Municipal Health Councils of Brazil: a debate on the democratization of health in the twenty years of the UHS

Conselhos Municipais de Saúde do Brasil: um debate sobre a democratização da política de saúde nos vinte anos do SUS

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Abstract *Over 17 years, Health Councils were created in the 5,564 Brazilian towns, recruiting about 72,000 councilors. Authors affirm that the institutionalization of the Council is important for the democratization of municipal health policy, as it increases the actors who are participating in its decision-making process. However, they state that this is not enough to make this process fully democratized. This setting is investigated through a new census research about the functioning of the Municipal Health Councils. To understand it, we use three analytical dimensions (autonomy, organization and access) made up of 18 variable. The analysis of results shows that the MHCs have problems with autonomy and organization and good performance in access. Distribution by population size reveals that the best results are in the MHCs of towns with more than 250,000 inhabitants, and the worst are those in towns with a population below 50,000. The problems identified are reactions to the institutionalization of the MHCs. These reactions come from governors who consider the attributes and the deliberative character of the MHCs to be threatening to their interests. They occur due to their low cost, as the rules of the decision-making process do not discourage them. Here, we seek to understand reactions and rules, presenting proposals for overcoming problems.*

Key words *Democratization, Participation, Health policy*

Resumo *Em dezessete anos, os Conselhos de Saúde foram criados nos 5.564 municípios do país, arregimentando cerca de 72.000 conselheiros. Autores afirmam que a institucionalização dos Conselhos é importante para a democratização da política municipal de saúde, pois amplia os atores que participam de seu processo decisório. Constatam, porém, que isto é insuficiente para tornar tal processo efetivamente democratizado. Este cenário é investigado por meio de inédita pesquisa censitária sobre o funcionamento dos Conselhos Municipais de Saúde (CMS). Para compreendê-lo, utilizam-se três dimensões analíticas (autonomia, organização e acesso) compostas por dezoito variáveis. A análise dos resultados mostra que os CMS têm problemas com autonomia e organização e bom desempenho no acesso. A distribuição por portes populacionais revela que os melhores resultados são os dos CMS de cidades com mais de 250.000 habitantes, e os piores, de população inferior a 50.000. Os problemas identificados são reações à institucionalização dos CMS. Estas proveem de governantes que consideram as atribuições e o caráter deliberativo dos CMS, ameaças a seus interesses. Ocorrem por seu baixo custo, pois as regras do processo decisório não as desestimulam. Busca-se, aqui, compreender reações e regras, apresentando-se propostas de superação de problemas.*

Palavras-chave *Democratização, Participação, Política de saúde*

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Introduction

The year 2008 is an important mark for Brazil's recent democratization: in October, the Federal Constitution declared in 1988, which established health as a right for all and a duty of the state, completed twenty years with no authoritarian intervention, a fact that has never occurred before in Brazil. For their part, Laws 8080[1] and 8142[2], which organize the workings of the Unified Health System (UHS) laid out in the constitution were eighteen years old in September and December.

A direct result of the struggles against the military dictatorship (1964-1985) and the battles for hegemony in conducting the re-democratization process, this set of laws produced important changes in the institutional design of the Brazilian state, reinvigorating traditional spaces of participation in society and creating new ones.

As they institutionalized the participation of organized society in the social policy decision-making process, the managing councils are the main examples of this democratization of the state[3]. Among them, the Health Councils, created in the 5.564 Brazilian towns, stand out. These represent the broadest initiative for politico-administrative decentralization ever implemented in the country.

The importance and complexity of this political process has been highlighted by different authors[4-10] whose analysis, elaborated at different moments and based on conceptual approaches or local and regional case studies, converge on one aspect: the institutionalization of the councils is important for the democratization of municipal health policy, as it broadens and diversifies the number of actors that participate in its decision-making process. However, in itself, it is not enough for the decision-making process to be fully democratized.

This article investigates this setting, relating it to reactions from public power to the institutionalization of the MHCs, especially regarding the attributes and the deliberative character of the councils. For this purpose, it analyzes a new census study about the functioning of Brazilian MHCs, seeking to identify how and in what situations these reactions interfere with the democratization of municipal health policies.

Democratization and public policies

In contemporary society, few political ideas are as widely accepted as democracy[11]**.** This influence, while positive, reflects and nurtures the polysemic nature of democratic conceptions, generating the need, in order to be fully understood, for adjectivation[12,13]; representative, participatory, deliberative, direct, substantive, formalist, elitists, pluralist, etc.

Questions on who takes the decisions that interfere in the directions of society; what decisions they can take; and how the decision-making process works are common and central elements of these conceptions[14]. Therefore, the scope and the limits of their answers constitute their main divergences.

Postulating as democratic a political regime in which the state is almost entirely responsive to all of its citizens, Dahl[15] considers that although there are regimes that seek to be so, none really is. Starting with a regime where the state and the decision-making process are controlled by a group – a closed hegemony – he identifies three paths for this search: (i) increasing the possibilities for participation of new actors (***inclusiveness***) in a setting where institutions that would allow it do not exist or are not legitimized by the governors, transforming the regime into an ***inclusive hegemony***, where new actors participate in the decision-making process, but have little power; (ii) consolidating and broadening the institutions that make public participation and debate possible (***liberalization***) in a setting of restricted inclusiveness, which generates a ***competitive oligarchy***, where institutions make possible the expressions of internal contradictions in the oligarchies that control the state and the power of decision; and (iii) increasing inclusiveness and liberalization more or less concomitantly, where new actors can participate effectively in the decision-making process because there are autonomous and organized institutions that work well, no matter who occupies the government.

Considering this last one to be the path to democratization, Dahl states that the regimes which followed it and those that arrived at it through an evolution of the first two have considerably institutionalized and increased the number of citizens whose interests are considered by the state. They have achieved this because they elevated the costs of suppressing participating and of the institutions above the costs of acceptance, restricting the state's opportunities to act non-responsively. As they have not reached the limit of this process, the author considers them to be not yet democracies, but ***polyarchies.***

Przeworski[16] deepens Dahl's analysis in the liberalization path, considering institutions as vital for democratization, since their rules of functioning define the increase/reduction of the costs of suppressed/acceptance alluded to. For him, increasing participation, while fundamental, in itself generates

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conflicts of interests. In order for there not to be any steps backwards, the conflicts must be made public and fought in institutions capable of: guaranteeing the right of different political actors to pursue the satisfaction of their interests; allowing different interests to always be able to dispute their satisfaction; preventing any interest from being significantly affected during this dispute; not allowing any actor to be certain in advance that their interests will win; and not encouraging any actor to expect to alter, ***ex post***, the result of the dispute.

Dahl's analysis values actors and institutions in representative democracy, although he recognizes the importance of organized society and, in a recent work[17], opens space for participatory and deliberative democracy. Przeworski, closer to the Latin-American countries that fought against dictatorships in the 1980s-1990s, states that, in authoritarian periods, the actors that are able to voice their interests don't do so through political parties (usually forbidden) but through unions, churches, local associations and other movements of organized society which, if they are successful, are unlikely to be incorporated by traditional representative institutions.

This situation locates democratization in two arenas[11]: that of macrostructures which define the broader and more traditional institutional framework of a representative democratic regime; and that of the participation and deliberative spaces that offer to incorporate the new and different actors that wish to participate in the decision-making process. Recognizing that these spaces – institutional innovations – could even risk the existing macrostructural arrangement, Santos & Arvritzer[18] consider democratization to necessarily pass through the ***most profound articulation between representative democracy and participatory democracy*** [**...**] ***recognition by the government that participatory proceduralism, the public forms of government monitoring and the public deliberation processes can substitute part of the representation process*** [**...**] ***a new political institutionalism that puts back on the democratic agenda the questions of cultural plurality and need for social inclusion***[18].

Manim[19], for whom democratization is also the fruit of discursive battles fought in institutions that bring together the different actors, seeks to give concrete forms to this articulation. For him, these institutions should be deliberative, that is, they should allow all political actors to be equally able to defend their interests, explaining the differences in the arguments presented to them and, based on these, moving on to the construction of possible agreements.

Cohen[20] stresses that deliberative practice should not aim to reduce the diversity of interests, but rather to seek collective decisions, for he believes that democratization occurs when the authority to exercise state power is granted by the collective decision of those who are governed by this power.

Democratization can, therefore, in macro terms, be considered as the historical process in which, in a given political regime, the state/society relation gradually becomes closer and more responsive. This happens as an increasingly large number of citizens have the opportunity to participate continuously and deliberately in the institutional framework in which the decision-making process of public policies takes place. This participation is only possible when institutional rules make the costs of accepting the conflicts of interests lower than those of suppressing them.

However, public policies, as well as sector ones (health, education, social protection...) are subnational (formulated in states and towns where political power increases with the federalization of the regime). This means that democratization also occurs in micro terms, where actors, their interests, the decision-making process and the institutional framework vary according to the subnational units and the public sector producing the policies. It is in this sense that this article analyzes the democratization of municipal health policies.

Democratization of Municipal Health Policies in Brazil

The LOS – Organic Health Law (8080/90) determines that the management, the actions and the services of the UHS must follow certain structuring principles and be in agreement with the directives set out by the Federal Constitution for health policy. In both cases, society's participation appears. Regulating LOS, Law 8142/90 defines health councils and conferences as mandatory events that, on national, state and municipal levels, institutionalize participation.

In the health sector, therefore, democratization was incorporated to the rule that makes the decision-making process official. This is the result of the path dependence of the sector, the actors of which, in preceding historical moments, gave preference to such choices, connecting them to future political action and producing the current institutional[21] arrangement. For this reason, in order to understand the MHCs' shortcomings in democratizing the decision-making process of municipal

health policies, it is necessary to study the path of its institutionalization.

Carvalho[22] linked the origins of the health councils, among other factors, to the actions of organized society in the period 1970-1990, emphasizing the struggle against the military dictatorship. Escorel and Moreira[23] updated this reflection to the second half of the 1990s and 2000s, focusing on the transformations of the role it plays in health policy making.

The starting point for these authors is the coverage extension programs financed by the international health agencies that, in the 1970s, encouraged the serviced communities to participate in the execution of sanitary works. This "community participation", disconnected from the discussion of social problems, was advocated as an autonomous for of organization capable of generating social improvements.

For them, the addition of organized society action and the radicalization of political opposition to the military dictatorship created, still in the 1970s, new directions for participation: the focus started to be "the people", understand as the part of the population that was excluded or subordinate in the access to goods and services (thus, "popular participation"); the overcoming of local problems was placed in the context of overcoming national problems; the locus of action went beyond health services, spreading to society as a whole; and the objectives started being universal and free access to health services, and control of the state, which represented the interests of the dominant class.

The movement for Sanitary Reform, which saw as inseparable the struggles against dictatorship, in favor of re-democratization and the guarantee of health as a citizen's right and duty of the state, incorporated popular action and acted through it. The height of this process occurred in 1986, at the 8th National Health Conference (CNS), the Final Report[24] of which proposed the creation of a universal, public and free health system, which would have participation as one of its principles. To put it into practice, the Report proposed, among other measures, the creation of municipal councils made up of health users and workers elected by local society to fulfill the role of controlling executive power and the private sector.

This proposal was not incorporated by Law 8142. Through this law, an attribute of the MHCs is participation in the formulation of strategies and control of health policy execution, including in economic and financial aspects. For this, they should promote, in ordinary and periodical meetings, the debate about health policy, in a deliberative process with the participation of sectors the interests of which are affected by health policy: UHS users, represented by civil society entities, who hold 50% of the places; and health workers, service providers and managers who, together, have the other 50%.

This indicates the rise of "social participation" which, preferring agreement, articulation and associativism, stops referring only to the people (although it considers its importance) to take into account the diversity of interests and projects in society, recognizing the state as an arena for articulation and political struggle between the different interests that dispute space and power. It does not mean, however, that it has become consolidated as predominant, as "popular participation" also remained influential in organized society. Besides, the position that society should participate directly in the execution of policies, an essence of community participation, was taken up with the managerial reform of the state promoted by the Union from 1994-2002.

Keeping to certain limits, as the author deals with democratization in a societal scope while this article tackles a sector dimension of the process, it is possible to consider that, in its institutional experimentalism, the MHCs are uniquely inserted in the Dahlsian axes: at the same time that they increase the participation of new actors in the decision-making process, they are one of the institutions where the interests of these compete with those of other political actors. The results of these competitions, at least in theory, become interests of the MHCs, which will dispute their satisfaction with the interests of the other institutions that participate in the decision-making process.

This characteristic represents ***double participation***[25]: the participation of new political actors in the MHCs and the participation of the MHCs (and, as a result, of the new actors) in the decision-making process of municipal health policies.

This double participation multiplies the forums where the actors and the interests they represent dispute power. In general terms, it can be said that there are two macro-forums: an internal one, made up of the council chambers during their meetings; and an external one, which is the decision-making process of municipal policies itself, in which the MHCs have to dispute space and power with other institutions to satisfy their interests.

In both, for the MHCs to be successful, there has to be recognition and legitimization, whether from the political actors who have a voice in the council or from the political institutions that take part in the decision-making process of municipal health policies. This relationship is structured on a

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unique point: the Municipal Health Offices (MHOs), which represent the executive branch, as well as being the only actors with prerogatives and legal obligations that demand participation in all stages of the decision-making process, they are also responsible for providing adequate conditions for the functioning of the MHCs, especially infra-structure and human and financial resources, which indicates a concentration of power similar to what Abricio classifies as "ultrapresidentialism": [when] ***executive power*** [**...**] ***is the main agent in all stages of the government process, relegating the legislative assembly to a secondary plane*** [**...**] ***the mechanisms of control of public power*** [**...**] [are] ***not very effective, turning the political system into a presidentialism without checks and balances***[26] .

Although the author refers to the state decision-making process, here this reality is considered to be reproduced at a municipal level since Brazilian towns experienced more restricted democratic processes than those of the Union and the federal units. It is enough to remember that, in different historical moments and political situations, mayors were nominated by state interveners, governors and even by the president of the republic.

Mayors who use ultra-presidentialist practices – because they continue a pre-existing political setting or because they adhere to authoritarian, clientelist and physiological practices – have such inflated interests that any proposals of change, even if measured, always seem to threaten them.

As this article is not interested in discussing the justice of this position, but rather in understanding its repercussions for the democratization of the decision-making process, the analysis of this situation through Przeworski's proposal demonstrates that the element which most provokes uncertainty in the municipal executive in relation to its interests being respected is the deliberative character of the MHCs.

Although it doesn't define this deliberative character and say how it works, law 8142/90 establishes and defines that it is up to executive power to authorize MHC deliberations within 30 days. For the current practice of councilors, health workers and even academics, a deliberation is a decision made by the MHC chamber, usually by vote, on health policies, indicating that in this aspect "***popular participation***" proposals prevail over "***social participation***" ones.

From the point of view of the other political actors involved in the decision-making process, this process tends to be seen as a problem: in an institution where half of the councilors represents the same segment, there are concrete possibilities for these, alone or with a low cost of transaction, to be able to unite in order to have their interests met – especially the veto ones – independently of the interests of other represented segments.

The trend is exacerbated because the deliberations can be made by a reduced quorum of councilors. Depending on the internal regime of each MHCs, it can happen that most councilors present at a meeting, regardless of how many there are, are authorized to approve a deliberation about health care.

There is another aggravating factor: as there is no legal definition for the deliberative character of the MHCs, there are also no rules to hold the MHCs responsible for the results and impacts of their deliberations.

This deliberative practice has negative repercussions on ultra-presidentialist managers who, having no guarantee that their interests will be respected (which, generally, is also felt by the service providers), start to find the costs of MHC acceptance to be high.

As law 8142 defines that in order to receive the resources from the National Health Fund, towns, states and Federal District must create and maintain their respective councils, the costs of MHC suppression become prohibitive, guaranteeing the advancement and consolidation of inclusiveness. On the other hand, the fact that there are rules that make the UHS responsible for providing conditions of autonomy for the MHCs, but these rules do not stipulate sanctions for noncompliance, considerably reduces the costs of reactions that mitigate or deny them structure, equipment, staff and budget. Besides, there are powerful arguments for fiscal and monetary austerity that also reduce these reactions.

The reduction of MHC autonomy is reflected in their organization, chiefly with respect to internal bodies (board table, executive office and permanent commissions), which need a place to work, employees to systematize their work and organize documents, resources to finance their daily costs, etc. As these are important for the good functioning of the councils[6,27], being responsible for strategic tasks such as initial appreciation and triage of subjects to be debated in a chamber, elaborating technical reports and making administrative and normative decisions, their nonexistence would affect the participation of the councilors in the decision-making process. This is even more damaged in the MHCs where the UHS, as well as not permitting conditions of autonomy, holds the presidency, a position that allows it to concentrate and control power over the agenda and the discussions and, therefore, the direction of the meetings and decisions.

This situation reveals how institutions can react to other institutions, seeking to shape them and even paralyze them; [...] ***based on the distribution of financial, organizational and ideological resources, institutions determine in advance the likelihood that certain private interests will be realized*** [...] ***this distribution of likelihoods – which is nothing more than political power – is jointly determined by the resources that the*** [...] ***[actors] bring to politics and by the specific institutional arrangements***[16].

In this way, there is a strong elevation of participation costs, which demands personal investments from councilors (dedication, time and money) to fill institutional gaps. The negative impacts are felt most by representatives of UHS users. Differently from other councilors who, as a rule, participate in the council as part of their paid professional activities, these are mostly militants from entities whose institutional mission is not necessarily linked to the health sector.

Dependency and functional disorganization, as mentioned above, corrode the consolidation of the MHCs as institutions that make deliberative participation possible for the different actors interested in the decision-making process of municipal health policies. Therefore, they affect the sector's liberalization, taking over the actors' power to intervene in the directions of social decisions.

The Brazilian democratic process, regarding the health sector at a municipal level, takes on characteristics of inclusive hegemony that, in seventeen years, became capable of promoting a vigorous increase in participation, but was still not able to legitimize and consolidate the institutions that are responsible for making the effective participation of new actors viable.

This analytical picture was applied to the data collected by a census research that aimed to study the functioning of the MHCs and the methods and results of which are presented and debated below.

Methodological aspects

Produced within the scope of the research "***Monitoring and Support of UHS Participatory Management"***[28], the data was collected via an instrument applied to all the MHCs in the country (5,564) and answered by 5,463 (98%), which constitute the work universe, for the year of 2007.

To analyze it, three dimensions were elaborated: (i) ***"autonomy"***, the capacity for councils to function independently of the political convictions of those who occupy the municipal executive. To portray the conditions of this functioning, the more structural aspects of autonomy were worked on, such as the physical part, equipment, human and financial resources; (ii) ***"organizations"***, which refers to the existence of internal bodies and to the performance of qualification and meetings; and (iii) ***"access",*** which reflects the possibilities for all councilors to run for the position of MHC president and for the population to take part of the daily life of the councils.

These dimensions are made up of eighteen variables, presented in Table 1. As sixteen of these are dichotomic, it was decided to work in their way. For purposes of comparison, the remaining two were transformed into dichotomies, based on the following criteria: for ***"frequency of meetings"*** frequencies equal or lower than ***"monthly"*** were found to be adequate, while frequencies higher than ***"monthly"*** were considered inadequate; and for the variable ***"President's sector"*** the segments ***"users", "service providers"*** and ***"workers"*** were considered inadequate.

To ensure the research is ethical, it is necessary to explain that the MHCs, municipal executive organs, are legally responsible for making accessible a series of information that is in the "public interest". As the information worked on here fits into that context, it is considered that this publishing, apart from not causing any harm, brings benefits to society, as it will have access to data which, although it is public, has not been widely worked on. Besides, all those who answered the instrument were informed (and consented) that the data collected would be published, including on a virtual site[28].

Municipal Health Councils in Brazil

Table 1 presents the year of creation of the 5,463 MHCs that make up the universe of this article, showing that the period 1991-1997 had the highest number of councils created (76.7%). These years are marked by the initial impact of the rules that create and make MHCs compulsory and by the great quantity of locations that became towns, which also explains the fact that, over the following years, MHCs continued to be created.

The 5,463 MHCs count with 72,184 titular councilors, out of which 36,638 represent UHS users. In national terms[4], 66% of the 27,669 entities that represent UHS users are neighborhood associations (25%), religious groups (21%) and workers' organizations (20%). Then come entities that represent aspects related to gender, ethnicity and age bracket (7%), bearers of disabilities and pathologies (5%), philanthropy (4%), education,

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Table 1. Municipal Health Council - MHC according to year of creation, Brazil.

Year of creation	MHC created	
	N	%
Before 1991	312	5.7
1991	1351	24.7
1992	281	5.1
1993	758	13.9
1994	477	8.7
1995	176	3.2
1996	145	2.7
1997	1003	18.4
1998	196	3.6
1999	98	1.8
2000	50	0.9
2001	233	4.3
2002	38	0.7
2003	31	0.6
2004	27	0.5
2005	98	1.8
2006	18	0.3
2007	13	0.2
Not informed	158	2.9
Total	**5463**	**100**

Source: ParticipaNetSus – 2008 (www.ensp.fiocruz.br/participanetsus), Moreira and Escorel[28]. Organized by the authors.

sports and culture (4%), patronage (4%), public power (3%) and the users on unspecified services (2%). There are also 5% of representatives who belong to entities so diverse and rarely mentioned that they had to be grouped into a category called "other entities".

Regarding entities that represent health workers, unions and workers associations from diverse UHS categories predominate, with the emphasis on the division between workers who are high school graduates and those who are college graduates. Service providers are mostly linked to hospitals and private establishments hired by the UHS. Managers, when not represented by the health secretary himself, are nominated by him.

Chart 1 presents and systematizes the MHC functioning conditions according to the size of the population of their respective towns. Analyzing Brazil as a whole, a panorama can be seen in which there are great limitations both in the dimension "autonomy" (especially with respect to nonexistence of headquarters, administrative support staff and own budget allocation) and in "organization" (especially in relation to the non-realization of qualification, which represents the worst results of all indicators).

The "autonomy" dimension is the one that presents, in national terms, the worst results, since, with the exception of the "telephone line" variable, all others display negative performance. Among these, it has to be emphasized that "internet access" has the least negative result, overcoming, curiously, the one about existence of a computer.

In this dimension, the worst results are the ones that refer to: financial resources – only 265 MHCs studied have their own budget and only in towns of more than 2 million inhabitants can a positive result be seen; human resources – there are administrative support teams in 940 MHCs and this variable is positive only in towns of more than 500,001 inhabitants; and physical structure – especially the existence of headquarters, positive for only 906 MHCs.

The dimension "organization" also presents bad national results, especially as, out of the 18 variables, it contains those that have the worst performances: "qualification of councilors", passable for the year 2003 and terrible for 2004, when 90% of the MHCs present a negative response; and "permanent commissions", which are absent from 89% of the MHCs and have a negative performance in all sizes of towns, which does not occur with any of the others.

There are, however, two variables that present positive results on a national scale and in the diverse population sizes, and which refers to the MHC meetings, which are monthly in 82% of the MHCs and which, in the 12 months preceding the research, were not cancelled for a lack of quorum in 66% of the councils.

For its part, the dimension "access" is the one presenting the best results, once more than 70% of the MHCs elect their presidents and, when they hold their meetings, they directly give voice to any citizen who would wish to participate in it. Only the president's segment has a result that is considered negative, for only in towns with between 1,000,001 and 2,000,000 inhabitants are the managers not the presidents of the MHCs.

The two variables in which the MHCs have the best performance make up this dimension: ***"population with a right to a voice at meetings",*** with the least positive result reaching 75%, and ***"meetings open to the population",*** which is the best of all, starting from a minimum level of 83% and reaching 100% for the two largest population sizes.

Chart 1. Profile of the Municipal Health Councils - Distribution of indicators per populational dimension and size of their respective municipalities and Brazil.

		Variables /Size	Up to 5.000	5,001 to 10 thousand	10,001 to 20 thousand	20,001 a 50 thousand
Autonomy	Physical Structure and Equipments	Head Office	No (88%)	No (86%)	No (84%)	No (79%)
		Telephone line	Yes (62%)	Yes (59%)	Yes (63%)	Yes (64%)
		Computer	No (76%)	No (75%)	No (70%)	No (65%)
		Access to the Internet	No (54%)	No (53%)	No (53%)	No (51%)
	Human Resources	Support team	No (88%)	No (85%)	No (83%)	No (76%)
	Financial resources	Own budget	No (90%)	No (88%)	No (89%)	No (88%)
Organization	Meetings	Periodicity	monthly (72%)	monthly (79%)	monthly (85%)	monthly (90%)
		Cancelling of meeting because of lack of quorum	No (78%)	No (68%)	No (60%)	No (56%)
	Training	Training 2003	No (75%)	No (74%)	No (72%)	No (66%)
		Training 2004	No (91%)	No (90%)	No (91%)	No (90%)
	Internal levels	Board of Directors	No (64%)	No (60%)	No (59%)	No (52%)
		Executive Office	No (79%)	No (72%)	No (66%)	No (58%)
		Permanent Com.	No (94%)	No (93%)	No (91%)	No (83%)
Inclusiveness	Access to the Chair	Chair division	Managers (62%)	Managers (65%)	Managers (72%)	Managers (70%)
		Elections for Chair	Yes (74%)	Yes (70%)	Yes (69%)	Yes (68%)
	Participation Meetings	Meetings made public	Yes (69%)	Yes (67%)	Yes (69%)	Yes (70%)
		Open meetings	Yes (84%)	Yes (83%)	Yes (87%)	Yes (90%)
		Right to speak	Yes (73%)	Yes (72%)	Yes (76%)	Yes (80%)

it continues

Table 2. Performance of Municipal Health Council according to selected variables and population size, 2007.

Population size	MHC		MHC *performance*		Inhabitants (%)
	Nº	%	Variables with positive performance	Classification	
Up to 5,000	1349	24,7	6	+	2,7
5,001 to 10 thousand	1281	23,5	6	+	5,5
10,001 to 20 thousand	1364	25,0	6	+	11,7
20,001 to 50 thousand	949	17,4	6	+	17,1
50,001 to 100 thousand	297	5,4	10	++	12,4
100,001 to 250 thousand	141	2,6	11	++	13,1
250,001 to 500 thousand	52	1,0	13	+++	10,7
500,001 to 1million	18	0,3	13	+++	7,5
1,000,001 to 2 millions	7	0,1	14	+++	5,6
Over 2millions	5	0,1	14	+++	13,9
Total	5.463	100	6	+	100

Source: ParticipaNetSus – 2008 (www.ensp.fiocruz.br/participanetsus) - Moreira and Escorel[5]
Organized by Authors

Chart 1. continuation

50,001 to 100 thousand	100,001 to 250 thousand	250,001 to 500 thousand	500,001 to 1 million	1,000,001 to 2 million	Over 2 million	Brazil
No (56%)	Yes (53%)	Yes (71%)	Yes (78%)	Yes (71%)	Yes (60%)	No (81%)
Yes (71%)	Yes (78%)	Yes (87%)	Yes (94%)	Yes (100%)	Yes (100%)	Yes (63%)
No (49%); Yes (49%)	Yes (65%)	Yes (83%)	Yes (89%)	Yes (100%)	Yes (80%)	No (69%)
Yes (52%)	Yes (63%)	Yes (74%)	Yes (61%)	Yes (100%)	Yes (80%)	No (52%)
No (66%)	No (55%)	No/Yes (50%)	Yes (83%)	Yes (100%)	Yes (80%)	No (81%)
No (81%)	No (62%)	No (67%)	No (61%)	No (43%); Yes (43%)	Yes (80%)	No (87%)
monthly (91%)	monthly (88%)	monthly (88%)	monthly (89%)	monthly (86%)	monthly (100%)	monthly (82%)
No (61%)	No (64%)	No (60%)	Yes/No (50%)	No (57%)	No (80%)	No (66%)
No (54%)	No (55%)	Yes (52%)	No (61%)	No (57%)	No (60%)	No (70%)
No (83%)	No (88%)	No (81%)	No (72%)	No (86%)	No (80%)	No (90%)
Yes (48%)	Yes (57%)	Yes (63%)	Yes (78%)	Yes (86%)	Yes (60%)	No (58%)
Yes (63%)	Yes (69%)	Yes (75%)	Yes (100%)	Yes (100%)	Yes (100%)	No (66%)
No (72%)	No (80%)	No (71%)	No (72%)	No (57%)	No (60%)	No (89%)
Managers (59%)	Managers (58%)	Managers (60%)	Managers (72%)	Users (57%)	Managers(40%); %Users(40%)	Managers (66%)
Yes (65%)	Yes (64%)	Yes (58%)	Yes (56%)	Yes (86%)	Yes (80%)	Yes (70%)
Yes (76%)	Yes (86%)	Yes (85%)	Yes (83%)	Yes (100%)	Yes (80%)	Yes (70%)
Yes (94%)	Yes (97%)	Yes (98%)	Yes (94%)	Yes (100%)	Yes (100%)	Yes (87%)
Yes (88%)	Yes (89%)	Yes (85%)	Yes (83%)	Yes (86%)	Yes (100%)	Yes (76%)

Source: ParticipaNetSus – 2008 (www.ensp.fiocruz.br/participanetsus), Moreira and Escorel[28]. Organized by the authors.

Table 2 systematizes the MHCs' performance according to the 18 variables selected and the size of the population. The functioning of the councils was classified based on the number of variables in which the set of MHCs of each size obtained positive results: positive performance in up to 3 variables would receive the symbol '-'; from 4 to 7, '+'; from 8 to 11, '++'; 12 to 15, '+++'; and from 16 to 18, '++++'.

It can be seen that none of the MHCs obtained the worst ('-') nor the best ('++++') classification and that the national total fits into the classification '+'. As the population size grows, there is a trend for improvement in the results, even though specific indicators may show a break in this pattern (election of the president, for example) and, at least for towns with up to 50,000 inhabitants, the most appropriate way of describing the results would be to say they are "the least bad". Adding the number of MHCs in towns that fit the four population sizes that concentrate the best results, only 82 is reached (2% of the total). However, about 38% of the population studied lives in these locations. On the other hand, the four population sizes where the MHCs have the worst performance contain 4,943 towns, that is, 90% of the universe studied, where 37% of the population lives.

Municipal Health Councils: factors that aid and hinder the effective democratization of the decision-making process of municipal health policies

The MHCs are a reality in the Brazilian institutional framework: over 17 years, they were created

in 5,564 towns, bringing together a contingent of around 72,000 titular councilors, 20% more than the approximately 51,000 councilors in Brazil[29]. Out of the councilors, approximately 36,000 represent UHS users, having been nominated by almost 28,000 civil society entities.

The numbers show the advance of inclusiveness in the health sector at a municipal level. Reinforcing them and giving them new qualities, the positive performance of the "access" dimension indicates that the MHCs also open space for the participation of the non-organized population and for councilors of all segments to arrive at the presidency.

In isolation, this setting is positive, for it inserts an increasingly large and more diversified number of interests in the decision-making process of municipal health policies. However, ultra-presidentialist managers tend to see the advance of inclusiveness as an increase in the veto power given to users, which generate reactions that seek to prevent this fear from materializing. The result of these conflicts is directly linked to the way institutional rules deal with these reactions.

The poor performance of the MHCs in the "autonomy" and "organization" dimensions, national keynote, indicates that the existing rules have not been enough to elevate the costs of reactions to the institutionalization of the MHCs. It also shows that increasing the population's participation as a strategy for broadening the MHCs' social support base has also not been effective for stopping managers' reactions.

In this way, the MHCs tend to become dependent on the political interests that direct Executive power, being prevented form, for example, contracting audits, research and consultancies that would increase their capacity and technical knowledge; from consolidating agendas with other councils and institutions; and from establishing a daily relationship with the population.

This is the kernel of the problems that prevent an effective democratization of the decision-making process of political health policies: the rules that regulate the institutional relations in the decision-making process of municipal health policy allow the MHCs to advance on the path of inclusiveness, but favor contrary reactions from those who consider the increase of social participation a problem, which hinders their path towards liberalization. For this reason, the MHCs are not in themselves enough to construct a health sector with polyarchic characteristics.

This is because the "success" demanded from the MHCs does not depend exclusively on them, for their powers cannot be exercised in isolation: participation in the decision-making process of municipal health only materializes through the interaction of actors who are interested in the public problems touched by those policies (UHS, Municipal Legislative Branch, Judiciary Branch, Public Prosecutor's Office, agents linked to private and market interests). If these actors do not legitimize the MHCs, they are unlikely to be successful.

An analysis of the data shows that even though there are no rules to inhibit the reactions, there are MHCs that have good autonomy and organization. As these perform slightly better in the access dimension, this fact must be a result of the consistent reduction of or the absence of manager reactions. This hypothesis is corroborated by the data on the MHCs that have the best functioning conditions, the ones in towns of more than 250,000 inhabitants: out of the 82 in this group, 70% are governed by parties that, in some way, place participation in their program/statute. This index is higher than for the total MHCs in the country (37%) and for towns with the worst results, those with fewer than 50,000 inhabitants (56%)[28].

Furthermore, the MHCs that have the best conditions of autonomy and organization are also those located in towns with a more mobilized civil society accustomed to negotiation and political articulation. In the health sector, for example, they are the ones who present the highest quantity of local health councils and health unit management councils[4].

This confirms that articulation between the different actors and institutions involved in the decision-making process is the element capable of leading municipal health policy to democratization. Although it is not the only articulation possible, the combination participatory city hall/negotiating organized society, which would represent the articulation between organizations in representative and participatory democracy, is the most important political element to advance the democratization of the decision-making process of municipal health policies, for it is what can give the MHCs legitimacy, clearing the path to liberalization.

Final considerations

As the combination participatory city hall/negotiating organized society arise from complex political relations that are not yet clearly defined and are therefore difficult to (re)produce, it is important to think about proposals that can be achievable in the short and medium term and that, while not leaving aside the search for the combination, can

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contribute to the democratization of health policy.

Perfecting the institutional rules and the deliberative process could potentially reduce the tensions arising from the Executive's concern that its interests will not be met, on the one hand, and raise the costs of negative reactions from sector managers, on the other hand. Examples: elevating the costs of suppressing MHC autonomy; defining the scope of the deliberations, that is, the questions that can be deliberated; denying the possibility that councilors only veto proposals from other councilors; holding the MHCs responsible for their deliberations; forcing managers to send to the MHCs the public budget and health actions, programs and policies in their formulation stage, preventing councils from appreciating projects that are practically closed, with little possibility for change and committed to certain interests.

In this way, MHC deliberations, because they arise from debates that consider the set of existing positions and not the attempt by one position to subjugate the others, would be more representative of the set of actors involved, truly becoming an interest of the MHCs.

Agreement on these – and other – rules constitutes a challenging proposal that the evidence analyzed here presents to the actors and institutions directly involved in the municipal decision-making processes. However, it is also a challenge for the National Health Council and the Department of Health. With the support of these (which are already developing important actions with the MHCs, but which are not as tied to the context explored here), it would be possible to establish a closer relationship between the subnational and national levels, helping the democratization of municipal health policies to spread to other sector policies and, as a result, to positively influence the political macro-structures that define the advance of democratization in Brazil.

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