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Building up user participation: councils and conferences in the Brazilian Health System

Soraya Maria Vargas Cortes*

Introduction

The article discusses some statements in the international literature, on the issue of participation in the context of public sector reform in developing countries, especially in the health area. According to the authors (Grindle and Thomas, 1991; Ugalde, 1985), it would be of utmost difficulty to create participatory channels in the so-called developing countries in general, and specifically in Latin America, due to the features of their political institutions. It is believed that these would be dominated by pacts and informal elitist deals and would present weak civil societies (Grindle and Thomas, 1991). In the field of health, the initiatives to promote participation would have resulted in the manipulation of the participants and in the destruction of popular forms of organization (Ugalde, 1985). The Brazilian experience, with the councils and the conferences in health, does not wholly confirm such statements. Studies reveal that, in some cases and in certain circumstances, these fora have participated in the decision making process of the area as well as user representatives have take part in this process (Carvalheiro et alii, 1992; Cortes, 1995, Cortes, 2000). One can ask about the origins and the institutional role of these fora in the context of the reform of the Brazilian health system, as well as about the conditions fostering such participatory experiences. The second and third parts of this article will attempt to answer such questions.

In order to make the discussion understandable, it is necessary two initial elucidations. First, the literature on the theme has considered as potential participants the consumer, the popular classes (popular participation), the citizen and the user. The use of one or another concept of *participant* shall depend mainly in the political and ideological orientation of the person who is using it. In this article, the concept *user participation* is the mostly used. It encompasses the ones who use determined services in a certain territorial area. Although there is some similarity with the concept of *consumer participation*, it is not restricted to the commercial perspective. It incorporates the notion of social rights, which the concept of

* Federal University of Rio Grande do Sul (UFRGS), Núcleo Interdisciplinar de Pesquisa em Saúde Coletiva (NIPESC) [Interdisciplinary Research Center in Collective Health]

citizenship normally presupposes. Moreover, since the second half of the previous decade, the term *user participation* has been the most frequently used by scholars, as well as in the Brazilian official documents. Second, the literature deals with different modalities or levels of *participation* (Arnstein, 1969; Cortes, 1996(a); Ham, 1980; Lee and Mills, 1985; Paul, 1987). The forms of involvement of participants may be qualified as manipulation, deliberation, negotiation or even participation. In this article, it is considered that there is participation when the one involved takes part in the decision making process (Lee and Mills, 1985; Paul, 1987).

Consolidation of participatory-inclusive channels in the health field in Brazil: unlikely but possible.

During the last two decades, in developed countries the institutionalization of participatory-inclusive mechanisms has been seen as a complement or as an alternative to traditional forms of political representation in the liberal democracies. In the same period, the international agencies have recommended that in developing countries the economical self-sustainability and the community participation be promoted as means of achieving development. The primary health care would be one of the main strategies to improve health standards in these countries. One of its main policies consists in stimulating community participation. Nevertheless, the possibility of creating mechanisms that allow the popular participation in the decision making process in developing countries has been questioned, particularly in Latin American countries.

Since the thirties, political and academic leaders considered that the State should be responsible for the economic growth and for the social well being (Grindle and Thomas, 1991, p.2). The central governments would give impulse to progress, mainly in the developing countries. In these countries, the great distance between the objectives proposed and the reality, that shows huge social and economical problems, seemed to justify the defense of central planning. During the eighties, the aggravation of the international economical crisis and the rise of conservative politicians to power in developed countries, have determined a change of focus. The political leaders in these countries began to defend ideas that were inspired by the new right thought, thus influencing the international agencies to propose a structural changesd in the economies in developing countries by means of policies that would drastically reduce the size of the State. The international agencies recommend reforms that were based in neoclassical economical theories, challenging the idea of the State inducing economic growth and social well-being. It was argued that there should be a larger distribution of power, through privatization and the transfer of functions and resources to sub-national levels of government (Grindle and Thomas, 1991, p.2). In the eighties, the new conception of development together

with the idea of primary health care had a major influence in the reform of the Brazilian health system.

The strategy of primary health care criticized the concentration of investments in few complex health units, mainly in hospitals, mostly based in some urban centers with huge population density (Walt, 1994, p.5, 24). The resources should be used rationally, emphasizing the application of simplified technologies, the constitution of a network of hierarchical services. It would care the whole population, though it would focus primarily the poorest social sectors. In the developing countries, the introduction of policies inspired in this strategy has frequently resulted in the extension of health service coverage to rural regions and to urban areas that concentrated low-income populations (Paim, 1989, p.19; Walt, 1994, p.5). The administration of a network of services should be decentralized and would include the participation of the community.

The notion of participation as it had been initially conceived by the defenders of primary health care was vague and its meaning would vary according to the peculiarities of the social and political organization in each country, or to the political ideological position of the political player who embraced the idea. According to Grindle and Thomas (1991, p.43-69), the kind of relation that is normally established between political institutions and civil society in the developing countries would hinder the constitution of participatory mechanisms. One of the characteristics of these countries would be the weakness or absence of an organized civil society capable of counterbalancing the political power of the economical and military elite in alliance with the state burocracy. In Latin America mainly, the political decision making process was traditionally conducted by means of informal channels, through which the entrepreneurial and military interests would have been directly represented within the burocratic structure of the State (Cardoso, 1975, p.165-86). In the Latin American countries, the non-dominant interests – represented by the unions, the rural workers, the associations of poor urban dwellers – would be systematically excluded from the decision making process. Their demands would be filtered by relations established by public servants with leaders and individual clients.

Although this characterization may be appropriate for the major part of the Brazilian republican history, it is only partially adequate to portray the Brazilian political life during the eighties. The prescriptions of the international agencies, defending the reduction of the federal government's role – as provider of goods and services – and proposing the participation of the community, reached a country whose economy had practically stopped growing. The eighties became known as the "lost decade", mainly because they were characterized by high rates of inflation with negative or very low economic growth. The decline of the economic activity had virtually neutralized the central government as an inductive agent of economic development. Nevertheless, at the same time, the civil society had demonstrated a capacity of organization never seen before; at the same time that political life became liberalized.

At the end of the seventies the mobilization and organization of the Brazilian civil society became more intensified. The “new union movement” actively demanded salary raises and freedom of organization, at the same time that there was open opposition to the military dictatorship (Almeida, 1984, p.191-214; Keck, 1989, p.252-96). For the first time, since the beginning of the seventiies, rural workers´ unions and the landless movement demanded agrarian reform and the extension of welfare benefits to rural workers. (Grzybowski, 1987; Hall, 1990, p.187-232). In the urban areas, dwellers´ associations promoted campaigns demanding better services or even, at times, occupied empty residential and public buildings (Baierle, 1992; Martes, 1990). New social organizations were created such as ecological organizations and feminist groups. These movements and organizations were all equally opposing to the military government.

The climax of the political liberalization during the eighties was reached with the end of the military dictatorship and the promulgation of the Constitution in 1988. The Constitution instituted “a competitive liberal regime of oligarchies”, in which all the Brazilians were formally considered as citizens (Weffort, 1988, p.16). It created mechanisms that granted the involvement of popular classes in public administration – such as the referendum, the plebiscite, the popular initiative – and determined that there should be popular participation, mainly in the field of health (Moisés, 1990, p.33; Brasil, 1988, art. 194/VII).

The organization of the civil society and the political liberalization that occurred has not been incorporated in many analyses of the recent processes of social reform and of political institutions change in Latin America. Grindle and Thomas (1991, p.63) stated that, in most developing countries, a great percentage of the population – peasants and urban slum dwellers – are not organized so as to support regular political activities. The social interests would be frequently represented by means of informal processes, instead of by public forms of pressure. This was the case of Brazil, mainly during the sixties and the seventies, when there was a combination of lack of political democracy and exclusion of millions of people to the access of goods and basic services, available to others through the rapid industrialization and modernization. However, in the eighties and the beginning of the nineties, this characterization became imprecise, for it portrayed just partially the social and political dynamics of the country. In several cities, especially in the field of health, sectors of the urban, rural and union movements became mobilized and, initially, submitted their claims directly to administrators and politicians. After the second half of the eighties, these movements began to focus their demands to the health interinstitutional commissions in the municipalities and, thereafter, to the health councils and conferences. By means of these participatory channels, the demands of social sectors recurrently excluded from the decision making processes were submitted formally and publicly. In order for this to happen in a systematic and continuous basis, some preconditions had to be established.

Firstly, the establishment of these channels of effective participation required the existence of organizations of civil societies that could sustain and legitimize the ones who represented the interests of the social sectors that they bound together (Marmor, 1983, p.92). Secondly, it would be necessary to count with a *policy community* that would be interested in building up participatory-inclusive channels. A *policy community* refers to an community of political players, who are organized on behalf of a common social policy project (Jordan and Richardson, 1982, p.83). An important player in this community is the sectorial political elite, made up of professionals and academic people, who directly collaborate for the elaboration of reform projects (Grindle and Thomas, 1991, p.20). In the case of the reform of the Brazilian health system, there were the activists of social movements, who were eager to influence in the formulation and implementation of the policies in the area. There was also elite of reformers attempting to create alliances and coalitions so as to influence the decision-making process in the government (Melo, 1993, p.130-136).

Grindle and Thomas (1991, p.32-4) related the weakness of the representation mechanisms of collective interest in the developing countries to the strong role that the sectorial political elites had in the formulation and implementation of reforms, independent of articulations with organizations of civil society. Nevertheless, the elite of reformers of the Brazilian health system represented just one of the components of the *policy community* that defended the reform. On the one hand, the elite of reformers attracted popular and union leaderships so that they would engage in the public fora of political representations that were being created. On the other hand, they took an active role in the design of policies and strategies that would boost the reforming process. Instead of making decisions by means of na informal process of inquiring a civil society that was weakly organized, they promoted the regulation of representation mechanisms on behalf of collective interests in the health area, having as a presupposition, the existence of popular and union movements that were sufficiently organized to grant the continuity and the consistency of this representation process.

Although there has been intense mobilization of the civil society in Brazil during the eighties, the organizational structure that resulted from this varies according to the region in the country as well as to the state and the demographic, economic and political features of the cities. The strength of the political institutions and of the popular and union movements in the big cities, for instance, may cause the participation of pressure groups to become feasible, thus determining the type of involvement users would have in the councils and conferences in the field of health (Carvalho et all, Cortes, 1995; IBAM et all, 1991; IBAM et all, 1993; L'Abbate, 1990; Martes, 1990). Clientelism and paternalism are still remarkable features in the relations between the government and interest groups in Brazil, especially in the small cities and in the rural areas that are less industrialized in the country. Although the existence of these fora may collaborate for the consolidation of more democratic forms of interest representation, their

operation is limited and conditioned to the concrete reality of the institutions and of the political culture of the Brazilian municipalities. Even if these restrictions are taken into account, in the federal, state and municipal levels, where the popular and union movements are more organized, there has been a constant involvement of representatives of users, in the public spaces of councils and conferences in the field of health (Carvalheiro et all, 1992; Cortes, 2000; Vargas et all, 1985).

The statements by Grindle and Thomas, on the weakness of the civil society and the informality of the representation of interests in Latin America, are incomplete, and so are the ones by Ugalde. He (1985, p.43) stated that in Latin America, the experiences of participation inspired by the principles of primary health care would have contributed to the increase of exploitation of the poor, by means of the use of his free work. This would have contributed for cultural discharacterization at the same time that it has increased political violence due to the suppression of leaders and to the destruction of grassroots organizations. The councils and conferences in health are not "participatory experiences". They are institutionalized fora, similar to the ones in England, Italy, the USA or Canada (Cortes, 1996 (b)). However, an inspiration for its creation was primary health care policies incentive to community participation statement proposal. Ugalde´s statements may be considered partially adequate so as to characterize participatory activities that have taken place during the last decades in projects of coverage extension of health care, in the countryside and in poor urban areas in Brazil. However, they do not apply to the health councils and conferences.

For this reason, the statements made by Grindle and Thomas and Ugalde are inadequate, for they underestimate the possibility of participation of popular social sectors in reforming processes or in actions that are inspired by the strategy of primary health care in Latin America and, consequently, in Brazil. The circumstances that are involved and the characteristics that have conformed to the creation health councils and conferences and their legal and political consolidation have demonstrated this inappropriateness.

Historical antecedents of the creation of health participatory fora

In Brazil, until the seventies, there have been institutionalized participatory mechanisms solely in the social security system. It offered benefits and services to the workers who were inserted in the formal labor market and paid taxes. Among these services was the ambulatorial and hospital individual assistance. During the military regime, which took place from 1964 to 1985, all types of participation of workers representatives, in social security system, was suppressed. Nevertheless, from 1974 on, there were some initiatives to stimulate the involvement of the "community" in the health area. The first efforts, however, were implemented in the area of public health, whose services were aimed at that percentage of the

population that was excluded from access to health services offered by social security sistem.

Since the beginning of the Brazilian social security system, and in 1923, with the creation of the Pension and Retirement Funds, there was election of workers representatives for the decision making committees within these institutions (Oliveira and Teixeira, 1986, p.22). These Funds were organized by companies, as civil societies in which the only participation of the state was done by means of the normatization of its functions, controlled by federal law, approved by the Congress. They responded for maritime and railroad workers and their families, offering retirement, pensions, money reserves and medical and hospital assistance, in case of surgery (Oliveira and Teixeira, 1986, p.22). The participation of workers´ representatives took place in its main management office, which was composed of three members assigned by the company and two from the group of employees, who were directly elected. (Oliveira and Teixeira, 1986, p.32-3).

The Retirement and Pension Institutes, created after 1933, also had participatory mechanisms, although they lacked autonomy in relation to the Sate. The welfare institutes were autarchies linked to the Ministry of Labor, which encompassed national categories of urban workers such as maritime workers, stevedores, industrial workers, bank clerks, salespeople and federal public servants (Malloy, 1977, p.46-7). Other categories of urban workers – domestic and autonomous workers, municipal public servants – and the ones from the rural area were not included in the system. The federal government interfered in the choice of the representatives of workers, who acted in the direction of the institutes (Oliveira and Teixeira, 1986, p.118-131). After 1945, the political democratization and the industrial economical growth favored the strengthening of the union movement, increasing its influence in the choice of the directors of the institutes.

After 1964, the military authoritarian regime promoted the centralization of the political institutions and stimulated the growth of the private provision of goods and services. The fiscal reform, the Institutional Acts, the outorgated Constitution of 1967 and the Constitutional Amendments of 1969 concentrated political power, competences and financial resources in the hands of the Union. Together with the centralization of power, there was an authoritarian mode of public administration, which defended planning and management based on technical decisions and the suppression of open channels for the public manifestation of sectional interests. In this realm, the mechanisms for workers´ participation in deciding and consulting organs of social security system were discontinued.

Nevertheless, after 1974 the government starts to show more concern towards policies that would promote the expansion of provision of heath services. At the same time that there was a reduction of the economic growth, which had characterized the so-called “Brazilian economical miracle”, the military regime faced the weakening of its social bases of support. The new military president, who had taken office that same year, proposed a gradual political

liberalization and a new social discourse, consubstantiated in the II National Plan for Development (Paim, 1989, p.19). The Plan defended the implementation of new strategies for social planning and the rationalization of the health system. Following the policies, the plans of extension of coverage were created, vertically planned and executed by the federal government and imposed to the states and municipalities. The most innovative actions were the ones that aimed at extending the coverage to segments of the population that had been excluded to all kinds of access to health services, until that moment. The most ambitious proposal was the attempt, in 1979, of implementing a National Program of Basic Health Services (PREVSAUDE). Although this initiative has not been successful, it was the first time that a proposal incorporating among its core elements the notion of community participation in the area, was discussed at the national level (Paim, 1989, p.20).

Another set of initiatives that aimed at modifying public health services, had as leading members some municipal health authorities. At the end of the seventies, in small and medium cities generally governed by opponents of the military regime, municipal health authorities implemented policies that were inspired by principles of primary health care. Besides offering basic care for the needy population, they aimed at involving the users in the decisions taken in the municipal secretariesof health. The intensity of this involvement varied in each case, but the idea of participation in the health field began to spread. It is important to call the attention to the fact that many health professionals participated in these experiences.

Until the mid eighties, the Brazilian health system was divided between its sub sectors of social security and of public health, both acting at the same time, offering similar services, lacking integration in the planning of their actions. The social security sub sector held most of the financial resources. It offered ambulatorial and hospital services to worker who contribute, by means of their own units and, increasingly, by means of private providers. The economical crisis and the growing costs with the provision of health assistance strengthened the proposals made by politicians, administrators and leaders of popular and union movements, aiming at reorganizing the system so as to make it universal, decentralized and better integrated. The reorganization would imply in the transfer of the political power and the financial resources of the social security sub sector to the public health and of federal government to state and municipal governments. The political democratization, the strengthening of the sub national levels of government (Souza, 1994, p.588-589) and the recommendation of international agencies motivated the implementation of policies and the constitution of legal rules so as to universalize the access, to integrate and to decentralize the Brazilian health system. For the ones who defended the state's reduction in size and in the proportion of expenses with public social protection, the main objective was to reduce costs. In contrast, the ones who defended the democratization of access to services and the widening of the state control over the services that were financed with public resources set forth the importance of stimulating the participation of

users.

During the seventies and the first half of the nineties, the military government took measures so as to constitute new channels of representation of interests, with the aim of liberalizing the regime, since the economical crisis had reduced its political legitimacy. Its aim was to legitimize the authoritarian regime and enhance the social bases of support by means of the implementation of policies that would reduce poverty and expand the welfare coverage. Simultaneously, the corporativist relations between the entrepreneurial interests and the technocracy in the public sector (Cardoso, 1975, p.181-6) were criticized even by the bourgeoisie, who was unhappy with the decline in the economical activities. Democratic forms of representation and political expression were created or reestablished, such as election of mayors and governors, freedom in the press, and in associations and party organizations. Governmental programs foresaw the creation of commissions or councils that should have representatives of the civil society among its components. During the eighties, a remarkable characteristic of the reform in the Brazilian health system was the creation of this type of participating mechanism.

The creation of participatory fora in the context of the reform of the Brazilian health system.

During the eighties, two federal government programs and a set of legal provisions may be considered as the institutional fundaments of the reform of the Brazilian health system. These were the Program of Integrated Actions in Health, of 1984, the Unified Decentralized Systems in Health, of 1987, the Federal Constitution, in 1988 and the Federal Laws nº 8.080 and 8.142, of 1990.

The Program of Integrated Actions in Health, created in 1984, was part of a strategy of the military regime to reduce the costs of the welfare system, which had grown too much during the seventies. It established that the social security would transfer the financial resources to the state and municipal government that opted to take part in the program. The main objective was to improve the network of services offered in the three levels of government, retaining the demand for medical and hospital services financed by the social welfare. In an attempt to facilitate the integration of actions of the public providers of services, interinstitutional commissions were created in the federal, state, regional, municipal and local levels of the public administration. These commissions were called, respectively, Interministerial Commission of Planning and Coordination (CIPLAN), Interinstitutional Commission in Health (CIS), Regional Interinstitutional Commission in Health (CRIS), Municipal Interinstitutional Commission in Health (CIMS) and Local Interinstitutional Commission in Health (CLIS). The former three were commissions composed by representatives of the providers and of the government, as

opposed to the last two, which had also the participation of *entities of the community, unions, societies and representatives of the local population* (Brazil. Ministry of Welfare and Social Assistance and others, 1984, p.8). With the exception of the regional commissions, the remaining ones were becoming institutionalized as important fora of debate in the area. In addition to helping in the interinstitutional integration, the new fora were gradually transforming into channels of political representation within the state organization.

The municipal commissions had to decide on the distribution of social security financial resources transferred to the municipalities and monitor the way they were spent. The health care that was directly offered by the federal, state and municipalities, finaced with the resources of the budgets from these levels of public administration were not included in the agendas of the meetings held by the commissions. Mainly in the capitals and big cities, where there were strong social and union movements and interest groups – such as dwellers associations, unions, organizations that represented professionals and health workers – there was pressure for the inclusion of such issues in the agenda of meetings. The empowerment of these fora was sought as a possibility for increase participation in the decision making processo of the area (Carvalheiro et all, 1992, p.116-27).

In August 1987, the federal government issue the Program of Unified Decentralized Systems in Health, with the aim of universalizing the access to health care and, at the same time, rationalizing costs and use of resources, by means of the unification of health services of social security and public health sub sectors. The proposal was to integrate social security health services to the decentralized network of hospital units and, mainly, medical services of the sub sector of public health, belonging to the state and municipal governments. The state governments signed agreements, and, by means of these, the social security system transferred financial resources and management functions to the states. The program also established that the municipalities that adhered to the state agreement would be able to receive resources and become responsible for the management of ambulatorial and hospital units that were previously federal as well as the state ones, which were located within municipal territory. The program proposed integration, virtually extinguishing the direct involvement of social security system in the provision of health care and in the purchase of services. If there was municipalization, the municipal health authorities could become the managers of the existing services in their territories, with exception to the ones that, due to their higher level of complexity, were references for the populations of more than one municipal.

The reformers of the Brazilian health system considered an issue of principle the fact that the civil society had control over the system. In the meantime, interest groups that were mobilized thanks to the participation fora could help expand the political support to the reform process. The program allowed popular participation through the state interinstitutional commissions in health and reinforced the role of the representatives of civil society in the

municipal and local commissions. Once municipalization had occurred, the Program made it possible for the municipal commissions could have participate in the decisions made over health services, funded with public resources, within the city territory.

to take part in decisions on health services provided within city's territorial jurisdiction, whose financing was public.

The Brazilian Federal Constitution, promulgated in 1988 (Brazil, 1988), and the Laws nº 8.080 and 8.142, approved by the National Congress in 1990 (Brazil. Congress, 1990 (a); Brazil. Congress, 1990 (b)), were influenced by the policy community of the reformers of the Brazilian health system, in alliance with organizations that represented the users´ interests. The general strategy was to build a universal health system, funded with the resources of social security – created by the new Constitution – and with the federal, state and municipal budgets. The biggest part of the direct provision and of the services funded with public resources would be under the responsibility of the municipalities. Federal and state spheres took the responsibility for monitoring and evaluating the system and for provision of more complex services, which were references for the populations of more than one municipal. Although in legal terms health had become the responsibility of the municipalities, until the nineties, mainly in the big cities, the municipalization depended on the success of complex negotiations, most of the time conflicting, between dignitaries of municipal and state health. The issue debated was on the way and the time when the services would be transferred to administration of the municipalities, which of them would be transferred and, mainly, what financial agreement would allow the municipal to take the new responsibilities.

Law nº 8.142/90 (Brazil. Congress, 1990 (b)) enhanced even more the possibilities for user involvement in the health area decision making process. Permanent health councils had to be constituted in the federal, state and municipal levels of public administration, and these should be made up of representatives of the government, health care providers, health professionals and users. Half the council would be formed by users´ representatives and the other half should come from the other social segments. One of the requisites for the state and municipal government to become liable to receive federal funding was the existence of organized councils in accordance with legal determinations[1]. These fora had to participate in the planning of strategies, decide on the distribution of financial resources and monitor the implementation of policies. As the provision of services had become mainly a municipal obligation, once the process of municipalization had occurred, the municipal councils could have the control over health services, funded with public resources, within the city territory.

Although there were constrainsts to make the political proposals and the legal determinations real, by the year 2000, 97.04% of the municipalities in the country (5.343 in

[1] To receive federal funding, the state and municipal health governments had to have: (1) health funds, (2) health councils, (3) health plans, (4) management report, (5) considerable counterpart of financial resources from their own budgets, destined to health, (6) carrer plan for positions and salaries.

5.506) had municipalized the basic public medical network and the health vigilance services (epidemiology and sanitation) in their territories. Nevertheless, just 8.97% (494 in 5.506) had begun to have control over all the services funded with public resources – medical, hospital, therapeutical and diagnostic support – including the ones provided by private sector (Brazil. Ministry of Health, 2000). The organizations that represent users´ interests have attempted to increase their influence over the national, state and municipal health councils. They seem to recognize that in the new institutional design users could participate in the sectorial political decision.

The same law created the health conferences in the three levels of public administration. They should have the same council composition and should occur every four years. They should evaluate the health situation and propose plans for the formulation of health policies in the correspondent levels. Although there were eight national councils in health before 1990, just the last one – the 8th National Health Conference – had a remarkable popular participation. It was so, probably because it took place in 1986, in the context of political democratization, of conflicts and negotiations that preceded the constitutional process and of the intense discussion on the future of the reform of the health system. From then on, two national conferences were held – in 1993 and in 1996 – preceded by the organization of about five thousand municipal and state conferences in all the states of the federation. The mobilization that they provoked may be confirmed by the process of choosing delegates, which sometimes involved serious disputes among different entities in order to guarantee the presence of their representatives in the event. There is evidence that the legal demand for parity among the representatives of users has been respected, *vis-a-vis* other social segments (Cortes, 2000).

The legislation created the councils and the conferences in the federal, state and municipal levels of the public administration, but they have not been instituted based on an institutional emptiness. In most of the cases, the councils originated from the adaptation of the existing interinstitutional commissions. The organization of conferences was a tradition in the area since the beginning of the century. The main difference introduced was the rule concerning the periodicity and the involvement of representatives of civil society.

These fora have been modifying their character within a health system in process of change. Since 1984, when the federal health dignitaries gave priority to the interinstitutinal integration and to the descentralizatin by means of the Program of Integrated Actions in Health, the permanent fora – initially commissions and then councils – besides facilitating the integration, become a space to which the demands were focused and the interests of contractors, of workers and health professionals, of public administrators and representatives of the popular and union movement (Cortes, 1995).

However, studies have demonstrated that, from the beginning of the nineties, the representatives of the medical profession and of the private providers have been leaving the

participatory fora, especially in the municipal councils (Cortes, 1995). Leaders in these social sectors argue that the cuncils are hostile for the physicians and to the private service. They were subrepresented in these fora, considering their importance in the area (Entrevista 16, 1992; Entrevista 21, 1992). Obviously, such interest groups have not been excluded from the decision making process that take place in the area. Their demands are presented directly to health autorities, through formal and informal channels of political pressure. Examples of formal channels could be the legislative, the media or the public presentation of demands to the administrators. The informal channels were constituted, mainly, by means of health authorities identified with the demands of physicians and private providers. The identification sometimes has a corporative character, since the public administrators are frequently physicians or owners of hospitals or health equipment for diagnostic or therapeutical support. It is important to call the attention to the fact that the legislation prohibits service owners from taking top positions in the public health system. However, many times the physician, the owner of a hospital or other equipment, formally abandons the direction of that organization, just during the period in which he was in government. However, during this period, his identification with the interests of medical corporation and private providers remains.

Different from what occured in the second half of the eighties, the councils and the conferences in health in the nineties seem to have lost its role of being the main place for negociations and mediation of interests in the health area. These fora however, have assumed two fundamental institutional roles. In the first place, in the fora and during the conferences in health, social forces that were favorable to the deepening of the process of system reform join their strategies e proposals. In the second place, as the process of municipalization became more consolidated, they became the locus where the users´representatives – mainly the dwellers of the poorest regions in the cities – presented their demands to the public administrators. The mediation between the conflicting projects for the area seems to be occuring, preferably, in the offices of the health authorities.

The conflicting projects are basically two. On the one hand, we find the reformers of the Brazilian health system, who defend the expansion of the public provision for services, the increase of the state control over the market of health services and the universal access to the system for all the citizens. The policy community of reformers is led by some health authorities, mainly the ones at the municipal level, who are interested in increasing the autonomy of municipalities and in obtaining funds to support the network of services under their responsibility. It is also led by activistst of popular movements, of unions, of health professional unions who are interested in the expansion of access to universal services and in guaranteeing the expansion of the provision of health care. Especially in states capitals and in big cities, they meet in the municipal councils and during the conferences, supported by the political and legal legitimacy of these fora, confronting opposers, pressing mayors, governors and the federal

government, demanding, for instance, more funds for the health area.

On the other hand, we find the liberals who defend the private provision of services for the ones who can pay and the offer of public financed services only for the poorest. The main leaders of the resistance to the health system reform were medical entrepreneurs, the Brazilian Federation of Hospitals (FBH) and their state branches, the Brazilian Association of Health Maintenance Organizations (ABRAMGE), the Federal Council in Medicine and its state branches, besides some medical unions. For them, the councils and the conferences are considered enemies.

Even if we take into account that councils and conferences play a limited role in mediating the interests in the area, the novelty is in that a gradual formation of a new type of relation in the helath area in Brazil is evolving. There is a possibility that interests of the popular sectors, traditionally excluded from the decision making process, have begun to be there represented formally and publicly (Carvalheiro et all, 1992; Vargas at all, 1985; Cortes, 1998).

Determinants of user participation

It has been stated before that health councils and conferences are public spaces in where interests of the popular social sectors represented and in which the representatives of these sectors participate in the decision making process. We will now examine the determinants of user representatives' participation in these fora. The review of the literature on the subject (Cortes, 1995; Jacobi, 1993; Lee and Mills, 1985; Marmor, 1983; Martes, 1990; Vargas et alli, 1985) has shown the following factors as the most influencing ones on this participatory process: (1) the recent changes on the institutional structure of the Brazilian health system, (2) the organization of popular and union movements, (3) the relationship between health professionals and popular and union leaderships, (4) the position of the federal, state and municipal authorities in the health area concerning participation, (5) the dynamics by which the fora work. Two preliminary observations must be made to explain the nature of these determinants. In the first place, all of them affect each other mutually, making up the parts of an integrated and conflicting whole. In the second place, the first two factors are the most decisive ones. In other words, the fora would not exist if there was no institutional rules creating them and there will only be participation if there is organization of the civil society. In some cases, there may be resistence of municipal health authorities concerning the participation of users and it may still happen, due to the pressure of the social movements (Cortes, 1995, p.135-137).

The recent transformations in the institutional design of the Brazilian health system may be considered as the most influencial factor in determining the participatory process that take place in the councils and conferences of health. These changes form the set of programs and legal statments implemented during the eighties, added to the operational norms of the Ministry

of Helth, edited between 1993 and 1996, which have established the norms guiding and stimulated the municipalization process. They have offered the political and legal bases for the Brazilian health system to become: (1) more integrated by means of the unification of the sub sector in public health (Ministry of Health, State and Municipal Secretariats in Health) with the sub sector of social security health care (own and contracted services); (2) more decentralized, transferring the functions as well as equipment and financial resources to the state governments and, later, to the municipalities; and (3) universalized, formally offering health care to all the Brazilian population. In this context, the importance of the health councils and conferences has increased since the beginning of the nineties, both as an articulatory *locus* for political forces in favor of the reform of the health system as well as a formal and open channel where representatives of the popular social sectors could present their demands and propositions.

Nevertheless, the force of popular and union movements is what will determine if there will be participation of legitimate and autonomous representatives of the popular social sectors in these fora. Moreover, the organization pattern of the social movements influences the way by which the users get involved in the activities of the councils and conferences. If the pattern of organization is more centralized, the tendency is that user representatives get more directly involved in the activities of the national, state or municipal councils. If the pattern of organization is more decentralized, the user representatives will participate through local organizations such as the local councils in health, the mothers´ associations, community or dwellers´ associations (Cortes, 1995). The importance of the urban social movements especially in the bigger cities is decisive, since representatives of the union movement in the councils have been a minority – with the exception of the ones who represent the health professionals or health workers. It is because the most mobilized categories of workers are the ones whose members already have insurance or special health plans, and do not depend solely of the public system to meet their needs. In smaller towns, where the rural workers union is strong, they have become the main basis of support for the continuous participation of its representatives before the municipal cuncils (Vargas et all, 1985). We should call the attention to the fact that these workers can only count with the public system to meet their health needs. The possibilities of autonomous involvement of the user representatives in the municipal conferences that choose delegates, who will participate in the state and federal conferences, depend on the consistency of their involvement in the municipal councils. The episodic character of these conferences transforms them in culminating movements of a long process, which is administered along the four years that precede the occurrence of each one.

A third factor that has been stimulating the envolvement of the users in the councils and conferences is the combined action of the reformers of the Brazilian health system with the ones of the activists of urban, rural, and union social movements (Cortes, 1995; Martes, 1990; Vargas et all, 1985). The elite of reformers have been acting together in executive and legislative

arenas, aiming at the introduction of political-institutional changes that shall make the user participation feasible. These reformers defend participation because they believe in the democratization of the decisiona making process. Moreover, the alliance with social movements offers political support when facing the resistence of interest groups that are contrary to the reforms and in the confrontation within the government with other political areas that compete with health area for obtaining the scarce resources.

The interests of the social or union movement in claiming the improvement of access and of service quality does not automatically mean presenting demands before health councils and conferences. The elite of reformers has stimulated the involvement of popular and union leaders in the contacts that they have established as public health professionals in medical units, located in poor urban areas or in regions that concentrated rural workers. They have also favored the involvement of users in these fora when they occupied positions as federal, state and municipal administrators in health. In some urban areas, such as District 4 in Porto Alegre (Cortes, 1995), in the East District of São Paulo (Jacobi, 1993; Martes, 1990) or in Ronda Alta, in the State of Rio Grande do Sul (Vargas et all, 1985), the already existing and intense popular mobilization concerning the health issues was concentrated for these fora. In other areas where there was also a predominance of poor population but health issues were not regar as a priority by the local social movements, the incentive of public health professionals became decisive for the involvement of popular leaders with health issues. Without this, the mobilization regarding health problems would have probably been less intense and the political action in these leaders would not have necessarily converged to the health participatory fora. The counterpart for the leaderships of urban social movements and union movements was the increase of their political influence on the decision making process in the health area. By means of the direct access of health authorities in these fora, they placed pressure on behalf of the quality improvement of health services offered to the poor population, whom they represented. At the same time, they reinforced their leading position within their organizations.

A fourth factor that contributed to user participation in health councils and conferences is the position of the municipal, state and federal health authorities concerning the user participation. The position of the health authorities may be considered as decisive, since quite often they conduct the council and the organization of the conference. Even when this is not the case, as public administrators they influence directly on: (1) the organization of the discussion agenda, (2) the general organization of the forum, (3) the possibility of complying with the decisions taken there and (4) the possibility of pressing other administrators and health service providers to comply with decisions. It is important to mention that, as the decentralization process advances, the responsibility of the municipal health authorities on the system and on the possibilities of having user participation will increase, whereas the influence of the federal and state authorities will decline.

A fifth determinant of participation is the dynamics in which the fora work. It is linked to the way forum works and the position of health autorities regarding participation. It could explain quick changes in the user involvement (Cortes, 1995). In the councils the excess of detailed discussions about the expenses that will occur, may lead to the lack of attendance in the councils meetings (Cortes, 2000). A clear division of the competences among technical, legal and political commisions may help to avoid this type of problem, if the intention is to avoid it. If not, it may become a strategy to diminish the deliberative power of the council. Similarly, when limiting the issues that appear in the agenda, health authorities may choose that important issues for the municipal health policies remain as *non-questions* (Bachrach and Baratz, 1963). By being out of the agenda, the decisions regarding some issues will be made in offices, away from the public scrutiny.

Summing up

After the eighties in Brazil, some sectors of public administration, especially in the health area, have been permeable to the representation of interests of social sectors, which were traditionally put aside of the political process. It is natural that this new situation faces the permanence of elitist political arrangements and of clientelist and paternalistic practices that hinder the generalization of this new permeability. The economical crisis of the eighties destroyed the bases of the authoritarian pact that excluded the representations of workers and of other popular social sectors from the centers of political decision. The political liberalization allowed the public manifestation of a civil society that demonstrated a capacity of autonomous organization, at least in the main urban centers and in rural areas that concentrated the most active unions of rural workers. The health councils and conferences beceme the locus to where the popular and union movements present their demands, as wel as a policy community of reformers articulates political alliances. This community was composed by elite of reformers of the Brazilian helath system, in alliance with leaders of popular and union movements. The alliance that has happened in the health councils has become manifest in the health conferences. Thus, the statements by Grindle and Thomas and by Ugalde, who considered it improbable to constitute formal and public mechanisms to represent the interests of the popular classes in Latin America, do not integrally portray, nor value the novelty that is constituted by the councils and conferences in health for the political and institutional life of the country.

Nevertheless, the delay in the municipalization process of the health services in many states has limited the possibilities of extension of the agenda in the municipal councils. The power of municipal councils and conferences within the general decision making process of the area will always be limited if municipal health authorities does not have the control over services provided in the city. In other words, without municipalization the increase of user control over these fora will not imply in increase of control over the administration of health

services in the city. The sole municipalization of basic attention, as has been occurring in the majority of the Brazilian municipalities, causes the municipal health authorities and, consequently, the councils to have limited influence on the process of sectorial decision.

It is necessary also to point out that the helth assistance in Brazil is divided beween the care that is available to the ones who have helath private insurance or who can buy private services directly and the assistance that is accessible to the ones who can only depend on the services financed with public resources. This has caused the poor population and the ones who suffer from chronic ilnesses to become interested in having influence over the decision making process, which takes place in the participatory fora.

Even if we consider such limitations, it has been possible to observe that in some cases and in some situations, the health councils and conferences have provided a public representation of the interests in the popular social sectors and the representatives of these sectors have participated in the decision making process that occurs there. The main derterminants for the participation of user representatives in health councils and conferences have been: (1) the changes in the Brazilian health system, (2) the features of popular and union movements, (3) the relationship between public health professionals and popular and union leaderships, (4) the position of health federal, state and, mainly, municipal authorities health concerning participation and (5) the dynamics by which the fora work. As was seen, these determiners are deeply related and affect each other mutually, although the first two may be considered as the most decisive ones.

We cannot state that the reform in the Brazilian system has improved the quality of care offered and that it has allowed the services to become more accessible or it it, on the contrary, intensified previously existing territorial and social inequities. Undoubtedly, however, it has created at the municipal level of the government a participatory forum that has contributed for the democratization of the decision making process in the health area. A higher participation of users does not guarantee the reduction of inequities in the promotion of health care for the population. Nevertheless, the consolidation of participatory fora may help the democratization of Brazilian institutions, empowering social sectors that were traditionally excluded from direct representation in the political system. Thanks to them, their representatives may influence in the decision over the destination of public resources in the health area, may obtain information, may control the quality of the services and may influence in the formulation of policies that favor the social sectors that they represent.

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ABSTRACT

The article discusses the literature that states that creating channels of participation in developing countries in general, and in Latin America in particular, is too difficult, due to the weakness of both the political institutions and the civil society. In the field of health, the initiatives to promote user participation would have supposedly resulted in failure. However, the Brazilian experience with health councils and conferences does not confirm such statements. The article also examines the historical origins, the creation of these fora and the politico-institutional role they play in the context of the Brazilian health system reform. Finally, the article analyzes the factors that determine the success of a participatory process in health councils and conferences.

Keywords: participation, health councils, health conferences.

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