional agendas. Thus, the Brazilian Center for Health Studies (CEBES) encouraged the discussion of WH in the journal 'Saúde em Debate' since 1976 and published a book that can be considered the first bestseller on health policy in Brazil[10], including chapters such as 'Labor and Disease'[11] and 'Group Medicine: Medicine and the Factory'[12]. Some authors of this book contributed to developing the SUS proposal, presented by CEBES in 1979 at the First National Health Policy Symposium of the Health Committee of the House of Representatives, which delved deeper into the discussions of the Eighth National Health Conference (8ª CNS) and the Constituent Assembly between 1987 and 1988.

Regarding international influences, we should underscore the collaboration between CEBES leaders and Italian trade unions and, especially, with Senator Giovanni Berlinguer, professor of Occupational Medicine at the University of Rome. Thus, the book 'Medicine and Politics'[13] was launched in Brazil by CEBES, including chapters on the national health service in Italy, the development of health awareness, and capital as a pathogenic factor. During this period, several books on this topic were published in Latin America[14-16].

In a situation in which new trade unionism is emerging, and the struggles against the dictatorship in Brazil are escalating, notable are some initiatives of the trade union movement, such as the holding of the Workers' Health Weeks (SESAT), the creation of the Inter-Union Department of Workers' Health Studies (DIESAT) and the campaign against the monetization of risk at work[17] with the slogan 'health cannot be exchanged for money'.

At the institutional level, we can mention the 'bridge strategies' for the SUS (Unified Health System), such as the Integrated Health Actions (AIS) and the Unified and Decentralized Health Systems (SUDS). These strategies supported the development of WH within the National Institute of Medical Care and Social Security (INAMPS) and state health secretariats. The establishment of the Salvador Allende Center for Workers' Health Studies (CESAT) within the Bahia State Health Secretariat (SESAB) in 1988 is one example of this contribution from the AIS/SUDS.

During the constituent process, the WH issue was one of the most controversial[18], because it involved contradictions and struggles in the capital-labor relationship and, consequently, competing interests and powers. The heated controversies and confrontations were reminiscent of what occurred with the Agrarian Reform proposals regarding land ownership and possession.

The 1988 Constitution, by adopting the principle/guideline of comprehensiveness, conferred on the SUS a specificity that sets it apart from other universal health systems worldwide. Thus, the integration of preventive/curative and individual/collective (biopsychosocial) actions generated alternative proposals for care models[19]. In the case of WH, even though it was emptied compared to the initial proposals, some of SUS attributions were defined as "to implement health and epidemiological surveillance actions, as well as those of WH" and "to collaborate in the protection of the environment, including the work environment"[20(31)].

From this perspective, SUS implementation over the last three decades warrants a critical analysis of its achievements and failures, its limits, possibilities, obstacles, threats, and challenges. Thus, WH advances, and setbacks in its connection to the SUS prompt new reflections. Thus, this article aims to revisit some aspects of Brazilian health policies, discussing the current situation and the importance of the SUS for the development of the WH sector.

## SUS: Some background

Latin America, except for Cuba, has not prioritized the implementation of public and universal health systems in recent decades, such as the Unified Health System (SUS), which has always faced an adverse environment[21]. Since the constitutional process, Brazil has witnessed both victories and defeats. Thus, unlike education, health has failed to establish a minimum budget, so the issue of financing has been problematic throughout the SUS history.

Right-wing parliamentarians and even some then-progressive opposed the proposal to set a minimum budget for health, arguing that such a measure would hamper the budget and hinder government action. Even so, the General Transitional Provisions of the 1988 Constitution established that at least 30% of social security resources should be allocated to health[20]. This was not respected by the Sarney and Collor administrations nor by the National Congress in subsequent years.

At the beginning of the SUS, when the system covered more than a third of the population, the federal government halved healthcare funding. This marked the beginning of the 'discredit operation' against the SUS. During the Itamar administration, SUS resources were seized by the Minister of Social Security, forcing the Ministry of Health (MS) to take out a loan from the Workers' Assistance Fund (FAT) to pay contracted hospitals.

At that time, the Proposed Amendment to the Constitution (PEC) Nº 169/1993 was

presented by Representatives Eduardo Jorge (SP) and Waldir Pires (BA), establishing a minimum of resources for health at the federal, state, and municipal levels. However, it was only approved, with modifications, seven years later through Constitutional Amendment (EC) Nº29/2000 and transformed into Complementary Law Nº 141/2012 almost two decades later.

Meanwhile, the Provisional Tax on Financial Transactions (CPMF) was implemented in 1996 but was distorted by the economic department of the FHC administration and finally abolished by Congress in 2007, jeopardizing investments in the Mais Saúde Program (More Health Program) developed by Minister Temporão's team. Subsequently, through coordination between the Executive and Legislative branches, the 'Saúde+10' (Health+10) Popular Amendment Bill, which in 2012 proposed allocating at least 10% of the Federal Government's gross revenue to healthcare, was shelved. Between 2014 and 2018, further blows were perpetrated against the SUS (Unified Health System), culminating in EC-95, which radically compromised its funding[23].

More recently, EC-95 gave way to several initiatives that shaped the New Fiscal Framework (NAF). Of note is PEC Nº 32/2022, replaced by LC Nº 200/2023, both of which brought greater flexibility compared to EC-95 but showed similar problems. Subsequently, several spending cuts were announced, including establishing a minimum wage adjustment cap, reducing the salary bonus, eliminating loopholes that circumvent the super-salary cap in the public service, changing the rules for the Continuous Cash Benefit (BPC), establishing a limit on the growth of parliamentary amendments; extending the Unlinking of Federal Revenues (DRU); and reforming military pensions. The minimum wages for health and education were left out of the package[24,25].

Throughout this trajectory, the so-called economic divisions of all governments have colluded against the SUS, with the acquiescence of the Chief of Staff, the Presidency of the Republic, and the National Congress, besides the omission of the Supreme Federal Court. If the SUS had had the support of the Brazilian state through adequate funding, it could have strengthened public infrastructure with investment and operating resources, providing better services to the population and no longer being held hostage by the private sector, especially in specialized and hospital care.

## The emergence of WH and the SUS legal framework

When systematizing the historical aspects of the construction of Workers' Health (WH) in the SUS, researchers[2] point to the emergence of the first Occupational Medicine services in the late 19th century, generally inserted in the personnel administration sector, with the State responsible for inspecting factories and regulating working conditions and relations.

These occupational Medicine actions were strengthened with the establishment of the Ministry of Labor (MT) in the 1930s. Later, under the influence of the World Health Organization (WHO) and the International Labor Organization (ILO), the OH emerged, a proposal originating in the United States after World War II aimed primarily at healthy workers[3]. In the 1980s, a movement developed, encompassing unions, health workers, and academic groups identified with the RSB and the nascent CH:

> Workers' Health (WH) conforms to the creation of new conceptual and practical bases, essentially interdisciplinary, on work-health relations, based on Epidemiology, Planning and Management, and Social Sciences applied to health, among other disciplines. [...] Therefore, it opposes and surpasses the logic of Occupational Medicine in its traditional conformation and OH[1(513)].

In this work, the authors systematize the main characteristics and differences between Occupational Medicine, Occupational Health (OH), and Workers' Health (WH), considering

these proposals as 'models for organizing occupational health care'[1]. In the case of WH, the fundamental difference regarding the proposals that preceded it is that it considers the worker as a subject of decisions, not merely as an object of health actions. Furthermore, it focuses on the production process and the work process as analytical categories, recognizing the worker's right to refuse unsafe and unhealthy work.

We should reiterate that the controversies surrounding the Workers' Health (WH) during the constitutional process were not limited to the capital-labor issue, conceptual distinctions, or disagreements between employers and workers[18]. The confrontations also encompassed institutional and corporate dimensions, such as disputes between the bureaucracies of the Ministry of Workers' , including Fundacentro, and the Ministry of Health, and between health professionals, researchers, engineers, and occupational doctors. Thus, it was predictable that the forces that lost out to the incorporation of WH as a responsibility of the SUS (Unified Health System) in the 1988 Constitution would attempt to interfere in the drafting of the Organic Law, the draft of which was to be submitted by the Executive Branch to Congress 180 days after the promulgation of the Constitution.

The Executive Branch, however, failed to meet this deadline, and while it delayed the process, numerous discussions and clashes occurred among unions, central organizations, and technicians within the SUDS/SUS. Faced with the severe economic crisis and the results of the 1989 presidential election, besides the spread of the 'results-driven unionism' ideology, the social and political bases focused on WH invested more limitedly in the legislative process that would result in Laws Nº 8.080/1990[26] and Nº 8.142/1990[27], even though they were represented at the National Health Plenary.

Noteworthy are some highlights regarding this legal framework. Thus, the Organic Law does not only apply to the SUS (Unified Health System) but also healthcare[28]. It encompasses the private sector, including the services of "legally qualified independent professionals and private legal entities in the promotion, protection, and recovery of health"[26(18058)] through "a contract or agreement under public law"[26(18058)]. Its responsibilities include "preparing standards to regulate the activities of private healthcare services, considering their public relevance"[26(18057)], and:

> [...] to meet collective, urgent, and temporary needs arising from situations of imminent danger, public calamity, or outbreak of epidemics, the competent authority of the corresponding administrative sphere may requisition goods and services, both from natural and legal persons and shall be assured of fair compensation[26(18057)].

The Organic Health Law ratifies the execution of WH actions as a SUS role, including "collaboration in the protection of the environment and the work environment"[26(18055)], defining its scope as:

> [...] a set of activities that are intended, through epidemiological surveillance and health surveillance actions, to promote and protect the health of workers and recover and rehabilitate the health of workers subjected to risks and harm arising from working conditions[26(18055)].

In addition to highlighting surveillance actions aimed at promoting and protecting health, it brings the principle of comprehensiveness to WH in the SUS, incorporating the components of health recovery and rehabilitation. In this case, it entails a broader intervention than that provided for in the health chapter of the Constitution, as it encompasses rehabilitative measures. Thus, the scope of WH in the SUS is explained in eight topics[20], as follows:

> a) Assistance to victims of work-related accidents, occupational diseases, and work-related illnesses; b) Participation in studies, research, assessment, and control of risks and injuries in

> the work process; c) Standardization, inspection, and control of the conditions of production, extraction, storage, transportation, distribution, and handling of substances, products, machinery, and equipment that attach risks to WH; d) Assessment of the impact of technologies on health; e) Information to workers, their unions, and companies about the risks of work-related accidents, occupational diseases, and work-related illnesses, as well as the results of inspections, environmental assessments, and health examinations; f) Participation in the standardization, inspection, and control of WH services in public and private institutions and companies; g) Periodic review of the official list of diseases originating in the work process, with the collaboration of unions in its preparation. h) Guarantee to the workers' union to request the competent body to close down a machine, service sector, or the entire work environment when there is an imminent risk to the life or health of workers[26(18056)].

From an organizational viewpoint, Law Nº 8.080/1990 also indicates WH as the object of intersectoral committees that involve areas not exclusively included within the SUS, such as human resources, sanitation, environment, nutrition, and health surveillance[24]. It defines, among the common attributions of the Union, states, Federal District, and municipalities, "the elaboration of technical norms and establishment of quality standards for the promotion of WH"[26(18057)].

Regarding competencies, the national SUS management is responsible for "participating in the formulation and implementation of policies related to working conditions and environments"[26(18057)] and "defining norms, criteria, and standards for controlling working conditions and environments and coordinating the WH policy"[26(18057)]. In the case of the state SUS management, it has the function to "participate in actions to control and evaluate working conditions and environments"[26(18057)]. The municipal SUS management is responsible for "participating in the implementation, control, and evaluation of actions related to working conditions and environments"[26(18055)] and "performing WH services"[26(18057)].

## Developments of the SUS legal framework in WH

The SUS legal framework provided some further detailing that could have contributed to the institutionalization of WH. However, the operational standards, ordinances, and agreements that progressively guided the organization and functioning of the SUS did not prioritize WH. Although the general and thematic National Health Conferences addressed the issue of WH, formulating several proposals, a significant portion of the actions and services remained linked to the then-OM (Occupational Medicine).

From a strategic perspective, during the implementation of the RSB and the SUS, three pathways were pursued: legislative-parliamentary, socio-community, and technical-institutional[9]. In the specific case of WH, the technical-institutional pathway appears to have been prioritized. This enabled the establishment of the Workers' Health Reference Centers (CEREST), but it had little involvement or participation from organized workers, whose unions focused more on health care, demanding private health plans in collective bargaining agreements[29,30].

Consequently, the policies formulated within the WH, instead of prioritizing SUS competence regarding the assignment of implementing WH actions, especially those linked to the work environment control, were limited to valuing the functional integration between ministries (labor and health) and state and municipal health secretariats, apparently going back to the times of the AIS/SUDS.

Still, it is possible to highlight some significant initiatives for WH structuring within the SUS, such as (a) Establishing CEREST); b) Organizing the Intersectoral Committee for Workers' Health (CIST) in the National

Health Council (1991); c) Proposing the National Network for Comprehensive Care for Workers' Health (RENAST) in 2002; d) Publishing the National Workers' Health and Safety Policy (PNSST), by Presidential Decree Nº 6.602 of September 7, 2011; e) Developing the Workers' Health Surveillance (VISAT); f) and Formulating the National Workers' Health Policy (PNSTT), published in 2012[1,2,5].

The technical-institutional pathway that made such initiatives possible was led by SUS workers, health counselors, professors, researchers, intellectuals, and activists from entities linked to the Brazilian Health Reform Movement (MRSB), although the conferences also included the participation of representatives from unions, confederations, and trade union centers.

In the 1990s, the socio-community approach suffered from the limited involvement and participation of organized workers in the struggles for the advancement of WH in the Unified Health System (SUS). With this limited social participation, which undermined the WH movement demands and struggles of the 1970s and 1980s, the achievements achieved were limited.

Consequently, as relevant as it is to recognize, conceptually, scientifically, and institutionally, the social determinants and conditions of health – among which are the work processes and environment – and SUS principles and guidelines, this does not seem sufficient to emphasize their relevance in the development of WH.

## SUS today

Brazil still lacks a truly 'unified' SUS[31]. Ultimately, the SUS has been recognized almost as a mere acronym, constrained by a constantly growing private sector[32,33]. Thus, the Brazilian health system is configured as a segmented system whose hybrid structure reproduces itself to the detriment of the public interest[34]. Furthermore, it has a public and a private component that, far from being parallel or isolated, are interconnected differently. Consequently, the SUS (Brazilian Unified Health System) is integrated across federal, state, and municipal levels, coexisting with privatization and financialization processes that reconfigure its structure and dynamics despite the legal framework. The combination of privatization and financialization encourages the exploitation of public funds or collective resources earmarked for other social policies, intensifying social dissatisfaction and increasing inequality[35].

Privatization manifests itself eventfully as purchases of private services, loans from public banks to medical companies, and support, subsidies, and tax breaks. It is also reflected in legislation that hinders the development of public infrastructure (NFF, New Fiscal Framework, and similar). It encourages the private sector, besides management models that reproduce the business logic in the public sphere, such as Social Organizations (SOs), Civil Society Organizations of Public Interest (OSCIPs), Public-Private Partnerships (PPPs), outsourcing, and the like. These privatization mechanisms are more visible and are becoming the subject of debate and struggle among health policy stakeholders[32,36].

Healthcare financialization is not easily observed through a superficial examination of reality; that is, only research with a consistent theoretical framework could describe and explain it[37,38]. The examination of the movement of capital in the acquisition and sale of shares on the stock exchange, the acquisitions and mergers of medical companies, and the negotiation of client portfolios by health plan providers become intelligible only in this way. It is, therefore, expressed on a structural level in such a way that financial capital, defining contemporary capitalism's game rules, invaded the Brazilian healthcare sector at the turn of the 20$^{th}$ century and currently shapes the Brazilian healthcare system, constraining the development of the Unified Health System

(SUS)[39]. Thus, research produced by CH in recent years indicates severe restrictions to the consolidation and sustainability of SUS[33,40–43] as a universal public health system:

> Such restrictions are not limited to underfunding, lack of government priority, partisan political use in management, reproduction of the hegemonic medical model, rising healthcare costs, nor unresolved issues regarding education and work management[39(74)].

We are witnessing radicalized privatization processes that, through financialization, restructure the basic rules of the so-called Brazilian health sector. They, therefore, exceed the privatization of facility infrastructure, the purchase of services from the private sector, and privatized management models such as outsourcing, PPPs, OSs, and OSCIPs.

The financial dominance that has taken hold in contemporary capitalism is reproduced, especially in the segment of intermediation of private plans and insurance[37]. It also invades the acquisitions and mergers of hospital, laboratory, and imaging companies, expressing "a structural determination on the development of the Brazilian health system with severe repercussions on the SUS in the near future"[39(74)].

On the other hand, the third most powerful business group in Brazil is the private healthcare group (laboratories and health plans), composed of a group of seven companies that characterize the total healthcare oligopoly[44]. Thus, healthcare financialization continues to represent one of the greatest threats to the SUS and tends to compromise the State's regulatory power in the face of financial capital globalization.

This brief systematization of the current situation of the Brazilian health system allows us to identify, specifically, the privatization of health at the eventful level and health financialization at the structural level within the SUS.

## SUS relevance to WH

During the implementation of the Unified Health System (SUS), several publications emphasized its relevance to Workers' Health. The expanded concept of health and its determinants and conditioning factors has been formally recognized, and proposals for care models and service organization based on comprehensiveness and social participation have gained widespread dissemination. After three decades of implementation, the SUS has both successes and failures. Many of these achievements justify its relevance to the Health System, such as:

a. Inspired by civilizing values such as equality, democracy, and emancipation, the SUS is established in the Constitution, in ordinary legislation, and technical and administrative standards produced through participatory management;

b. The MRSB, which politically supports the SUS, consists of entities with over four decades of history defending the universal right to health, having expanded its partnership with other collective stakeholders in the health policy process;

c. In participatory management, the SUS relies on health councils and conferences at the national, state, and municipal levels, which contribute to developing health policies, monitoring, and evaluation guidelines;

d. The SUS has an education and research network that enables the production and dissemination of scientific knowledge, information, skills, and values for health workers and organizations committed to the health of the community;

e. SUS decentralization allows for capillary action across territories, facilitating citizens' access to health facilities, services, and teams through Primary Health Care (PHC), with coverage of over 60% of the population;

f. The formal recognition of the right to health has motivated demonstrations by citizens, the media, the Public Prosecutor's Office, and the Judiciary, which sometimes present themselves as health judicialization or social mobilizations that "can evolve into critical health awareness"[45(1725)].

However, obstacles to SUS consolidation persist: chronic underfunding, limited social and political bases, the reproduction of the hegemonic medical model, management problems, resistance from specific categories of health professionals, opposition from the mainstream media, the devaluation of health workers, and health financialization.

Even before the COVID-19 pandemic, the SUS (Unified Health System) was already suffering from economic, political, and social crises, an unfavorable balance of power, and the adoption of fiscal austerity policies[23]. In 2020, the health crisis took hold, deepening the political crisis. Even so, despite deteriorating and collapsing in several regions, the SUS managed to respond by caring for patients and vaccinating the population, facing several setbacks, including political maneuvering and private sector lobbying in Congress and the Executive branch[46].

This concrete situation indicates that economic, institutional, political, and scientific-technological sustainability stands in the balance between SUS limits and possibilities[28]. This issue permanently affects the SUS and needs to be addressed and faced so that its challenges and perspectives can be examined.

In this regard, it has been emphasized on several occasions that the SUS greatest challenge is political[40,45], and that more promising prospects necessarily involve expanding its social and political bases, accumulating energy and organizing to influence an unfavorable balance of power, and building alternatives for development and overcoming inequalities in Brazilian society. Strengthening the Workers' Health System (ST) is among these prospects. However, one question remains: Why has WH not achieved development within the SUS as would have occurred with epidemiological and health surveillance, its sisters, and companions in Art. 200 of the 1988 Constitution?

For some authors, the Cerest network was unable to be implemented in a coordinated fashion[3], forming a parallel structure that was poorly integrated with the PHC[2], such as the network of Psychosocial Care Centers (CAPS), so that the scarce coordination regarding PHC units, family health teams, former Family Health Support Centers (NASF) and general hospitals may have compromised comprehensive care.

Perhaps future research should consider Sergio Arouca's allegory about "the ghost of the absent class"[9]. This refers to the limited participation of the working class in defending the right to health and the Unified Health System (SUS) and even in supporting and sustaining policies, programs, organizations, establishments, and services focused on WH.

Several theses, articles, studies, and essays have attempted to decipher this apparent enigma, sometimes blaming the MRSB for failing to establish bridges of dialogue with workers, including unions, trade union centers, and political parties, in the construction of the SUS[29]; sometimes pointing out the lack of commitment of these organizations to public health services, prioritizing private health plans in union conventions[30]; sometimes explaining this absence by the working class political weakening from the productive restructuring in modern capitalism, the hegemony of neoliberalism, and the capital's persecution of unions[47].

If the knowledge produced in these initiatives is consistent with the current reality, we can admit that the rhetorical defense of the SUS and the reiteration of its importance for the Health System are insufficient to transform the concrete situation. From this perspective, the construction of a research program, the development of critical health awareness,

the formation of social stakeholders, and the organization of political struggle[48] can be seen as a robust response to the apparent inaction and resignation in the face of the inertia and delay of incremental changes in the SUS, as well as the setbacks observed in WH.

In this sense, several other paths could be considered for the development of WH within the SUS. The first consists of exploring the potential of the legal and regulatory framework already available in the system to advance WH initiatives. The second involves reviving the initiatives undertaken over the last three decades within WH, despite the challenges, and incorporating them in the future through specific legislation aimed at consolidating the SUS.

This legislative-parliamentary route was heavily emphasized as an RSB strategy for implementing the SUS. Even after the Organic Health Law, specific laws were enacted, such as those related to HIV/AIDS treatment, transplants, psychiatric reform, Indigenous Health, and health surveillance. In the case of the Workers' Health (WH), where tensions between capital and labor are evident, in addition to corporate and institutional disputes, obtaining specific legal support could contribute to its consolidation and advancement within the SUS. However, we should recognize that the law should be considered a starting point, not an end. Having the law is not enough; political action is necessary to ensure its respect and enforcement.

In addition to the three avenues used in the RSB process (legislative-parliamentary, technical-institutional, and socio-community), the judicial avenue should be added. The partnership built over recent decades with the Public Prosecutor's Office, the accumulated experience, and some positive developments of 'health judicialization' can be reconfigured in this fourth avenue. WH has relied on the support of the Public Prosecutor of Labor's Office (MPT) in recent years, holding public hearings and signing Conduct Adjustment Terms (TAC) with companies[5].

## Final considerations

In the several discussions, seminars, interviews, and texts produced in recent years, one question has become recurrent: What is the future of the Unified Health System (SUS)? While this question is justified in light of setbacks, obstacles, and threats, especially after the 2016 coup, with the risk of a reduced SUS becoming a simulacrum[45], on the one hand, the outbreak of the COVID-19 pandemic in 2020 revealed that the SUS has never been so necessary, if not indispensable[46]. Never before has the SUS achieved such public visibility. Never has it been so championed by sincere, enthusiastic, and well-intentioned people, and even by cynics, opportunists, and the mainstream media! Therefore, with even a cursory understanding of the SUS difficulties and dilemmas, some concern about the aftermath of COVID-19 and of the 'storm government' (2019-2022) is to be expected.

Thus, the SUS was not consolidated as a universal health system, as proposed by the RSB and guaranteed by the Constitution. The expansion of public services over these three decades was accompanied by the increased private sector's service provision, financing, management arrangements (OS, PPP, and public companies), and, especially, the growing intermediary companies, such as a private health plan and insurance providers.

The strength of these private interests is evident in the National Congress and, for a long time, in the financing of electoral campaigns for candidates for the Executive and Legislative branches. The government resulting from the 2016 impeachment strengthened an ongoing process, radicalizing the Brazilian state's opposition to the Unified Health System (SUS) and seeking its replacement with a segmented, fragmented, and Americanized healthcare system.

EC-95 constitutionalized the chronic SUS underfunding and defunding, representing the most radical intervention aimed at consolidating a 'minimal SUS'. Thus, the government

deepened the RSB counter-reform, turning the SUS into a sham and compromising the universalized and expanded public services[21]. Regarding the NFF established during the Lula III administration, the MRSB celebrated the government's decision to maintain the constitutional minimum wage for healthcare in 2024, emphasizing that this contribution could mitigate social impacts. The Frente pela Vida (Front for Life – FpV) declared its support and defended social security. However, the organizations and scholars highlighted the continued concern, as two competing projects are underway: the minimal state and the constitutional citizenship framework that provides for social rights.

Currently, beyond financial dominance, it is important to discuss the paths of the SUS linked to the advancement of the RSB process, building an agenda that encompasses economic development, the reduction of inequalities, environmental issues, the expansion of the public sphere, and the consolidation of democracy. The COVID-19 pandemic has highlighted the limitations and perversions of neoliberal economic policy options. Thus, Brazilian economists, intellectuals, and research centers have been experimenting with developing counter-hegemonic proposals to rally political forces behind their support.

Thinking about settings for the SUS necessarily involves revisiting its history, the obstacles, threats, and opponents it has faced, and the inertial nature of its trends or trajectories, reproducing a passive revolution[49]. The trends of universal health systems around the world, on the one hand, point toward privatization and, on the other, suggest that they are sensitive to the political mobilizations of citizens, unions, parties, and social movements that have prevented the adoption of more regressive health policies[21].

From this perspective, the COVID-19 pandemic revealed the importance of universal public health systems and health surveillance organizations in mitigating the harmful effects of this humanitarian tragedy. In the case of the SUS, despite its weakened status, MRSB activists established the FpV, expanding reconnections with the organized civil society where it originated, in addition to political action on the Executive, Legislative, and Judiciary branches in defense of democracy and the right to health[46].

Notably, the creation of the FpV signals an opportunity for resuming the RSB through the socio-community route[46,50]. However, despite support for the SUS, studies have shown that professional categories and currents of the union movement defended corporate issues (corporate health plans), moving away from the original RSB project[9,30,51,52].

On the other hand, a recent survey evidenced a change in these relationships, and, therefore, a rapprochement of entities representing workers with the MRSB – National Network of Popular Doctors (RNMP), Unified Workers' Union (CUT), Brazilian Nursing Association (ABEn), among others –, especially from 2020 onwards, with the pandemic and the creation of the FpV[50,53].

The tragedy suffered by the Brazilian population due to the COVID-19 pandemic and the criminal actions of the Federal Government could result in a shift in the balance of power and renew the practices of individuals and groups[48]. Since politics is the greatest challenge facing the Unified Health System (SUS), social struggles are antidotes to setbacks and restorative elements of the RSB.

## Collaborators

Paim JS (0000-0003-0783-262X)* and Reis CR (0000-0001-5646-4355)* contributed equally to the design, analysis, critical review of the content, and approval of the final version of the manuscript. ■

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## References


1. Santana VS, Dias ED, Silva JM. Atenção integral a saúde dos trabalhadores. In: Paim JS, Almeida-Filho N. Saúde Coletiva: Teoria e Prática. Rio de Janeiro: MedBook; 2014. p. 513-539.

2. Santana VS, Corrêia Filho HR, Silva JM, et al. A construção do campo da saúde do trabalhador e sua institucionalização no SUS. In: Paim J. SUS Sistema Único de Saúde. Tudo o que você precisa saber. São Paulo: Atheneu; 2019. p. 327-347.

3. Lacaz FA. Diferentes formas de apreensão das relações trabalho e saúde/doença. O campo saúde do trabalhador: aspectos históricos e epistemológicos. In: Paim JS, Almeida-Filho N. Saúde Coletiva: Teoria e Prática. Rio de Janeiro: MedBook; 2014. p. 595-610.

4. Possas C. Saúde e Trabalho: a crise da Previdência Social. 2ª ed. São Paulo: Hucitec; 1989.

5. Gomez CM, Vasconcellos LCF, Machado JMH. Saúde do trabalhador: aspectos históricos, avanços e desafios no Sistema Único de Saúde. Ciênc saúde coletiva. 2018;23(6):1963-70. DOI: https://doi.org/10.1590/1413-81232018236.04922018

6. Melo Filho DA. Epidemiologia social: compreensão e crítica. São Paulo: Hucitec; 2003.

7. Breilh J. Epidemiologia crítica: ciência emancipadora e interculturalidade. Rio de Janeiro: Fiocruz; 2006.

8. Paim JS. Desafíos para la salud colectiva en el siglo XXI [Internet]. Lanús: Remedios de Escalada; 2021 [acesso em 2019 jul 25]. Disponível em: https://livros.unb.br/index.php/estante/catalog/book/324

9. Paim JS. Reforma Sanitária Brasileira: contribuição para a compreensão e crítica. Salvador: EDUFBA; 2008.

10. Guimarães R. Saúde e Medicina no Brasil: contribuições para um debate. Rio de Janeiro: Edições Graal; 1978.

11. Tambellini A. O Trabalho e a Doença. In: Guimarães R. Saúde e Medicina no Brasil: contribuições para um debate. Rio de Janeiro: Edições Graal; 1978. p. 93-119.

12. Teixeira SMF, Oliveira JA. medicina de Grupo: a medicina e a fábrica. In: Guimarães R. Saúde e Medicina no Brasil: contribuições para um debate. Rio de Janeiro: Edições Graal; 1978. p. 181-205.

13. Berlinguer G. Medicina e Política. São Paulo: Hucitec; 1978.

14. Basaglia F, Giovannini E, Maniati S, et al. La salud de los trabajadores. Aportes para uma política de la salud. México: Nueva Imagen; 1978.

15. Timio M. Clases sociales y enfermedad. México: Nueva Imagen; 1979.

16. Ricchi R. La muerte obrera. México: Nueva Imagen; 1981.

17. Ribeiro HP, Lacaz FAC. De que adoecem e morrem os trabalhadores. São Paulo: Diesat-Imesp; 1984.

18. Rodriguez Neto E. Saúde: promessas e limites da Constituição. Rio de Janeiro: Fiocruz; 2003.

19. Paim JS. Modelos de Atenção à saúde no Brasil. In: Giovanella L, Escorel S, Lobato LVC, et al., organizadoras. Políticas e Sistema de Saúde no Brasil [Internet]. Rio de Janeiro: Fiocruz; 2012 [acesso em 2025 jul 10]. p. 459-491. Disponível em: https://books.scielo.org/id/c5nm2

20. Presidência da República (BR). [Constituição 1988]. Constituição da República Federativa do Brasil de 1988. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1988 out 5; Seção 1:1.

21. Paim JS. Os sistemas universais de Saúde e o futuro do Sistema Único de Saúde (SUS). Saúde debate. 2019;43(5):15-28. DOI: https://doi.org/10.1590/0103-11042019S502

22. Câmara dos Deputados (BR). Projeto de Lei Complementar nº 123/2012. Regulamenta o § 3º do art. 198 da Constituição Federal para dispor sobre os valores mínimos a serem aplicados anualmente pela União. Revoga dispositivo da Lei Complementar nº 141 de 13 de janeiro de 2012. Brasília, DF: Câmara dos Deputados; 2012.

23. Teixeira CF, Paim JS. A crise mundial de 2008 e o golpe do capital na política de saúde no Brasil. Saúde debate. 2018;42(Esp 2):11-21. DOI: https://doi.org/10.1590/0103-11042018S201

24. Máximo W. Entenda pacote fiscal de R$ 70 bi anunciado por Haddad. Agência Brasil [Internet]. 2024 nov 28 [acesso em 2025 fev 7]; Economia. Disponível em: https://agenciabrasil.ebc.com.br/economia/noticia/2024-11/entenda-pacote-fiscal-de-r-70-bi-anunciado-por-haddad

25. Conceição P. Estaria a saúde fora da mira do ajuste fiscal? Observatório de Análise Política [Internet]. 2024 dez 6 [acesso em 2025 fev 7]; Notícias. Disponível em: https://analisepoliticaemsaude.org/noticia/estaria-a-saude-fora-da-mira-do-ajuste-fiscal/

26. Presidência da República (BR). Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1990 set 20; Edição 182; Seção I:18055-9.

27. Presidência da República (BR). Lei nº 8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. Diário Oficial [da] República Federativa do Brasil, Brasília, DF. 1990 dez 31; Edição 249, Seção I:25694-5.

28. Paim JS. O que é o SUS [Internet]. Rio de Janeiro: Fiocruz; 2016 [acesso em 2019 jul 25]. Disponível: http://portal.fiocruz.br/pt-br/content/o-que-e-o-sus-e-book-interativo

29. Teodoro R. A Teoria Sanitária e o Momento Corporativo: a crítica de um desafio não superado. In: Fleury S. Teoria da Reforma Sanitária: diálogos críticos. Rio de Janeiro: Fiocruz; 2018. p. 183-219.

30. Menicucci T. Política de Saúde do Brasil: continuidades e inovações. In: Arretche M, Marques E, Faria C. As políticas da política. São Paulo: Unesp; 2019. p. 191-216.

31. Ocké-Reis CO. SUS: o desafio de ser único. Rio de Janeiro: Fiocruz; 2012.

32. Santos JÁ. A ampliação do processo de privatização da saúde pública no Brasil. São Paulo: Hucitec; 2018.

33. Silva THS. Entre o Consenso e o Minotauro da Saúde: um balanço da estratégia da Reforma Sanitária Brasileira. In: Fleury S, organizadora. Teoria da Reforma Sanitária: diálogos críticos. Rio de Janeiro: Fiocruz; 2018. p. 291-336.

34. Scheffer M, Bahia L. Público e privado na saúde. In: Paim J. SUS Sistema Único de Saúde: tudo o que você precisa saber. São Paulo: Atheneu; 2019. p. 219-231.

35. Andrietta LS, Sestelo AF, Bahia L, et al. O sistema de saúde brasileiro na pandemia de covid-19: reflexões a partir do conceito de financeirização. In: Lavinas L, Martins NM, Gonçalves GL, et al. Financeirização: crise, estagnação e desigualdade. São Paulo: Contracorrente; 2024. p. 657-686.

36. Melo MFGC. Relações público-privadas no sistema de saúde brasileiro [tese]. São Paulo: Universidade Estadual de Campinas; 2017. 206 p.

37. Sestelo JAF. Planos de Saúde e dominância financeira. Salvador: Edufba; 2018.

38. Lavinas L, Martins NM, Gonçalves GL, et al. Financeirização: crise, estagnação e desigualdade. São Paulo: Contracorrente; 2024.

39. Paim JS. O futuro do Sistema Único de Saúde em questão. In: CONASS Debate: o futuro dos sistemas universais de saúde. Brasília, DF: Conass; 2018. p. 66-78.

40. Paim JS, Travassos C, Almeida C, et al. The Brazilian health system: history, advances and challenges. Lancet. 2011;377:1778-97.

41. Monteiro MG. As Mudanças de Direção das Políticas Públicas: atores e estratégias ocultas na implementação do Sistema Único de Saúde. In: Fleury S. Teoria da Reforma Sanitária: diálogos críticos. Rio de Janeiro: Fiocruz; 2018. p. 247-289.

42. Castro MC, Massuda A, Almeida G, et al. Brazil's unified health system: the first 30 years and prospects for the futures. Lancet. 2019;394(10195):345-56. DOI: https://doi.org/10.1016/s0140-6736(19)31243-7

43. Paim JS. Sistemas Universais de Saúde e novos desafios no século XXI. Texto produzido para o encontro promovido pelo Conselho de Secretários de Saúde em 2024. In: Seminário Internacional "O desafio da sustentabilidade dos sistemas universais de saúde nas Américas"; 2024; Brasília, DF. Brasília, DF: Conass; 2024. [No prelo].

44. Rodrigues EM. Quem está no comando? Poder entre grupos econômicos hegemônicos no Brasil. Pesqui Debate. 2023;35(1(63):171-92. DOI: https://doi.org/10.23925/1806-9029.v35i1e62294

45. Paim JS. Sistema Único de Saúde (SUS) aos 30 anos. Ciênc saúde coletiva. 2018;23(6):1723-8. DOI: https://doi.org/10.1590/1413-81232018236.09172018

46. Paim JS. A Covid-19, a atualidade da Reforma Sanitária e as possibilidades do SUS. In: Conselho Nacional de Secretários de Saúde. Reflexões e futuro. Brasília, DF: Conass; 2021. p. 310-324.

47. Paim JS. Posfácio. In: Ribeiro HP. De que adoecem e morrem os trabalhadores na era dos monopólios (1889-2016): sociopatias, produção, violência, trabalho e saúde coletiva. São Paulo: Cenpras; 2017. p. 378-379.

48. Paim JS. Reflexiones teoricas sobre sujetos de la praxis y sujetos de la antíteses para la Reforma Sanitaria Brasileña. Salud Colectiva. 2017;13(4):599-610. DOI: https://doi.org/10.18294/sc.2017.1400

49. Paim JS. Reforma Sanitária Brasileira: expressão ou reprodução da revolução passiva? In: Fleury S, organizadora. Teoria da Reforma Sanitária: diálogos críticos. Rio de Janeiro: Fiocruz; 2018. p. 85-113.

50. Santos JS. Movimento da Reforma Sanitária Brasileira na conjuntura 2013-2020: resistência e revitalização [tese] Salvador: Universidade Federal da Bahia. 2023. 328 p.

51. Santos NR. SUS, política pública de Estado: seu desenvolvimento instituído e instituinte e a busca de saídas. Ciênc saúde coletiva. 2013;18(1):273-80. DOI: https://doi.org/10.1590/S1413-81232013000100028

52. Santos RPO. Reforma Sanitária Brasileira e o sindicalismo na saúde: quais perspectivas no contexto atual? Saúde debate. 2019;43(8):234-247. DOI: https://doi.org/10.1590/0103-11042019S817

53. Teixeira CF, Santos JS. Análise estratégica da atuação do governo federal brasileiro na pandemia de COVID-19: 2020-2021. Ciênc saúde coletiva. 2023;28(5):1277-86. DOI: https://doi.org/10.1590/1413-81232023285.10502022

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