Brazil's health-care reform: social movements and civil society

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Although health-care reforms need strong social support to be successful, the reform in Brazil is unusual because it was designed fully by militants of the so-called Sanitary Movement[1] about a decade before health care was added to the Brazilian Constitution of 1988 as a citizens' right.[2] The reform was subsequently institutionalised in the 1990s with the formation of a national health system called the Unified Health System (SUS-Sistema Único de Saúde).

Originally, the struggle for a new comprehensive model of social protection had a component of social mobilisation in favour of expanding social rights as part of the transition to a democratic regime. The singularity of a social policy project designed by social movements, and the strong association of this project with the transformation of the state and society into a democracy, added some important characteristics to the Brazilian social security system, including pensions, health, and social assistance. The new constitutional model of social policy is characterised by universality of coverage, recognition of social rights, affirmation of the State's duty, subordination of private practices to regulation on the basis of the public relevance of actions and services in these areas, with a public-oriented approach (instead of a market approach) of co-management by government and society, and with a decentralised arrangement.

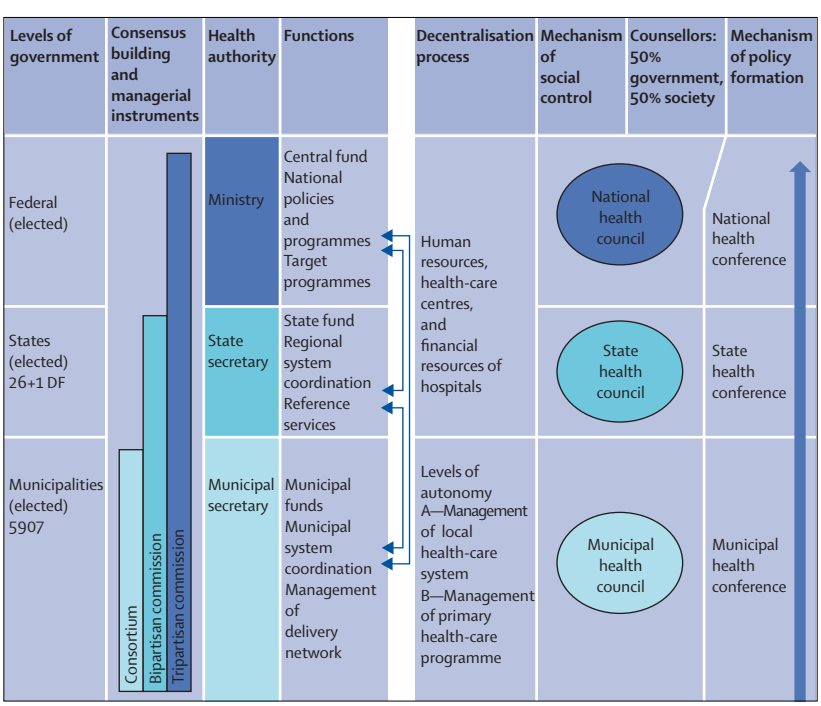

Figure: **Sistema Único de Saúde: process and decision-making structure for formation of policy in Brazil**
DF=federal district.

An important feature of social security in Brazil lies in the component of strong state reform, in redrawing the relations between federal entities and instituting participants, and social control with mechanisms for negotiation and consensus building, which involve municipal, state, and federal government. The reshaped federalism addresses the main responsibility in the delivery of social policies to the local authority. The systems of social protection have adopted the format of a decentralised integrated network with a political command and funding at each level of government, with deliberative instances of democracy that would guarantee the equal participation of organised society within these levels (figure).

The two participatory mechanisms (including health authorities and the population) are the councils and the conferences. The councils exist at every level of the system, and are mechanisms of social control and budget approval that assess executive proposals and performance. The conferences are called on periodically to discuss various subjects, to convey different interests to a common platform and form policy. Although many experts have discussed whether the councils have the capacity to control the government, the conclusion is not clear because of the great diversity in the political capacity of civil society in Brazil, and the unequal distribution of resources among its residents.[3-5] Social participation is regarded as an important component of sustainable health programmes. Brazil is now recognised as a model for mitigating the HIV epidemic because of its policy of universal access to free antiretroviral treatment.[6] This successful prevention policy has been based on public and non-governmental mobilisation, and is supported by international agencies. This pattern of cooperative association is thought to be central to the accomplishment of the programme's goals.[6] Despite this success, because the main feature of Brazilian society is the unequal distribution of power and resources, this challenge is also present in health-care goals, either by the absence of pressure to include neglected diseases in governmental priorities or by the appropriation of participatory mechanisms by more organised groups.

The use of social movements to fight for positions in the governmental hierarchy in the health sector in the

state has two consequences. It forces the transformation of administrative structures to increase the role of society in the decision-making process. But it allows leaders from civil society to be engaged in the design and execution of public policy, therefore losing their links with the original social bases. The three components of the health reform have been identified as the constitution of the political body, the formation of a legal framework, and the statecraft or institutionalisation.[7] Although these components belong to the same reform process, their different pathways and movement at different paces lead to an endless cycle of stress and challenges.

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I declare that I have no conflicts of interest.

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Do we need oncology trials tailored for the elderly or frail?

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Colorectal cancer is the most common tumour worldwide and the second leading cause of cancer death in European countries and the USA, with about 800 000 new cases yearly.[1] Tremendous advances in treatment options and long-term survival rates have been achieved in the past by improvement of screening and early detection, treatment of early stages (especially adjuvant treatment), and much more effective systemic treatment options for advanced disease, including secondary resection of metastases. Many large randomised trials worldwide have contributed to this increasing knowledge and the development of standard treatment algorithms.

Although most of these trials did not specifically exclude older or frail patients, as long as they have been suitable for the investigated treatment, there is always a strong selection process for patients who will be entered into clinical trials, especially if more toxic or somewhat innovative treatments are investigated. The median age at disease onset ranges between about 65–70 years and at death 72–77 years.[1] As the MRC FOCUS2 investigators point out in *The Lancet*,[2] 60% of deaths occur in patients older than 75 years and about 40% in those older than 80 years, at least in the UK. However, the median age of a typical trial population for advanced disease is 60–65 years, with a maximum age mostly of 75 years.[3,4] Thus the results of clinical trials are most applicable to a younger population of patients than that which represents clinical reality. The selection criteria of clinical trials usually exclude patients who are either frail or older, or both, and/or have single or even multiple organ problems which are not related to the cancer itself.

Although geriatric oncology is a fast-moving field, most doctors still follow their experience, intuition, or general oncology treatment guidelines when considering treatment selection and dosing in elderly and frail patients for adjuvant treatment, as well as for treatment of advanced disease. Retrospective analysis of randomised trials has shown that elderly patients have more or less the same response to chemotherapy as do younger patients.[3,4] Much of the data from randomised trials can—at least in principle—be translated into this older and frail population. However, much uncertainty remains about the real value of intensive combination chemotherapy or the optimum choice of drugs, as well as about such factors as treatment intensity, initial dosing, and treatment duration.

Matthew Seymour and the MRC FOCUS2 trialists must be congratulated for doing the first randomised trial specifically tailored for this group of patients—elderly, frail, or both—in advanced colorectal cancer, thus representing a major part of the typical population of