Rights to health and struggles for accountability in a Brazilian municipal health council

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The right to health is enshrined in Brazil's 1988 constitution, dubbed 'the Citizens' Constitution' for giving legal form to the demands mobilised in the struggle for democratisation. The realisation of this right is intimately linked with the pursuit of accountability. The architecture of the Brazilian health system has at its foundation an acknowledgement of the contribution that citizens can make to equitable and efficient service delivery through their role in mechanisms of accountability. The right to health is instantiated in the monthly meetings of *conselhos de saúde*, health councils, at municipal, state and national level, in which representatives of civil society come together with health workers and representatives from the municipal government to audit health spending and approve health plans. Endowed with the power to make binding decisions, the *conselhos* are mandated by law to approve budgets, plans and accounts before monies can be released from the federal coffers.

The health of the population is a fundamental resource for the nation; and maintaining national health systems that can deliver services to the mass of the population, especially those who can least afford health care, is of significant symbolic as well as political and economic importance. Yet the provision of public health services also requires resources. It involves significant investment and management of public monies, and difficult decisions over allocations of ever-diminishing budgets. Throw in the complications of a mixed health

system, where there is statutory acknowledgements of the limits of state provision and the need to contract out particular services to the private sector, and add historic distrust on the part of citizens in the probity of its bureaucrats, and the interplay between the realisation of rights and demands for accountability become all the more complicated.

This chapter is about how citizens in the small north-eastern Brazilian municipality of Cabo de Santo Agostinho, in the state of Pernambuco, have sought to realise the right to health through efforts to exact accountability from their municipal government. It tells the story of the evolution of the town's municipal health council, and reflects on some of the challenges for the realisation of the right to health that persist. It begins by introducing the health councils, their structure and functions, and the political context out of which they arose. It then goes on to explore the origins and evolution of the municipal health council in Cabo. Focusing on some of its successes and shortcomings in the pursuit of accountability, the chapter reflects on some of the challenges faced by citizen actors in pursuing the right to health through these institutions.[1]

Brazil's health councils: new democratic spaces?

Popular participation in the governance of health services has been on the international health agenda since the 1970s (Loewenson 1999; Cornwall, Lucas and Pasteur 2000). In many of the co-management and consultative institutions established as part of health sector reforms, citizens are provided with opportunities for involvement in discussion, and sometimes in decision making, over making the delivery of health services more effective. Less commonly found are institutions that offer citizens a role in deliberation over health policy and the nature of health service provision, matters that are often retained as functions of the state. Rarer still are institutions that endow social actors – not merely individual citizens but the representatives of organised civic associations – with the legal right to approve budgets and

health plans, and play a part in ensuring accountable governance. This is the function of Brazil's innovative participatory health councils (Coelho 2004; Coelho and Nobre 2004; Coelho, Pozzoni and Cifuentes 2005). Operating at each of the three levels of government – municipal, state and national – the health councils lend shape to a set of norms and institutional arrangements for the provision and governance of health care that provide new opportunities for citizens to engage directly in holding the state to account for their right to health. Each municipal and state government in the country is obliged to have a health council, with a structure that is predetermined by national decree.

The Brazilian health system – the Sistema Único de Saúde (SUS) seeks to embody the basic principles of universality, equity, decentralisation and *controle social*, a term which constitutes only part of what the word 'accountability' has come to mean in English. Health councils are organs of accountability in a number of senses.[2] They are sites for the pursuit of fiscal accountability, in which citizen representatives can literally audit the accounts of the local government, and pick up and pursue any anomalies. They are also sites for answerability, as public sphere institutions to which public officials are obliged to present accounts and explanations for health spending. And they are sites that provide citizen groups with a direct interface with health policy decision makers at every level, and which serve – in theory at least – to maintain the accountability of these public officials to diverse publics. They are open to members of the public and, whilst only elected councillors have the right to vote, all present have the right of voice.

Brazil's health councils represent a form of governance institution that has gained considerable popularity in recent years as a space for 'cogovernance' (Ackerman 2003). Writing on the challenges for accountability of these new governance institutions, Cornwall, Lucas and Pasteur (2000) suggest that one of their most pressing challenges is overcoming

embedded hierarchies that are so much a feature of the health sector, especially in the constitution of expertise and 'ignorance'. In Brazil, an unusual confluence of influences has made these dynamics more complex. For the generation of medical professionals now in senior positions within the public health system and in non-statutory health organisations, the national health system and its participatory institutions was the fruit of a long and intense struggle by the radical public health movement (the *movimento sanitarista*) of the 1970s and 1980s, in which many of them took part as medical students. A deep commitment to public health and to the right to health arose out of this movement, and inspired a generation of visionary doctors, whose agency has been so crucial at every level to seeking the success of democratising health reforms.

The system of participatory health councils was envisaged by the health reformers who mobilised for its institutionalisation both as a means of creating an interface for civil society with the government and as a further political means of democratising Brazilian society, by stimulating the engagement of associations, movements and other forms of popular organisation with the process of governance. The councils were seen as providing a complement to the representative democratic system, involving representation of a different kind – of civil society organisations rather than elected politicians. The councils are composed according to strict rules of parity. Civil society organisations constitute 50 per cent of the council's representatives. They are elected by civil society delegates at municipal conferences or in municipal assemblies. Representatives of health workers make up 25 per cent of the council's members, and include primary health care auxiliary nurses and outreach workers, doctors and specialist health workers. The last 25 per cent is made up of representatives from the municipal health secretariat and contracted-out service providers, consisting of the Secretary of Health, and managers of municipal hospitals and clinics in the public and private sector.

The notion of *controle social*, literally 'social control', represents at once the idea of 'the people' controlling what is rightly theirs *and* the enlistment of publics in the auditing of health spending. The term is often taken to extend to citizen engagement in health policy and planning, and to represent the right to participate at every level and in every aspect of health sector decision making. Yet in practice, as we go on to suggest, there are limits to citizen participation in this context that constrain the possibilities for engagement to a narrower auditing role.

Background

The municipality of Cabo de Santo Agostinho, with a principally urban population of just over 150,000 people, lies in the Greater Recife area in the state of Pernambuco. The town is an important economic centre because of its strategic location, its established industrial facilities and its expanding service sector, especially in the tourism, health and retail sectors. Despite those economic potentialities, Cabo de Santo Agostinho has low human development and infant development indices, substantial populations of people below the poverty line and an illiteracy rate of 21 per cent [source?]. Its mixed epidemiological profile reflects the diseases of poverty and those associated with urban living, such as cardiovascular and degenerative disease. Health services are provided at neighbourhood health posts, and by referral to municipal and private hospitals in the town of Cabo de Santo Agostinho itself. The successful implementation of a national primary health care programme – which involves teams of community health agents, who are linked to health posts staffed by a doctor and nurses, doing regular house-to-house visits – has brought marked improvements over the last seven years in a range of health outcomes, from a drop in the infant mortality rate (from 41/1000 to 18/1000) to reduced hospital admissions figures.

Cabo has a rich history of social movement mobilisation, dating back to agrarian struggles, the engagement of the progressive Catholic church, informed by Liberation Theology, during the period of the dictatorship, and a strong feminist movement with regional and national connections. Immediately after the return to democratic rule, a progressive democratic party held the municipal government until shortly after the first wave of implantation of the *conselhos*. A diversity of social movements, NGOs and corporate social actors exist in both urban and rural areas in the municipality. Some of these are long-standing organisations, supported by the progressive Catholic church's work with base communities. Others came into being as a result of the first wave of democratisation in the late 1980s with support from the municipal government, and continue to benefit from municipal government *subvenções* (literally subsidies, grants to support their activities). Others still are directly contracted through *convênios*, statutory agreements, with the municipal government for the delivery of social and health services. There are around 130 registered civil society organisations in the municipality, and many more small community-based organisations dealing with issues in their immediate locality. The character of the state and of civil society, the nature of mutual dependencies and of cross-cutting links that exist across their borders, mediated by the church and by political parties, is extremely significant in making sense of the struggles for accountability in the municipality.

Cabo's municipal health council: laws, structures and purpose

Cabo's municipal health council (*conselho municipal de saúde*, CMS hereafter) was officially inaugurated by Municipal Law 1.687 on 12 May 1994, according to Federal Laws 8080/90 and Law 1840 /90. It was established with the following goals:

1 To define municipal health priorities;
2 To establish guidelines to be followed when making the municipal health plan;
3 To act on making strategies and controlling the application of the health policy;
4 To propose criteria for financial and budget planning and application of the municipal health fund, auditing transfers and use of resources;
5 To follow, evaluate and audit health services provided to the population by public and private institutions with SUS service contracts in Cabo;
6 To define quality criteria for the functioning of public and private health services within the SUS;
7 To call the municipal health conference every two years, together with the executive, according to the Lei Orgânica da Saúde (Basic Health Law).

Cabo's CMS is made up of 20 members and 20 substitutes, distributed as follows: 10 service users; 5 health professionals; 3 public managers; 2 representatives of private services with contracts with SUS. Its legal status is that of a collective body of public administration linked to the executive branch of government. The CMS meets once a month for 3–5 hours, meetings are open to the general public and take place in a central location in Cabo, in a building – the Casa de Conselhos ('House of the Councils') - provided by the municipal government.

The CMS was established in Cabo just as the progressive Partido do Movimento Democrático Brasileiro (PMDB) government lost office to the conservative Partido da Frente Liberal (PFL). In its initial years, there was little opportunity to develop its potential. As in many parts of Brazil, the council came to be an extension of the municipal government, filled with appointments made by government and serving as a mechanism for rubber-stamping the government's decisions. This period of crisis was extremely significant in shaping the current

CMS. Popular movements, progressive Church interests, unions and the feminist movement joined forces in a popular front to pressurise the municipal government to democratise the health council. The return of progressive government in 1997 was accompanied by the recruitment of an energetic, radical reformer into the position of Secretary of Health, and the revitalisation of the CMS and reforms to the health system that ushered in what is today's SUS in the municipality.

While citizens can attend and have rights of voice in health council meetings, councillors are elected as representatives of civil society organisations. Terms are for two years, renewable for a further term. In 2000, the health council elected its first civil society chair – one of the first in Brazil, where it is usually the municipal health secretary who takes up this position. During 2000–2, intense discussions within the CMS gave rise to internal regulations that sought to further democratise the action of the council. Rules of representation were evolved to ensure a diversity of communities of place and of interest, with half of the civil society seats being allocated to representatives of neighbourhood associations and the remaining half to those representing particular interest groups, such as the women's movement, the black movement and disabled people. These efforts culminated in the largest municipal health conference held to date, in 2003, at which new councillors were elected by several hundred delegates who had been elected at pre-conferences in four regions of the municipality. Ranging in age from their early 20s to their late 60s, most of Cabo's councillors are lower-middle-class or working-class, on average having no more than secondary schooling and often only primary level education. During 2003–5, the council's civil society complement consisted of civil society organisations as diverse as an Afro-Brazilian cultural centre, a herbal medicine non-governmental organisation (NGO), an association representing 'progressive' elements of the Protestant church, a Catholic workers' movement and a feminist NGO, along with residents' associations from all over the municipality. To extend

the health council's scope yet further, in recent years efforts were made to inaugurate local health councils in neighbourhoods in the municipality.

The health council is notionally autonomous and thus independent of the municipal government. In practice, however, it is reliant on the secretariat of health to provide resources for it to function effectively, including paying for the costs associated with administrative support. This support is critical to the council's viability, as the administrator not only keeps records of meetings, prepares documents for councillors to read and convenes meetings, but also reminds the councillors of the meetings, keeps them up to date with any changes in policy at state or national level that are communicated to her by councillors involved at those levels, and helps to organise training, transport of councillors and logistics for participating in events such as conferences. Charged with functions that require both significant investments of time and money, this infrastructure and resourcing is critical – underfunding undermines both the possibility of the council being able to exercise social control effectively, and the trust that members have in the seriousness with which their work is taken by the government.

Council members are entitled to demand access to public health accounts and explanations about certain investment and spending decisions, as well as to pay visits to clinics, health units, and hospitals to carry out spot checks. An auditing committee, composed of two CMS councillors and a member of the public, is charged with carrying out a number of such checks, examining stock cupboards for expired or badly stored medicines and inspecting the facilities. The mandate of the councillors extends beyond that of a watchdog, however, in their function as representatives of broader community interests. One of their tasks is to consult broadly amongst their constituents about local health plans, and to become directly involved in organising biannual health conferences, where such plans are opened to discussion. Councillors' own perceptions of what being a member of the CMS entails varies

significantly, as does the way in which they frame their role in relation to the task of holding government to account. In a participatory workshop, councillors gave the functions of the health council as follows:[3]

- To facilitate popular participation in health public policies; to define priorities, audit resources and evaluate results.
- To develop projects as well as to audit what is approved by the council.
- To promote social control, with popular and democratic participation.
- To contribute to the system's better functioning, with popular participation.
- To enforce peoples' rights, already guaranteed by SUS.
- To audit users' demands for good service.
- To exercise social control through organised civil society, playing a central role and directing public policies for the sector.
- To jointly discuss and establish the best options for public policy.
- To propose and to follow public policies.
- To be a deliberative body where members have the opportunity to audit and to contribute to health policies.
- To provide citizens with conditions conducive to participation in public health policies in the community.
- To contribute to the management, auditing and construction of health policy.

A lack of clarity over what the role of the council ought to be, and what its limits actually are, is one of the factors that hampers the work of the council. Newly appointed councillors are sent on training courses, of variable quality, which teach them the basics about what their role involves, and instruct them in the various technical procedures that are part of health budgeting and planning. This is, however, a rather rudimentary education: necessarily so, as

the costs of providing such training are significant. Councillors talked about how useful and important the training they had received was for them, and how much they valued opportunities to go on further courses and attend events in the nearby metropolis, Recife, including state-level conferences on a range of health-related topics. For those who had been able to take up these opportunities, they were regarded as an invaluable opportunity for personal as well as professional growth, expanding their horizons and bringing them into contact with similar people from other municipalities. Not everyone, however, is interested in taking up these opportunities or able to do so, and there is a general feeling in the council that people do not have enough of an idea of what exactly they are there to do.

People enter the council with expectations that are shaped by their previous experiences, whether in political parties, social movements or their own communities. Their own interpretations of what *controle social* ought to be all about play a part in defining what for them are the appropriate concerns of the council, as well as the boundaries of their own interventions in this space. How do these different perceptions of the function of the health council play out in practice? The next section explores some of the everyday dynamics of the health council, and the meanings of accountability and rights that citizen representatives, health workers and managers bring to their engagement with the health council.

Accountability in practice

The everyday business of the CMS ranges from listening to presentations by organisations who deliver services, to being informed about the plans of the municipal health secretariat, to discussing specific incidents that have been reported by members of the public concerning the provision of health services. There is little deliberation on matters of health policy; health plans are prepared by the government, without any attempt to engage the participation of

health councillors in their formulation, and presented to the council for their approval, along with periodic presentations of the accounts. There is equally little expectation on the part of health councillors that they will be involved in the health policy and planning process, even though some see their responsibility in these terms.

Examination of the minutes of the CMS for the last three years reveals a series of patterns of interaction between health bureaucrats, citizens and health workers. One is a pattern of information provision followed by question and answer, which generally involves one of the managers, and most often the Secretary of Health. There is often little or no deliberation over the issues brought for consultation, nor does there appear to be any expectation of a more broad-ranging discussion: they are presented as matters of fact, questions are asked, and the matter is closed. This is the way that the municipal health plans tend to be treated. Another pattern is one of clarifying or contesting the way in which things are being done by debating whether something should be on the agenda, whether the council needs to have a position or a policy, and so on. At times, this appears to be about the council exploring the boundaries of what they are expected to do, at times about finding ways of working more effectively. Yet another interaction is more adversarial, generally involving denunciations of the quality of care or lack of services available in public health facilities, but also extending to critique of particular medical staff or failures to provide certain services. Rarely does this turn into constructive debate as to what to do about it, taking a more predictable pattern of making a complaint, and the complaint being recorded.

The minutes of the health council meetings support the impressions that we gained from our conversations with representatives. Users talked of the need for persistence, of wearing down a reluctant bureaucracy until they gave in to demands; managers spoke of the frustration of dealing with users who clearly did not understand either technical issues or the bigger picture;

and workers spoke of the difficulties they faced in meetings, being unable to speak out against managers, but equally feeling on the receiving end of the criticisms levelled by users in their denunciation of health service provision. These tensions are played out in the space of the meeting. Styles of interaction echo the different purposes that the council serves, from the adversarial, distrustful stance of user representatives in contests with the state through to the posture of consultation, with users and workers listening to and asking questions of the managers, to a more collaborative relationship, with users and workers making suggestions together, and management agreeing with them. These different purposes are held in a permanent tension and create significant paradoxes for what participation in the council comes to mean to different members.

Deliberation in the council often appears to be less about content than procedure; quite what councillors actually understand deliberation to mean says more about their perceived role in auditing and authorising decisions than in deliberating the nature of health policy and the content of health plans, as the following quote from a user representative illustrates:

> We are not a consultative body; we are a body that deliberates. The manager has his/her own planning team … he or she makes an action plan, what is going to be spent on health … he or she comes here and presents to us what is going to be spent within the plan for each account. It comes to us, we take a good look at it and then we say if we approve the plan or not. If it is approved the government can go ahead with it, it can spend the money approved … it is up to me, as a councillor, each three months, to say where it has advanced, because accounts are rendered every three months…. The Council audits them really closely, members have the right to go to take a look for themselves; if it is wrong, we can stop it. That is the role of the council.

Framed in this way, realising the right to health involves making sure the municipal health secretariat and the medical staff they employ do their job: discussions rarely stray outside the frame of what that job is defined as by the government. There are strict rules that are set by central government about the proportion of money that should be spent on primary care, and guidelines and models for the delivery of care at that level that municipal governments can opt out of, but doing so may present political risks, which are better avoided. Municipal health secretariats can, however, contract out a greater proportion of secondary and tertiary care to the private sector, if they wish, and pursue health plans that give less priority to the health rights of the poor. As one union activist – a former CMS representative and a regular and vocal figure in CMS meetings – pointed out, it was the job of the CMS to hold the government to account for the resolutions made in the health conference, not to make policy. Yet even he conceded that the long shopping list of promises that constituted these resolutions necessitated prioritisation, and that the lack of citizen engagement in that prioritisation process potentially undermined the prospects citizens had for holding the government to account for its role in realising their right to health.

The worlds of the bureaucrat and the citizen tend to intersect most on questions of probity, and very rarely around issues that might be regarded as ‘technical’. There have been notable exceptions. The current chair combed through the epidemiological report for the previous year and found a large number of untreated cases of one prevalent condition, which he brought to the health council as a concern. It was, however, not a concern that was debated: he simply informed them that he had composed a letter to the authorities noting the incidence of this condition, and calling for more attention to be paid to providing effective medical treatment. It was evident that his own technical knowledge did not extend to knowing exactly what that treatment might be – unlike treatment activists in other contexts, including parts of

Brazil, who would be able to demand specific medication. What mattered, for him, was putting on the record that not enough was being done: a form of interaction with the authorities that was as familiar to him, from his activist background, as it was to a number of his fellow councillors. It needs to be remembered that he, like many user representatives, has rudimentary education and does not come from a medical background. To take up an issue like this is in itself evidence of the kinds of changes that the CMS has made possible. It is, however, an exception: many of the most effective challenges to the municipal health secretariat tend to come from people with medical training, who are able to directly pursue lines of argumentation that are simply not available to ordinary citizens.

Making a difference

Despite difficulties and contradictions, CMS actors have been relatively capable of taking initiatives, speaking out, expressing criticism, proposing and resisting in their role as civil society representatives. Acting autonomously, they have sought allies in social movements and within the state on certain issues of mutual concern, such as outsourcing of services. Common political sympathies – such as anti-privatisation sentiments – create bridges across the health council, and have worked to strengthen the power of the CMS in seeking to withstand the tide of marketisation that threatens the public health system. Where the municipal government's policies are in the interests of poorer members of the community – and this could be said, by and large, for the Partido Popular Socialista (PPS) government that was in office when we carried out this research – then this auditing role within the broader ambit of a SUS that delivers on its promises of equity and equality makes management and political sense. Yet much comes to depend on the character of individual bureaucrats, as on the broader agenda of the municipal government. The scope for conflict and co-option is as present in these spaces as that for collaboration, and civil society representatives may adopt a range of strategies for engagement, which put them into conflict with each other.

Shifting alliances and commonalities between health bureaucrats, health workers and user representatives complicate attempts to categorise actors as part of bounded interest groups. These alliances take shape in other spaces – the space of the party office, the church, the neighbourhoods in which councillors live. Party affiliation may make more of a difference when it comes to some issues; belonging to a common faith may matter more when it comes to others. Debates in the space of the council call on these allegiances, and on cultural styles familiar from other spaces: they are often characterised less by the kind of detached rational argumentation that is evoked in the writings of deliberative democrats than by other processes of persuasion that are laden with power, whether bound up with personal loyalty, religious belief or belief in superior knowledge or expertise, and political strategies and tactics that make the CMS an intensely political arena.

When councillors were asked what difference the council had actually made to the well-being of people in the municipality, the answers were often couched in terms of the kinds of successes claimed by the municipal health secretariat. Health bureaucrats emphasised the importance of the CMS in creating a bridge with civil society, as much as some acknowledged the limitations that civil society representatives had in understanding the complexities of health provisioning. For a number of the user representatives, the successes of the CMS were closely identified with making the health system function better: they pointed to the successes of the CMS in dealing with demands to guarantee service provision and improve the quality of care, thus contributing to the accomplishment of municipal health plans and improving basic health care units, access to tests, specialised outpatient centres, social mobilisation for municipal conferences, and the establishment of local health councils.

There seems to be a broad acknowledgement by the actors involved that the existence of the council has made some contribution to reducing the practice of clientelism and exchange of favours as the predominant form of access to health services in Cabo. Similarly, there has been an increase in public recognition and identification of privileges existing in the sector as well as the possibility of fighting to end them. Yet a number of current as well as former user representatives were much more circumspect about the successes of the CMS. Yes, they said, there had been gains: the council is an institution worth having. But they highlighted a wide range of concerns, from the 'party-isation' of the space of the council, to the compacts between government and user representatives benefiting from service contracts that complicate prospects for accountability, to the lack of voice of more marginal members, silenced as much through fear of the repercussions of speaking up as through their own lack of confidence in what they might have to say. For some, these factors neutralised the potential of the council as a mechanism of *controle social;* for others, they were an inevitable part of it, something which required constant vigilance as well as active strategies for its further democratisation.

A further dimension of reflections on the council concerns the gap between the ideals of the SUS and the realities of scarce resources, and the difficulties of ever overcoming the barriers to access experienced by those with complex and expensive conditions that simply could not be treated effectively at this level because of shortcomings in the ways services are articulated. These raise larger concerns about the very way in which the SUS is organised, and about the tensions between democratising priority setting and the medical exigencies with which planners of public health have to deal in order to be able to contribute to guaranteeing the right to health.

Realising the CMS as an accountability space

Even when the practice of participatory governance institutions does not meet the expectations that were created as part of the political struggle that led to their institutionalisation, most case studies conducted in Brazil stress their 'positive impact on the process of construction of a more democratic culture in Brazilian society' (Dagnino 2002: 162). The significance of this impact cannot be underestimated in a country with such an entrenched authoritarian tradition as Brazil, which combines state centralisation with local clientelism, and where economic modernisation and the location of Brazil within international capitalism has been conducted under an authoritarian regime, worsening its elitist and exclusionary character. Institutionalised participatory spaces such as the CMS contribute, by and large, to the collective political effort to democratise the implementation of public policies in Brazil, since (1) they confront elitist conceptions of democracy, (2) they challenge authoritarian conceptions about the primacy of "technicians" and "the technical" in state decision-making processes, (3) they challenge state monopoly over the definition of what is public and what the public agenda should be, and (4) they contribute to reducing clientelism and to more transparency in government actions (Dagnino 2002).

From what we gathered in Cabo, the signs are there that the process of creating spaces for accountability is having some effect on the culture of politics, with the hope expressed by some councillors that the expansion of local councils will serve to further open, and broaden, spaces for participation. It is evident, however, that simply creating spaces for citizen participation is no guarantee that old political practices will not simply be reproduced within them (Cornwall 2002). The council is an intermediary space. It is one that lies in between a series of other spaces: those of associations, of the bureaucracy, of health providers, of political parties and a range of other social and governmental actors. It is one threaded through with relationships, with party political alliances, clientage relationships and tensions.

Social actors representing civil society are far from autonomous *vis-à-vis* a municipal government which gives many of them small grants to support their activities, and has contracts with others to deliver services. Neither civil society nor the state can be thought of as constituting a homogeneous bloc; and amidst the universe of civil society organisations in Cabo there exists tremendous diversity in terms of capabilities to engage in these spaces, as much as in their own internal democracy and accountability and claims to legitimacy, which further complicate their interactions within the space of the council.

To be effective in holding the state to account, health councils require a range of resources – the provision of which goes beyond the means and the responsibility of civil society members. Funds are needed to support the everyday functioning of the council, to provide a space to meet and someone to organise meetings, keep records and notify councillors of any pertinent changes in policies or upcoming events that require their attention. Financial resources are also required to support the training of representatives, not just from the users' segment – who require information on the structure and functioning of the health system, and on interpreting accounts and budgets to be effective – but also from the health workers and managers' segments, to equip them with the capabilities to participate in this kind of forum. Beyond these material resources, there are further technical and symbolic resources that are critically important if councils are to have 'teeth'. Active participation by user and health worker representatives is often not matched by commitment from managers, whose inaction and perceived lack of respect for councillors undermines the potential of the CMS as a space for accountability.

Although managers often voice professions of intent and eulogies regarding the importance of citizen participation in *controle social*, their conduct is perceived by many user representatives to reveal a very different attitude. The municipal government was charged by

some user representatives with failing to provide adequate and timely information; seeking to drive through plans and budgets at short notice; giving councillors very little chance to find out and debate what they entailed; and exerting 'pressure' at key decision-making moments. There is a significant consensus among user representatives – shared by some health worker councillors – that the lack of value given to the CMS by the bureaucracy acts as a critical brake on its effectiveness. There remains amongst bureaucrats a very real tension between the legitimacy the CMS can offer them, and a perception that 'the council wants to be the manager', displacing what they see as properly their prerogative in making decisions about public health.

Contests over the meaning of *controle social* lie at the heart of the ambivalent relationship between managers, workers and users in the CMS. Conflicts and tensions between users and managers can be interpreted in terms of contestation over two distinct although not entirely incompatible conceptions about accountability through participation. One conception (commonly held by managers) sees participation as a model for the management of public policies and another one (generally that of users) understands participation as a process of democratisation of those policies. Of course, that does not mean that managers are not interested in democratising the process, or that users do not see management as relevant. But it does shed light on why the demarcation of issues as 'technical' becomes so important in the conflicts that arise in spaces of *controle social* over public policies, and it is linked precisely to the struggle for effective power sharing between state and civil society actors in those spaces. On one hand, acknowledging the legitimacy of politicising the technical is a way for civil society actors to demand power sharing. On the other hand, the constant reaffirmation of the essentially technical character of decisions is an argument enabling state bureaucracy to retain maximal power. Which direction the balance tilts in will depend on actors' political forces in distinct scenarios, and the result is always provisional.[4]

Conclusion

For all the shortcomings people identified – and there were many – every one we spoke to, without exception, viewed the CMS as critical to the very possibility of accountability, and as an institution worth preserving no matter what difficulties were experienced in making it effective. People across the board – from the director of a maternity clinic to a temporary auxiliary health worker, to a worker at a programme for black youth, to the founder of a centre for herbal medicine – all felt that being part of this institution had provided them with opportunities for hearing new perspectives, learning new things and contributing to improving public health in Cabo. The very newness of this institution, and its counter-cultural nature in a political context marked by pervasive authoritarianism and clientelism, means that the potential for change may only be realised over a much longer term. The challenges are many, from changing the very dispositions of political society to transforming relationships in a sector marked by the hegemony of hierarchies of expertise. But there is every indication that, slowly, the CMS is beginning to make a difference, turning users into citizens who are aware that access to decent health services is not a favour, nor a privilege, but a right, and transforming a culture of clientelism into a culture of accountability.

Realising that right and enabling the cultural shifts that are required for accountability calls for continued efforts to change relations of power that enable managers to frame consultation and control the agenda, that deny lower-level health workers a voice, and that work to undermine the possibility of democratising health policy and planning. Overcoming these obstacles is a challenge that calls for new and imaginative ways of breaking and remodelling the old cultural patterns that limit the exercise of citizenship. As one councillor put it:

> When you begin to get the rights you have, and the way to seek those rights without the need for an intermediary, without favours or party-political bargains, then you change the character of the life of a society into one in which citizens have awareness, in which you know what you are entitled to.

To fulfil their democratising potential, participatory governance institutions like health councils require more than citizen awareness and active citizen engagement – although this, and the further democratisation of the public sphere that would lend greater legitimacy and representativity to civil organisations, is a vital precondition for their role in making the work of *controle social* effective. What is also needed is an active, engaged and enabling state, a state whose bureaucrats recognise the role of accountability in democratic governance and who respect their obligations in creating the conditions and providing the resources that can facilitate citizen engagement – both material and symbolic. On one hand, efforts to enhance accountability need to reckon not only with an often idealised model of 'civil society participation' but with particular and shifting configurations of state–society relations, and the extent to which such configurations condition the possibility of accountability and require a range of potential strategies on the part of social actors – whether inside 'invited spaces' such as the health council or in 'popular spaces' outside them. On the other hand, they need to take account not only of the possibilities presented by enabling legislative and institutional frameworks, but also of pervasive political culture. There are, in short, no easy recipes, and for all the enabling conditions that would seem to exist in this case – supportive legislation, a municipal government that has at least provided some material support and had a public commitment to participation, a strong and organised civil society – the struggle for accountability in Cabo continues.

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Notes

[1] This chapter is based on participatory research carried out in collaboration between the three authors – the ex-chair of Cabo's Municipal Health Council and director of the Centro das Mulheres do Cabo, a local feminist NGO; a political economist from the Rural University of Rio de Janeiro; and an anthropologist from the IDS, Sussex – and members of Cabo's health council and of the municipal administration. Parts of this paper are drawn from a longer paper (Cordeiro, Cornwall and Delgado 2004) prepared as part of the DfID-ActionAid

Brazil *Olhar Critico* ('A Critical Gaze at Practices of Citizenship and Participation in Brazil') project. Thanks to Alex Shankland for comments.

[2] See Goetz and Jenkins (2004) on different dimensions of and interpretations of 'accountability', and Cornwall, Lucas and Pasteur (2000) on these issues with reference to the health sector.

[3] Derived from cards produced at a participatory workshop held in Cabo on April 12, 2004, which included users' and health workers' representatives. Health managers chose not to attend.

[4] In countries with authoritarian political culture such as Brazil, it is probably more realistic to assume that the balance has a fatal attraction to State actors.