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Relations between Representation and Involvement at the Rio de Janeiro Municipal Health Council (CMS): user sector, 2013-2014

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Abstract *This article analyzes the influence of "Representative Configuration" of the Rio de Janeiro Municipal Health Council (CMS) on user counselor performance. Representative Configuration is defined as being a combination of two institutional rule axes: Axis 1 consists of eligibility and involvement rules, and Axis 2, of representation rules. The theoretical discussion was centered on the relationship between Representation and Involvement in its contemporary democratic context, and specifically relates to the Municipal Health Council (CMS). The study method focused on Participative Observation, Interviews, and Document Analysis. The results show that the district counsel representatives act based on the mandate of those they represent, since they create close ties with these institutions, whereas municipal counselors are more likely to lean towards autonomy in their representation, resulting in weaker ties with these bodies. The representatives' mandate-based posture is combined with a more in-depth involvement in meetings and greater expression of their represented citizens' interests.*
Key words *Health councils, Social participation, Representation*

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Introduction

The current Brazilian democratic structure is comprised of Management Councils whose role is to expand the involvement of the community in public policy decision processes and to act as a constant presence in renewing contemporary democratic actions[1-3]. Studies of these councils regularly monitor the advances and limitations of the involvement and actions of local political figures[4]. However, recent actions have also examined the possibility of reconfiguring the representation of the community in such instances and the effectiveness of its involvement[3,5-7].

The major strong suits of the Health Councils in this scenario are the strength of their institutionalization and their decision powers at all stages of the policy cycle[8,9], the latter assured by this sector's organic legislation. Accordingly, the councils encourage *social involvement* in the *SUS* (Single Health System) which includes sectors directly linked to this System: users, workers, managers, and service providers[10].

A significant proportion of the Health Council assessments address the advances and (especially) the limits of the effectiveness of the *social control* in *SUS*, and relates them to the inability of these bodies to transform the capitalist social structure[11] or to modify the traditional political culture of the national institutions, thereby prevailing over their authoritarian and elitist trends[12,13]. These criticis*ms* tend to undermine legal objectives and undercut the Councils' other Health management roles[10], such as voicing the demands of the community and deciding on the sector's policies[14].

Conversely, few studies have been made of representation within the Councils, which further diminishes exploration of relations between the counselors and the citizens they represent. The aim of this article is to contribute to bridging this gap by analyzing the relations between Representation and Involvement in the Municipal Health Council (*CMS*) environment, in the context of institutional regulations.

The premise applied was that *rules of representation* favoring contact between the counselors and the citizens they represent lead to greater representative involvement in the daily life of the Municipal Health Council (*CMS*) (i.e., in health policies), which also becomes more effective since it is based on the needs of the represented citizens. Furthermore, to the degree that the *rules of eligibility* enable democratic access to the Councils and the *rules of involvement* enable equitable conditions for counselor action, the greater the likelihood that the needs of the represented population will influence these bodies' activities.

This premise was tested at the Rio de Janeiro Municipal Health Council (*CMS*-RJ) and focused on the user sector. For this, an analytical model was prepared based on the concept of "Representative Configuration". This consists of two institutional rule axes: *Axis 1* involves the rules of eligibility, which define entities and counselors, and the rules of involvement, which create the limitations for these individuals' actions; *Axis 2* covers the rules of representation for the bodies that monitor counselor relations, and define the nature of the representation to be provided.

Thus, the aim of the article is to analyze the influence of the "Representative Configuration" of the Rio de Janeiro Municipal Health Council (*CMS*-RJ) in respect of the actions of its user counselors between 2013 and 2014.

Methodological Aspects

Here, a quality approach study was carried out analyzing the rules of eligibility and involvement of the CMS-RJ, via an assessment of this body's normative documents and interviews with the counselors, and the rules of representation of the user organizations, based on such interviews. The performance of CMS-RJ counselors in 2013 and 2014 was also analyzed via Participatory Observation and studies of the minutes of meetings and of the interviews.

All the interviews were based on script of 12 open questions and all were recorded. The entire material was transcribed and, immediately thereafter, the more material passages were systemized to enable their analysis. This analysis was based on data on the eligibility of the counselors, their relationships with one another and the citizens they represented, and the performance of the players in the CMS-RJ. Participatory Observation occurred during Council meetings from May to December 2014 utilizing a specific script to study the representation and involvement of these counselors.

The decision to examine the user sector was justified by the political innovation arising from the involvement of the organization's representatives in *SUS* decisions, including their majority representation on the Health Councils. In the CMS-RJ, this sector consists of 20 titular counselors. Two of them (and their substitutes) were absent from all plenary Council sessions during

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the period under study, which reduced the research to the 18 titular counselors who attended, at least, one meeting.

The study was approved by the Ethics in Research Committee of *ENSP/FIOCRUZ*. As required under Bioethics principles, the study was submitted to the plenary Council session of the CMS-RJ, in the presence of the researcher at the meetings, and the counselors were invited to take part in the research after clearly presenting their objectives. Accordingly, all 18 subjects decided to take part and signed the Free and Clarified Term of Consent.

In order to place the results of the study in context, we present the theoretical references on which the analytical model of the data collected is based.

Democracy, representation, and involvement

The historic debate on Democracy has always involved thought currents and political movements in theoretical and ideological conflicts arising from the hegemony of the most virtuous 'democratic ideal' for organizing the political and social areas. Here, the 'Involvement' and 'Representation' concepts appear as essential elements of contemporary democratic agreements since, respectively, they indicate the contingent of citizens involved in the election of government and its political instances[9,15] and the mechanism whereby involvement in mass democracies becomes operational via the actions of the representatives in the decision-making arenas[15,16]. Alternatively, the 'Representative Democracy' and 'Participative Democracy' models are locked in a dogmatic battle regarding the organizational format of the political systems, where the former has been undisputed leader over recent decades[1].

A leading player here is Robert Dahl's[15] polyarchy model, that demonstrates government capacity to continuously respond to citizen demand as an expression of the democratic ideal. It is Dahl's view that the institutional developments of national governments which lead to an increase in the number and variety of citizens whose interests are represented in the government, culminating in the formation of *Polyarchies*. This transition requires both the assurance of political equality distributed over the *inclusivity* axes, reflecting the increased numbers of political competition participants, and of *liberalization*, which brings together the rules and institutional conditions to ensure the feasibility of this competition.

Dahl indicates three main channels for a Polyarchy: (i) the simultaneous development of two axes; (ii) the advance of liberalization over inclusivity, thereby enabling the legitimization of democratic institutions prior to expanding citizen involvement; (iii) the advance of inclusivity over liberalization, which requires the formation of such institutions in areas of great conflict, due to the diversity of the players[15]. Although the author believes that the second trail, blazed by the more traditional polyarchies, is more successful in its mission to establish democracy, the last trail, closer to the reality of Brazilian history, has shown itself to be insufficiently stable for democratic consolidation.

In a context above and beyond the level of national governments, Dahl points out the importance of institutional rules to define the directions of involvement and representation in democratic instances[15], thereby enabling the application of his ideas in Health Council analyses.

In defining *eligibility* as the third axis of the polyarchy model, Wanderley Guilherme dos Santos highlights the importance of its role in democratic stability given that the changes in the rules of eligibility demonstrate the number of participants, both in democratic and non-democratic circumstances[17].

Recent work has criticized the representative model and challenged the difficulties in attaining effective citizen involvement in politics and in formalizing the representation of social demands. Democratic revitalization options based on complementing the representative structure with innovative mechanisms expanding the involvement and representation of citizens in public decisions, have been submitted[1,5,18,19]. In the Brazilian scenario, the Municipal Health Councils (*CMS*) report on important events experienced since they established a presence in all municipalities of the country as organizations with a decision role in health policies[8].

The increased communication between Representation and Involvement in the democratic field have been examined in the context of political representation as a *concrete activity* according to Hanna Pitkin[16], where the actions of the representatives in political situations and their relationship with the citizens they represent are the determinants that consolidate the representation of people and groups.

Pitkin shows that in their radical *mandate trend* ideas, representatives act specifically in the interests of the represented citizens, and take more helpful positions in the political proce3ss.

But, in the case of the extreme *autonomy trend* views, the path to addressing the general interests is to grant independence so that the representatives can act in accordance with their own judgments regarding the well being of the people, and where the government consists of rational decisions taken by the politicians, with minimal regard for the wishes of the general public[16].

For Pitkin, not only are they not representation since they ignore representing-represented relations, but these polar prospects represent a theoretical dispute and insoluble practice, known as the *autonomy mandate controversy*. Thus, representation involves elements of both trends, marking the boundaries of a dilemma for the representatives: to fight for the interests of the represented citizens via a *mandate posture* or to strive in the general interest according to their views, by assuming the *autonomy posture*? Within these limitations, effectiveness and legitimacy represent reasonably independent action by representatives who ally their political views to the interests of their represented citizens, defined as *autonomy-mandate posture*[16].

Since the above discussion shows that Representation and Involvement are indissolubly related in the context of democratic institutions, this line of reasoning will be projected into the context of the Municipal Health Council (*CMS*).

Representation and Involvement in the Municipal Health Councils (*CMS*)

The Municipal Health Council (*CMS*) experiment has been recorded in a series of studies describing their functions in a number of different local situations. Some point to obstacles in involvement, relating to asymmetrical counselor funds[20], the prevalence of the managers' technical pronouncements[21] and the pervading nature of authoritarian culture in the councils[22,23]. Others focus on decision attributions, and associate them with a number of different topics such as the dynamics of counselor action[24], specifics of associationism in Brazil[25], and functional assessment models[26]. Representation aspects have warranted very few consistent analyses, chief among which are suggestions of publicizing the selection of representatives and the application of more inclusive mechanisms of a variety of community organizations[27].

Furthermore, some studies stress the challenges of carrying out *social controls*, explaining them as: restrictions on the representations of the users in the neo-liberal environment[28], managers' control over the agenda[29], elitism and bureaucratic councils[30], and minimal disclosure of actions taken, and distancing between representatives and their bases[31].

In their review of these studies, Moreira and Escorel[8] show that Municipal Health Councils (*CMS*) contribute to democratizing municipal health policy by expanding and diversifying the players involved in *SUS* decisions, but this does not guarantee that they are sufficiently part of this decision process to ensure its full democratization. In their study of the Brazil-wide Municipal Health Councils (*CMS*), after applying an analytical model based on the Polyarchy theory[15], the authors conclude that the institutional rules successfully increase involvement, but are insufficient to ensure the institutional consolidation of the councils. This situation has encouraged the Municipal Health Councils (*CMS*) to take a veto player position in sector decisions. This caused managers to withhold needed working funds[8].

Following this view in the light of the autonomy-mandate controversy[16], Moreira[10] analyzed the representation of Brazil's Municipal Health Council (*CMS*) sectors, describing their users as being part of a "scattered multiplicity" – entities with a variety of interests and differing among themselves – which encourages the counselors to take mandate type positions whose decisions are based on vetoing other players' proposals. Equally, the representatives of the other sectors tend to take mandate positions, even if their interests are more consistent and the counselors' actions include alliances with other sectors.

In order to refine the results of these national studies[8,10], an analytical model of the Representation-Involvement in specific Municipal Health Councils (*CMS*) based on the "Representative Configuration" concept was drawn up, and applied to the reality of CMS-RJ users.

Representation and involvement in the Municipal Health Council – RJ (*CMS*-RJ)

Founded in 1991, the CMS-RJ is an integral part of the Rio de Janeiro Municipal Health Secretariat (*SMS*-RJ) structure. It is responsible for decisions on the management of sector policy, duly set forth in Municipal Law No. 5104/2009. The Council has its own headquarters, fixed meeting areas, an Executive Secretariat, telephone lines, computers with internet access, and a website for disclosing information on its activities. This is one of the reasons explaining its reputation as being one of the more competent Brazilian Municipal Health Councils (*CMS*)[8].

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Law No. 5104/2009 establishes that the Rio de Janeiro Municipal Health Council (*CMS*-RJ) functions on a quadrennial basis, with 40 establishments distributed on a user parity representation basis. This law also determines that the 20 user seats be divided among the ten District Health Councils (*CODS*) – located in the city's Health Planning Areas (*APs*)[32] – and 10 municipal entities. The composition of the current CMS-RJ sector includes the entities listed in Chart 1.

Although the institutional missions of these entities differ among themselves, thereby reproducing a "scattered multiplicity" situation[10], among the Brazilian Municipal Health Council (*CMS*) users, what actually defines the representative sector arrangement of the CMS-RJ is the split into two specific groups of the CODS and the municipal bodies.

While the municipal entity counselors are selected and regulate their actions based on a "dual representation mechanism" (representing their entities and the user sector[10]), the district counselors carry out these activities based on a *triple representation mechanism*, since they represent their own entities, the CODS, and the user sector. This third representation level (District Council) introduces specific duties that interfere with the CMS-RJ Representative Configuration and, thus, in the representative and involvement of the users and in the actions of the Council itself.

In order to display the central results of the study, the Representative Configuration established as being the category representing the two rule axes: *Axis 1* involves the rules of eligibility, which define the entities and counselors involved, and the rules of involvement, which demarcate the possibilities of action of these players; *Axis 2* covers the entities' rules of representation, which channel inter-counselor relations, and classify the type of representation carried out.

Axis 1 of representative configuration: rules of eligibility and Involvement

CMS-RJ rules of involvement, established by Law No. 5104/2009 and the Internal Regulations,

Chart 1. User representation entities with the Rio de Janeiro Municipal Health Council (CMS-RJ) (2012-2015).

1 District Health Councils (CODS) *AP* 1.0 (City Center, Port Zone, São Cristóvão, Rio Comprido, Santa Tereza, Ilha de Paquetá and neighboring areas)
2 District Health Councils (CODS) *AP* 2.1 (Copacabana, Botafogo, Lagoa, Rocinha and neighboring areas)
3 District Health Councils (CODS) *AP* 2.2 (Tijuca, Vila Isabel and neighboring areas)
4 District Health Councils (CODS) *AP* 3.1 (Penha, Ramos, Complexo do Alemão, Maré, Vigário Geral, Ilha do Governador and neighboring areas)
5 District Health Councils (CODS) *AP* 3.2 (Méier, Inhaúma, Jacarezinho and neighboring areas)
6 District Health Councils (CODS) *AP* 3.3 (Anchieta, Irajá, Madureira, Pavuna and neighboring areas)
7 District Health Councils (CODS) *AP* 4.0 (Barra da Tijuca, Jacarepaguá, Cidade de Deus and neighboring areas)
8 District Health Councils (CODS) *AP* 5.1 (Bangu, Realengo and neighboring areas)
9 District Health Councils (CODS) *AP* 5.2 (Campo Grande, Guaratiba and neighboring areas)
10 District Health Councils (CODS) *AP* 5.3 (Santa Cruz and neighboring areas)
11 Associação Carioca de Distrofia Muscular (*ACADIM*)
12 Associação de Movimentos dos Renais Vivos e Transplantados do Estado do Rio de Janeiro (*AMORVIT- RJ*)
13 Associação de Parentes e Amigos de Pessoas com Alzheimer, Doenças Similares e Idosos dependentes (APAZ)*
14 Grupo Unidos de Apoio aos Portadores de Hepatite C*
15 Associação de Amigos, Familiares e Doentes Mentais do Brasil (*AFDM*)
16 Associação Carioca de Diabéticos (*ACD*)
17 *Grupo Otimismo* de Apoio ao Portador de hepatite C
18 Federação das Associações de Favelas do Estado do Estado do Rio (*FAFERJ*)
19 Federação das Associações de Moradores do Município do Rio de Janeiro (*FAM-Rio*)
20 Instituto Afro Brasil Cidadão (*IABC*)

* Entities excluded from the study due to the absence of any representatives in Rio de Janeiro Municipal Health Council (*CMS*-RJ) meetings.
Source:http://www.rio.rj.gov.br/web/SMS/conselho-municipal-de-saude

create equitable conditions of action for the counselors at plenary meetings and for the election to positions of greater decision power in the entity (Chairman, Substitute Chairman, and Executive Committee), without permitting selective privileges and preserving representational parity.

However, the rules of eligibility of the CMS-RJ permit differing circumstances for user representatives, but require an in-depth examination. They establish life-time seats on the ten CODS and competition for the other ten vacancies in the Health Conference elections, for which a variety of entities with municipal jurisdiction of action can become candidates. Accordingly, that this last possibility involves "electoral" type rules, as opposed to the "non-electoral" rules to which the CODS are subject.

Selection of the counselors under these entities' internal eligibility rules is evidence of a second filter which further underscores the inequities between the users. At this level, the municipal bodies select the counselors under "non-electoral" rules, i.e., by recommendation of the President's office or the board of directors. This evidences procedures restricted to senior levels which greatly reduce members' ability to apply for the position of counselor and, normally, this process occurs with absolutely minimal competition. The CODS also have their own "electoral" rules for selecting their municipal representatives. In other words, there is a system of open elections for which these bodies may become candidates for office. Graphic 1 shows the opposition in the arrangement of the rules of eligibility for the two groups.

Graphic 1 shows that the selection of the selection of the CODS representatives is based on a combination of CMS-RJ "non-electoral" rules/ internal "electoral" rules. Inversely, the choice of municipal body counselors is based on a sequence of CMS-RJ "electoral" rules/ internal "non-electoral" rules. Since the rules of eligibility not only limit the selection of players involved in the CMS-RJ, but also represent the first level of relationships between the representatives and their represented parties, it is possible to link these rules to counselor representation practices as defined by Hanna Pitkin[16].

Axis 2 of the Representative configuration: r rules of representation

Here, we analyzed the rules of representation of the 18 entities that manage the interaction

Entity Rules *(y)*	+ ("Electoral")
District Health Councils (CODS) *AP* 1.0; District Health Councils (CODS)*AP* 2.1; District Health Councils (CODS) *AP* 2.2; District Health Councils (CODS) *AP* 3.1; District Health Councils (CODS) *AP* 3.2; District Health Councils (CODS) *AP* 3.3; District Health Councils (CODS) *AP* 4.0; District Health Councils (CODS) *AP* 5.1; District Health Councils (CODS) *AP* 5.2; District Health Councils (CODS) *AP* 5.3	+
- ("Non-electoral")	*(x)* Rio de Janeiro Municipal Health Council (*CMS*-RJ) Rules
-	*ACD; AFDM; FAFERJ; FAM-Rio; IABC; AMORVIT; ACADIM*; Grupo Otimismo**

Graphic 1. Axes of the Rules of Eligibility as applied to Rio de Janeiro Municipal Health Council (*CMS*-RJ) users.

* Entities indicated by *SMS*-RJ to be part of the Rio de Janeiro Municipal Health Council (CMS-RJ), despite the recommendations of the rules of eligibility.
Source: Preparation by the Authors based on the normative documents of the Rio de Janeiro Municipal Health Council (*CMS*-RJ) and on interviews with counselors in office during 2013/2014.

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with their representatives on the CMS-RJ, dealing with representation positions, duly classified as: mandate, autonomy, and autonomy-mandate. This analysis was based on interviews with the counselors, since the municipal entities and the CODS regulations do not explain these rules.

In assigning a value to the influence of the rules of representation in the context of the balance of the mandate and autonomy elements, *mandate* type positions were deemed to be those *chiefly* influenced by the interests of the entities and represented groups, while the internal rules were viewed as an important means for strengthening bonds between the counselors and the entities. *Autonomy* type positions embody the *majority* representation as guided by the judgment of the respective counselor on how to carry out health policies, in a context where the entities' rules have a reduced ability to define practices representing the interests of the represented citizens. However, *autonomy-mandate* positions are those where the rules of representation enable counselors to combine the two trends *in a balanced manner*, to thus represent the interests of the entity in line with the general interests of the *SUS* users, duly symbolized by the "*Health as a Right*" motto highlighted by Moreira[10].

Although the municipal entities hold meetings with their represented citizens to deal with health requirements, it is only in the cases of *ACD*, *FAFERJ*, *FAM-Rio,* and *IABC* that these meeting actually contribute to indicating the interests of the respective groups in order to give the representatives a base from which to work. Furthermore, only the *FAFERJ* and *IABC* counselors advised us that the meetings include specific debates on CMS-RJ matters and the transmission of the entity's involvement.

Thus, it can be seen that few of these entities have rules favoring effective representation practices by the Council. The most emphatic examples are those shown by *AFDM*, which, currently, does not hold meetings for structural difficulty reasons, and *AMORVIT*-RJ, and *Grupo Otimismo*, whose representatives state that the actions of the CMS-RJ make no contribution to these entities' objectives.

These rules of representation features were reflected in a scenario where almost all the municipal entity counselors (with the exception of the *FAM-Rio* representative) stated that their actions were substantially guided by their views on the interests of the entities and the needs of *SUS*, which underscores the influence of the *autonomy of representation trend*.

In turn, all the CODS have their objective rules for organizing monthly plenary meetings that, given the very nature of the subject matter, involve specific discussion on the health issues of the respective *APs*, including topics relating directly to the CMS-RJ agenda. Moreover, six of the group members interviewed, mentioned the utilization of practical representation tools, such as reports on involvement in the CMS-RJ, statements showing CODS requirements, and statements of position.

The CODS rules of representation also include monthly inter-district meetings between the municipal presidents and representatives of the ten bodies, covering CMS-RJ matters and health-related topics involving the *APs*. As stated by nine of the individuals interviewed, the purpose of these meetings was to discuss the interests of CODS users and reach a common decision regarding the topics under debate.

These rules ensure a robust working relationship between the CODS and their representatives, to the extent that all group counselors, with the exception of the *AP* 2.1, representative, stated that their actions were substantially based on the user interests agreed in these councils, a clear illustration of the *representation mandate trend.*

In order to specifically demonstrate these findings, Chart 2 shows the results of the analysis of the rules and representation relations of the 18 entities assessed and listing the rules of eligibility, thus characterizing the Representative Configuration of the CMS-RJ.

In the municipal entities, the *Electoral*"/"*Non-electoral*" section of the rules of eligibility (Axis 1) does not encourage contact between entities and counselors. This is because the "electoral" rules of the CMS-RJ contain some flaws – both institutions were indicated by the *SMS*-RJ and the other two (excluded from this study) did not even trouble themselves to be present at the Council – and the entities' internal rules order the selection of counselors via procedures that neither involve the actions of their members nor the *SUS* users. By combining this direction with the rules of representation (Axis 2), the counselors of this group tend to a certain *autonomy* in their CMS-RJ activities, as pointed out in the distribution of representation positions: 4 autonomy types, 3 autonomy-mandates, and 1 mandate.

In the CODS, the "*Non-electoral*"/"*Electoral*" sequence of the rules of eligibility requires that municipal representatives be chosen by elections involving user members in the respective *APs*.

This is combined with a standard set of rules of representation encouraging strong relations between counselors and instances, in addition to bringing together a group of representatives at the inter-district meetings, pursuant to the *mandate* type model representation, shown by the composition of positions of the group actors: 7 mandate types, 2 autonomy-mandates, and 1 autonomy.

Relations between Rio de Janeiro Municipal Health Council (*CMS*-RJ) representation and involvement

The representation scenario was based on the joint involvement of the counselors in the CMS-RJ, the analysis whereof included monitoring the 24 ordinary assemblies and the extraordinary assemblies of 2013 and 2014. To this end, the Council's discussion agenda was examined, with

Chart 2. Representative Configuration for Rio de Janeiro Municipal Health Council (*CMS*-RJ) users*.

Entity	Axis 1:Rio de Janeiro Municipal Health Council (*CMS*-RJ)rules of eligibility	Axis 1: Entity rules of eligibility	Axis 2: Rules of representation
ACADIM	"Electoral" type*	"Non-electoral" type (president)	Autonomy
Otimismo	"Electoral" type*	"Non-electoral" type (president)	Autonomy
AMORVIT-RJ	"Electoral" type	"Non-electoral" type (president)	Autonomy
AFDM	"Electoral" type	"Non-electoral" type (board)	Autonomy
ACD	"Electoral" type	"Non-electoral" type (board)	Autonomy-mandate
FAFERJ	"Electoral" type	"Non-electoral" type (board)	Autonomy-mandate
FAM-Rio	"Electoral" type	"Non-electoral" type (board)	Mandate
IABC	"Electoral" type	"Non-electoral" type (board)	Autonomy-mandate
District Health Councils(CODS)AP 1.0	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 2.1	"Non-electoral" type	"Electoral" type	Autonomy
District Health Councils(CODS)AP 2.2	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 3.1	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 3.2	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 3.3	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 4.0	"Non-electoral" type	"Electoral" type	Autonomy-mandate
District Health Councils(CODS)AP 5.1	"Non-electoral" type	"Electoral" type	Autonomy-mandate
District Health Councils(CODS)AP 5.2	"Non-electoral" type	"Electoral" type	Mandate
District Health Councils(CODS)AP 5.3	"Non-electoral" type	"Electoral" type	Mandate

* Entities indicated by the *SMS*-RJ despite the requirements of the rules of eligibility of the Rio de Janeiro Municipal Health Council (*CMS*-RJ)
Source: Prepared by the Authors based on documents of the Rio de Janeiro Municipal Health Council (*CMS*-RJ) and on interviews with the counselors active in 2013/2014.

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due importance placed on the three points that led to intense debates and provided opportunities for the counselors to take part in the Health Decision process (i) presentations on pathologies, situations, and health-related actions; (ii) explanations by the SMS-RJ; (iii) presentations of SMS-RJ management tools. Value was given to information provided by counselors that, despite not leading to consistent decisions, represented an important user situation activity.

Thus, 38 presentations were covered, 31 of them given by SMS-RJ members (among them some counselors). Of these, 11 were management tool addresses (SMS-RJ plans, budget directives, rendering of accounts, and administrative reports) with only five voting sessions which approved the materials; six explanations by the SMS-RJ, and 14 presentations on pathologies, situations, and health-related actions. This shows management sector leadership in covering these topics, while, in the study period, only three presentations were given by user counselors.

Our analysis of the involvement of these players considered *strength of action* as being the chief parameter. The criteria applied defined the level of action (+) such as merely attending meetings and taking part in CMS-RJ voting. The (++) level indicates that, in addition to voting, there is also the process of providing the council with important information and sporadic presence at the central points of the topic, without considering SMS-RJ management tools. Then, there is intensive action (+++), which is characterized by more frequent interventions in the chief topics with irregular action involving management tools. Lastly, intensity (++++) indicates involvement with consistent and constant interventions in the decisions of the CMS-RJ, including such tools.

Another standard utilized in the study was the counselors' *action profile*. This enables us to classify the players in accordance with the most characteristic involvement practice for the following categories: (i) claiming: action limited to voting; (ii) informative: searching for information on health-related actions; (iii) vocalizing: vocalization of the entities' interests; (iv) demands: demands for improvements in the *SUS* services; (v) evaluative: evaluations (and criticisms) of the manner in which *SMS*-RJ policies are carried out. Chart 3 shows the results of the assessment of the counselor involvement in the CMS-RJ with the findings on representation.

Chart 3 shows the disparity between the user groups: while all the municipal entity counselors (with the exception of the *ACD* representative) were classified by a degree of action (+) or (++), six district counselors took intensive action in the meetings, at (+++) or (++++) and none was classified at (+). In other words, half of the first Group players took part in the meetings purely by exercising their voting right, whereas, at some time, all the District Health Council (*CODS*) representatives took part in the central decisions of the CMS-RJ.

Since the Demanding, Vocalizing, and Evaluative profiles applied to six of the more active district players, it would seem that claims for improvements in the *SUS*, projection of demand by the entities, and evaluations of the *SMS*-RJ management policies reveal the actual action of Council users.

Considering that Chart 3 shows the Representation-Involvement relations of the 18 counselors assessed, advances in familiarity with these relations within the environment of the CMS-RJ require an analysis of the user groups. With this in mind, Chart 4 summarizes the research findings, and indicates the influence of Representative Configuration in this sector's performance.

Chart 4 shows that, in the municipal entities, the category of "*Electoral*"/"*Non-electoral*" of the rules of eligibility and the rules of representation resulted in an autonomy type representation model, which released an erratic involvement in the CMS-RJ, classified as intensity (+/++). In the CODS, the "*Non-electoral*"/*Electoral*" topic of the rules of eligibility combined with the objective rules of representation for the CMS-RJ show a representation model mandate, which reflected faster action at the council, and scored (+++/++++).

The protagonist role of the district counselors is borne out by the occupation of high decision power positions at the CMS-RJ, which offers increased opportunities for involvement in the topics and progress of the meetings. In an interval in the study, the two teams from the Executive Commission of the CMS-RJ included six District Health Council (*CODS*) representatives but only two municipal entity counselors. Furthermore, the President's two substitutes elected during this period represented the *AP* councils 5.1 and 5.3.

An analysis of the alliances and conflicts showed that the most active actions between users are District Health Council (*CODS*) representatives at the inter-district meetings, join forces to form an action bloc at the CMS-RJ. Conversely, the alliances between the municipal entity counselors were ineffectual as were those between the two user groups which limited

Chart 3. Representation-Involvement relations of Rio de Janeiro Municipal Health Council (*CMS*-RJ) users.

Group	Entity	Representation position	Degree of action	Synopsis of action
Representatives of Municipal Entities	*ACADIM*	Autonomy	++	Vocalizing
	Grupo Otimismo	Autonomy	+	Voting
	AMORVIT-RJ	Autonomy	++	Evaluative
	AFDM	Autonomy	+	Voting
	ACD	Autonomy-mandate	++++	Revindicative
	FAFERJ	Autonomy-mandate	++	Vocalizing
	FAM-Rio	Mandate	+	Voting
	IABC	Autonomy-mandate	+	Voting
Representatives of District Councils	District Health Councils (CODS)*AP* 1.0	Mandate	++	Revindicative
	District Health Councils (CODS) *AP* 2.1	Autonomy	+++	Evaluative
	District Health Councils (CODS) *AP* 2.2	Mandate	++	Revindicative
	District Health Councils (CODS) *AP* 3.1	Mandate	+++	Revindicative
	District Health Councils (CODS) *AP* 3.2	Mandate	++	Informative
	District Health Councils (CODS) *AP* 3.3	Mandate	+++	Vocalizing
	District Health Councils (CODS) *AP* 4.0	Autonomy-mandate	++++	Evaluative
	District Health Councils (CODS) *AP* 5.1	Autonomy-mandate	+++	Vocalizing
	District Health Councils (CODS) *AP* 5.2	Mandate	++	Vocalizing
	District Health Councils (CODS) *AP* 5.3	Mandate	++++	Revindicative

Source: Prepared by the Authors based on documents of the Rio de Janeiro Municipal Health Council (*CMS*-RJ) and on interviews with the counselors active in 2013/2014.

themselves to priority voting topics, to elections to the office of President, and to membership of the board.

At the level of inter-sector relations, whereas, municipal counselors took a neutral position both in respect of taking action and of conflict manifestation, the district counselors (with the exception of the *AP* 2.1 and 4.0 representatives) were more inclined to form alliances with the management sector in order to work in the interests of the users of the respective areas and to strive for upgrades in *SUS* services. Conflicts were noted between the District Health Council (*CODS*) representatives and the workers' sector, the latter persistently opposing the Social Organizations management model, in place at the *SMS*-RJ.

Accordingly, our findings show that the counselors of the more active users tended not to assume a veto player position in respect of management since their mission was to act in the interests of the represented citizens and for inter-district agreements. This bears out the Moreira and Escorel analytical model[8], since, the less users systematically veto the *SMS*-RJ proposal, the more management does not react by restricting funds. This is why the CMS-RJ functions better than most.

Final Considerations

The results shown would suggest that the outstanding involvement of the district counselors in the CMS-RJ shows a substantial representation of user interest as established in the domain of the CODS, resulting in its conspicuous position at municipal level. This underscores the importance of the political and strategic position of the CODS in municipal health decision policies, as much as for handling major *SUS* services management as for bringing to bear their proposals at the CMS-RJ.

It is also apposite to point out that the analysis of the Representative Configuration – jointly with the rules of eligibility, involvement, and representation – and its influence on the empirical actions of the counselors led to advances in the understanding of the Representation-Involvement relation at Municipal Health Council (*CMS*) level, through a specific study in Rio de Janeiro. On this matter, the article contributes

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Chart 4. Representative Configuration Influenceon user action.

	District Councils	Municipal entities
Axis 1: Rules of eligibility of the Rio de Janeiro Municipal Health Council (*CMS*-RJ)	"Non-electoral" type: Lifetime seat for all 10 District Health Councils(CODS)	"Electoral" type: Election of 10 entitiesat the World Health Conferences
Axis 1: Rules of eligibility for theentities	"Electoral" type: Election of the municipal representative from among the District Health Council(CODS) users	"Non-electoral" type: Recommendation of the counselor by the entities' boards/ president
Axis 2: Rules of representation	Monthly meetings covering topics directly relating to *SUS* and to theRio de Janeiro Municipal Health Council (*CMS*-RJ) agendas; Closer ties between the District Health Council(CODS) representative and inter-district meetings: Mandate Trend	Ineffective rules for running meetings involving debates about the Rio de Janeiro Municipal Health Council (*CMS*-RJ)and representations practices at this entity; Counselor-entity distancing: Autonomy Trend
Degree of action	(+++ /++++) Preferential occupation of senior positions on the Rio de Janeiro Municipal Health Council (*CMS*-RJ)	(+/++)
Alliances and Conflicts	Strong alliances in the inter-district meetings; Discussions with managers to confirm compliance with user demands	Alliances with users limited to central voting and elections of the Rio de Janeiro Municipal Health Council (*CMS*-RJ); Minimal alliances and conflicts with other sectors
Action: Representation-Involvement	Protagonism in involvement in user sector plan, dominating the representation of the interests of *AP* users; importance in the overall functioning of the *CMS*-RJ	Secondary involvement in the user plan sector, with limitations in entity representations; discreet role in the dynamics of the functions of the *CMS*-RJ

Source: Prepared by the Authors based on documents of the Rio de Janeiro Municipal Health Council (*CMS*-RJ) and on interviews with the counselors active in 2013/2014.

to improved familiarity with social involvement in *SUS*, particularly because it presents objective findings regarding interactions between counselors and entities.

Based on the above and, given the frequent criticisms directed towards the political actions of the councils, it could be suggested that the counselors, experts, and managers discuss relations between counselors, entities, and the population at large, in order to strengthen the representation of *SUS* users and to encourage effective and transformative social involvement. The perspective covered in the study is a good reason for discussing the impact of institutional rules on these outcomes. They suggest the need for robust regulations resulting in democratic counselor selection processes, allied to involvement practices representing user interests.

Collaborations

RB Rezende and MR Moreira participated equally in all stages of preparation of the article.

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