Brazil's Health Councils: The Challenge of Building Participatory Political Institutions

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1 Introduction

This article examines the experience of municipal and district health councils in the city of São Paulo in the light of the literature on citizen participation in Brazil. The literature has attributed the success or failure of participatory mechanisms either to the degree of civil society involvement, or to the level of commitment to such mechanisms on the part of the political authorities. This begs the question of what happens where both factors are present, but the participatory mechanisms nevertheless remain relatively ineffectual as institutions for promoting the interests of the excluded. Drawing on research into participation in São Paulo's health councils, the article argues that the success of this type of participatory mechanism depends not only on the involvement and commitment of civil society and state actors, but also on their willingness and ability to promote institutional innovations that guarantee clear rules of political representation and processes of discussion and decision making that lead to effective participation by representatives who command less technical knowledge and fewer communicative resources.

2 Citizen participation in Brazil

Brazil has a population of about 170 million, of whom 22 million live in conditions of extreme poverty. In this context, social inequality is a crucial problem and social policy plays an important role. Expenditure on social policy measures currently corresponds to 21 per cent of gross domestic product (GDP). However, despite an increasing supply of public education, healthcare and social security, there has not been a significant improvement in the quality of the services provided. Nor is there evidence that these policy measures are contributing to a reduction in social exclusion (IPEA 2001).

The 1988 Constitution, drafted during the redemocratisation process, attempted to solve these problems through a combination of universal social policies, decentralisation and mechanisms of citizen participation. Enabling legislation passed in the early 1990s to implement these provisions led to changes in revenue sharing among the federal, state and municipal spheres of government. City governments were strengthened and began to play a central role in the promotion of citizen participation in social policy management.

Thus in the 1990s, when there was an intense debate on the weaknesses of the welfare state and a growing emphasis on market-based solutions (Cornwall and Gaventa 2001), Brazil witnessed in the constitutional sphere a reaffirmation of the central role of the state in guaranteeing citizens' rights, in conjunction with a proposal to establish an alliance between the state and civil society with the aim of overcoming the weaknesses identified.

In the case of participation, this involved the creation of an extensive network of social policy management councils, each with responsibilities in formulating and managing policy for different areas such as education, health and welfare. These councils were set up at all levels, from local to federal, in accordance with a principle of parity between representatives of civil society (who occupy 50 per cent of the seats) on the one hand and on the other hand, representatives of government (25 per cent) and service providers (25 per cent). Thus,

the councils are responsible not only for taking government projects to the population, but also for taking suggestions from the population to the various levels of government: municipal, state and federal. Today there are 28,000 social management councils throughout Brazil. Other forms of participation were created in the 1990s. Examples include participatory budgets, public hearings and mechanisms for participation in regulatory activities.

This article analyses a particular type of management body: the health council. Brazil currently has 5,000 municipal health councils and more than 100,000 people participate in them. Large cities also have district health councils. Health councils make decisions, act as consultative bodies and exercise oversight.[1] They approve annual plans and health budgets. If the plan is rejected, the city does not receive funding from the Health Ministry. They also assist municipal health departments with planning, establishing priorities and auditing accounts. A major proportion of the funds transferred by the Federal Government to municipalities is channelled through a fund-to-fund transfer system and the councils must verify these accounts and notify any irregularities. District health councils have similar functions, but without decision-making powers, since they lack a Constitutional mandate (Coelho *et al.* 2002). It is important to note that although their legal powers reside mainly in the technical and administrative spheres, the councils are especially significant for their role in policy discussion (Mercadante 2000).

3 Conclusions from the literature

The authors who have analysed these experiments in participation have reached ambivalent conclusions, identifying grey areas with many cases of relatively little achievement and a few successful cases. The relative failures are attributed both to cultural factors such as authoritarian traditions in state and society, lack of social organisation and resistance to participation by social and state actors (Sposati and Lobo 1992; Abrasco 1993; Cohn *et al.* 1993; Carvalho 1995; Andrade 1998; Viana 1998; Carneiro 2002; Pozzoni 2002). The successes are interpreted as resulting from the organisation of civil society and/or the commitment of political authorities to the development of participatory mechanisms (Heller 2001; Boschi 1999; Abers 2001; Fung and Wright 2003; Marquetti 2003). In sum, the view of these authors is that participatory

mechanisms cannot be expected to succeed if civil society is not organised and the political authorities are not committed to developing participation. The chances of success increase in proportion to the commitment of these actors to participatory projects. But what is meant by success?

There is a heated debate about what to expect as a result of the development of participatory institutions. Participatory processes are expected by many to contribute to increased levels of information and greater tolerance of difference among the participants and to make decision making and management procedures more accountable. Where there is less agreement is in relation to the expected impact of participatory mechanisms on wealth distribution. The fact that, in the Brazilian context, participation has been held up as an element that is capable of counteracting distributive distortions and contributing to an improvement in the quality of services, implies that the ability to generate distributive impacts should also be taken into consideration when evaluating the success of such mechanisms.

In order for participatory institutions to have an impact on service quality or the equity of resource distribution, however, they must necessarily succeed in making a difference to public decision making. The rest of this article sets out to examine the organisation and functioning of health councils in the city of São Paulo; to verify whether the conditions for success postulated by those who have studied the subject, organisation and commitment on the part of social and state actors were present there; and to discuss the extent to which the councils effectively participated in health policy. The purpose of this article is not to evaluate the effects on the participants themselves or the distributive impact of health councils, but to focus specifically on investigating whether or not the councils have had a voice in decision making and why.

4 Health councils in São Paulo

The city of São Paulo, which has a population of some 10.5 million, is conspicuous for sharp social inequality and unequal access to public services (CEM 2002). The Workers Party (PT) currently governs the city and also had an earlier period in power between 1988 and 1992. In both periods it has prioritised citizen participation and the creation of public policy management councils as ways of combating inequality. Shortly after taking power

in January 2000, the PT administration subdivided the city into 31 administrative regions and 41 health districts, each with its own district health council. There is also a municipal health council for the entire city (as well as the São Paulo State Health Council and the National Health Council).

The population of the 41 health districts created in 2000 varies from 180,908 to 418,440. Much as in other Latin American "mega-cities", the poorest areas are located on the outskirts. Wealthier areas, concentrated in the city centre, receive more public healthcare services and have the largest numbers of hospital admissions.[2] Poorer areas, mostly outlying districts of the city, have the lowest levels of access to healthcare. Among the exceptions is the district of São Mateus, which has a high level of service provision even though it is a very poor area. São Mateus has a history of intense social mobilisation and struggle for better healthcare, suggesting that political participation can contribute to improvements in access to public services (Coelho *et al.* 2002). Several parts of the city in addition to São Mateus have a history of popular mobilisation, which helps to explain the high level of engagement with the process by which the councils were created. A total of 40 district councils were set up in two years, with each involving the mobilisation of over 1,000 people to participate in at least one monthly meeting; a significant number, especially considering the limited financial resources available to support the process.

The municipal council has 32 members and each district council has 16 members. Councillors' appointments are linked to the institutions that nominated them. The government is represented by civil servants appointed by the Municipal Health Secretary or by the director of the health district. In the case of users and service providers, the internal by-laws and rules of the council (drafted by the councillors) determine which groups are represented and how many seats are allocated to each group (Mendes 2002; Moreira 2002).

Despite the level of political commitment to, and civil society engagement with, the establishment of the councils, an analysis of the extent to which they influenced health policy reveals almost no such influence. The councils debated a number of policies and problems in the healthcare system, but influenced neither major nor minor decisions of the city's Health Department (Coelho *et al.* 2003). For example, two of the most important municipal

health policies in the 2000–02 period, the creation of *autarquias*[3] and the scaling-back of the expansion of the Family Health Programme,[4] were simply announced by the city government without adequate consultation of the councils,[5] despite promises from the municipal administration that it would promote citizen participation as one of its ten top priorities (SMS 2002).

This lack of impact raises the question of whether the political authorities were actually committed to developing participatory mechanisms or whether civil society was effectively organised. A review of data from the research suggests that the leaders of the process of decentralisation and creation of health councils were linked to the *sanitarista* movement[6] which for more than 20 years has advocated the construction of a public, universal and participatory health system. Of the civil society associations interviewed for this study and which had seats on the first councils set up, more than half had been established since the 1980s. These associations focus on promoting political participation and keeping citizens informed, besides taking part in other forums such as participatory budgeting and education councils. The profile of the state and social actors involved in the process and their success in creating the health councils in the first place, suggests the problem was not a lack of commitment on their part.

This article argues that the real issue was the failure of these actors to establish the councils as dynamic political institutions. This hypothesis is strengthened by analysis of the processes whereby the councils were organised and their members appointed and by observation of council meetings. The analysis presented here clearly shows that what is missing is an adequate balance between the need to guarantee the presence of civil society in newly organised councils and the need to establish political representation and decision-making processes suitable for institutions expected to participate in the formulation and oversight of health policy. Achieving this balance, it is suggested here, depends on the ability and willingness of the social and state actors involved to promote institutional development. Two aspects of institutional development are critically important if participatory mechanisms are to function as political institutions. The first is, the question of representation and the criteria for organising political representation (not a simple question, given the fact that while the principle of

one person, one vote, is fundamental to representative democracy), in this case we are dealing with a type of political representation that is designed to complement the state rather than substitute for it. Thus it is necessary to find alternative forms of representation capable of guaranteeing the presence of organised civil society or of groups traditionally excluded from access to public services.

Several alternative ways of organising representation in these bodies have been described. One possibility, outlined by Schimitter (2001), is to identify individuals and/or associations that represent groups in some way affected by the policy measures to be implemented. In other experiences the goal is to organise representation in such a way as to (1) reproduce the socio-demographic profile of the community; (2) represent the main positions in dispute; (3) make use of affirmative action; or (4) offer structural incentives for participation by low-income and low-status groups[7] (Fung 2003; Carpini *et al.* 2003).

In São Paulo, the rules for civil society participation in health councils are based on the segment of civil society that is represented. For example, the municipal council has six seats for representatives of popular health movements, five seats for social movements, two for labour unions, two for people with chronic diseases and one for disabled people. The problem is that this distribution of seats was decided by the councillors themselves when they drafted the internal rules for the council and reflect a pre-existing network of relationships among representatives of government and social movements (Coelho *et al.* 2003). There is no clear rationale for the choice of these groups or the number of seats allocated to each one. The result is a set of "new included", groups of the "organised excluded" who have links with the state actors and set up the councils in the first place. Non-organised excluded and even organised groups who lack such links remain unable to participate.

To the natural limitation of this type of representation, which is its inability to include all segments, was added the limitation derived from the way in which it was decided who should act as representatives. There are widespread doubts about the legitimacy of these representatives, but these stem from the selection process rather than from any lack of breadth in the pool of potential representatives, given that the number of active

civil associations in São Paulo runs into thousands. No doubt the cost of organising and publicising an electoral process involving a much broader range of associations would be high. But it is a crucial issue, as without clear rules and a transparent electoral process, the councils will remain lacking in political legitimacy.

The second point is the organisation of procedures for discussion and decision making suited to a participatory arena. This is not at all easy to do either, since in these arenas, there is a principle of equality among all participants and they must be sufficiently independent of each other for no one to be able to impose a solution, yet at the same time sufficiently interdependent for everyone to lose if they are unable to reach a solution. Thus the councils operate under different dynamics from the state, where decisions are taken in accordance with a rigid hierarchy, or from business organisations, whose decisions are market-oriented. In participatory arenas, it is expected that decisions will be taken on the basis of a process of public discussion in which the best argument will prevail. This process of discussion can be organised in two ways (Carpini *et al.* 2003). Consensus building is one, while the other emphasises the need to articulate differences and divergences by fomenting conflict.

In the meetings of both the municipal council and various district councils studied during the course of this research, a key role was consistently played by the personal intervention of the executive secretary of the council and/or the chairperson of the session in organising the discussion. This results in the development of highly varied and unsystematic procedures, which rarely achieve an adequate balance between the need to respect differences among councillors and ensure that everyone has a chance to speak and the need to organise an effective decision-making process. Achieving such a balance is crucial if health policy is to be influenced on the basis of a dialogue among social groups with clear asymmetries in communicative resources and levels of technical expertise (Fraser 1995; Pozzoni 2002; Carneiro 2002).

Several techniques have been and are being developed to enhance the dynamics of participation and could be used in health councils to make the discussion and decision-making process more effective. They include the use of flexible rules so that all participants can take turns to act as

coordinators and leaders. The involvement of trained facilitators to make sure all participants express themselves could also make the process more inclusive and effective, as would the use of participatory methodologies for collective establishment of objectives and joint planning, implementation and evaluation of activities (Montoya 2002). The formulation of an adequate agenda is another point highlighted by several authors, given that some areas are inadequately discussed because of the high levels of expertise required for participation in the debate. Other areas of debate make inadequate use of the potential for councillors to inform government officials and politicians about their preferences and convey local knowledge, including the kind of details of the district best known to residents. This implies that an effort should be made to produce a clearer definition of the areas in which there is most to be gained from investing in participation (Fung 2003).

5 Conclusions

The data collected for this study suggest that the councillors who represent civil society have less formal schooling and lower incomes than those who represent government and service providers.[8] The data also show high levels of meeting attendance, especially by representatives of civil society. This creates a real opportunity for debate among social groups who otherwise would be unlikely to meet to discuss health policy. However, the councillors themselves take an ambiguous view of the experience. They are pleased with the opportunity to participate, yet they acknowledge that the discussions are disorganised and that they have not succeeded in organising themselves so as to contribute to the development of solutions to the complex health problems faced by the municipality and the districts.

Our findings suggest that the improvement of council's participation in decision making depends on organising and publicising the electoral process as well as investing in methodologies and agendas that adequately respond to the specific characteristics and objectives of a participatory institution. But this entails a high cost. Under what conditions are social and/or state actors interested in bearing this cost? Although better knowledge of the actors' motivations is required to answer this question, it seems reasonable to assume that more organised social and political actors who are more committed to citizen participation are more likely to be willing to assume the cost. In any event, as the key actors behind the most visible experiments in popular participation in Brazil in general and São Paulo in particular, it is up to them to decide whether or not to invest in institutional development as a solution to the problems which health councils currently experience, which are associated with lack of legitimacy, the difficulty of promoting effective participation by the underprivileged and lack of effectiveness in influencing policy formulation.

In conclusion, this article has sought to present an idea of the process that is unfolding in Brazil of building participatory institutions associated with the executive branch of government. It is an impressive process in terms of the numbers involved, because of its dynamism and because it contains some important promises, especially the possibility of opening up public policy formulation and management to citizen participation as a means of enabling excluded groups to gain access to public services and social programmes. The results are not always interpreted as satisfactory, partly because there may sometimes be insufficient organisation or motivation for participation to be effective. There are difficulties even under favourable conditions, however. The reformers in the 1980s did not imagine that the cost of organising effective participatory institutions would be so high. The cost is high because participatory institutions must behave as political institutions if they are to have an impact on policy. In other words, they need clear criteria for deciding who will represent civil society and effective procedures for discussion and decision making. This is the challenge: it is up to the stakeholders to decide whether they will bear the cost or let such an important opportunity slip through their fingers.

Notes

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1. National Health Council Resolution 1992.

2. Rates of hospital admission were calculated in terms of the number of district inhabitants actually admitted and not the number of admissions offered by hospitals in the district.

3. *Autarquias* are semi-autonomous hospitals and outpatient clinics (comparable with foundation hospitals in the UK).

4. In the latter case the Municipal Health Secretary and the councils had the same position on the importance of expanding coverage of the Family Health Programme (PSF) from 7.35 per cent to 35 per cent of the population in 2002. The mayor vetoed this priority and determined deceleration of the programme.

5. In both cases the Municipal Health Council was consulted, but when it became clear that its position diverged from that of the Health Department it was kept out of the decision-making process.

6. A *sanitarista* is a public health professional. Since the early 1980s, this movement had defended profound health policy reforms and was a key player in the creation of Sistema único de Saúde (SUS), a universal, decentralised, tiered and participatory healthcare system.

7. These structural incentives derive from the goods that can be offered by the participatory process, in the sense of results that will accrue to the community rather than individual benefits.

8. It is also worth noting that in five councils studied, 75 per cent of the representatives of users were women and 78 per cent of the members of all five councils were over 50. Many were retired people. A total of 20 of the 33 user representatives interviewed voted for and/or had links with the Workers Party (PT) and three with the Communist Party of Brazil (PC do B). Ten of the 15 government representatives were members of the PT.

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