Discussing community participation in health: an approach from the Brazilian experience

Discutindo a participação comunitária na saúde: uma abordagem a partir da experiência brasileira

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Abstract *This article deals with the problem of community participation in the process of planning, management and decision-making in the Brazilian health system. It seeks to discuss the political process that gave rise to the formation of this model of participation in Brazilian health sector and to identify the reasons for possible weaknesses or constraints in the functioning participatory process.To that end, it makes a review on the literature to address the concept and approaches related to community participation, the advantages of adopting it, some obstacles to its implementation in health management and planning, as well as identifying three kinds of participation in health, according to different technical-political practices and rationalities. Special attention is given to Brazilian experiments in health participation, which culminated in the institutionalising of health councils. In this sense, emphasis is placed on the importance of the social process known as the "Health Reform Movement" and on the holding of the VIII National Health Conference in 1986. Finally, the study concludes that in countries with political, social and economic characteristics like Brazil, the task of incorporating community participation in the formulation and management of health policy depends on the creation of a new spirit of citizenship.*

Key words *Community participation, Health policy, Brazil*

Resumo *Este artigo lida com o problema da participação comunitária no processo de planejamento, gestão e tomada de decisões no sistema de saúde brasileiro. Procura discutir o processo político que possibilitou a conformação desse modelo de participação no setor saúde do Brasil e identifica razões para possíveis debilidades ou limitações no sistema participativo em funcionamento. Para este fim, foi realizada uma revisão na literatura cercando o conceito e as distintas abordagens relacionadas à participação comunitária, as vantagens em se adotar tal prática, os obstáculos para sua implementação na gestão e planejamento da saúde. Essa revisão também identifica três tipos de participação em saúde, relacionadas a diferentes racionalidades e práticas técnico-políticas. Atenção especial é dada aos experimentos brasileiros de participação em saúde que culminaram na institucionalização dos conselhos de saúde. Neste sentido enfatiza-se a importância do processo social conhecido como "Movimento pela Reforma Sanitária" e a realização da VIII Conferência Nacional de Saúde em 1986. Finalmente, o estudo conclui que em países com características políticas e socioeconômicas que guardem semelhanças com o Brasil, a tarefa de incorporar participação comunitária na formulação e gestão da política de saúde depende da criação de um novo espírito de cidadania.*

Palavras-chave *Participação comunitária, Política de saúde, Brasil*

Introduction

In Brazil, decentralization and community participation in the administration of the health system have emerged as a remedy for resolving various kinds of dissatisfaction concerning the authoritarian state, the shortcomings in public services and administrative difficulties and inefficiencies. In this respect, the creation of new political space, rules and structures, sharing and combining new power resources and ensuring the participation of social groups in the administration of this sector, have become necessary. It is in this context that the Health Councils (HCs) have been created.

The Health Councils have appeared on the Brazilian political health scene, as a result of sector reorganizations which, with the prospect of decentralization, gave rise to the current Brazilian Health System (SUS). They embody the institutional configuration of the decentralized health system, and it is their responsibility to ensure the realization of the constitutional principle of community participation, and that of safeguarding social control over health practices and services at the three levels of government, national, state and municipal.

Established on a basis of parity by representatives of the state machine and civilian society, and endowed with fairly extensive legal rights, the councils should be one of the most important components of Brazilian Health System.

Nevertheless, changes in the legislation are not always sufficient to guarantee an effective modification to the existing health situation. In Brazil, where there is a long tradition of authoritarianism in public administration and the situation of a developing nation, with fragile relations between the state and society, the idea of decentralization of the health services and community participation in its management should be viewed with a certain amount of caution.

The aim of this article is to present a literature review on community participation that enables to discuss the political process that gave rise to the formation of this model of participation in Brazilian health sector and to explore the possible reasons for weaknesses or constraints in the functioning participatory process.

In the first part, starting from a review of the literature are introduced a number of concepts and approaches related to community participation in health, the advantages of its adoption and some obstacles to its implementation in health management and planning.

The second part, using a typology devised by Carvalho,[1] set views about participation in health and the main forms of social practice corresponding to them.

Following this conceptual framework, the third part offers a description of the Brazilian experiences of health participation, which have culminated in the institutionalization of the Health Councils. Finally, conclusions are made by discussing the actual Brazilian case on the basis of the concepts and categories provided earlier in this article.

Understanding community participation

This initial part proposes to introduce the concept of community participation which will be used in this article; two of its most important approaches being that of identifying advantages and problems in its adoption, mainly in the process of health planning and decision-making.

The concept

The idea of community involvement in health programs and attention to health, in spite of not being a recent phenomenon, became popular and spread throughout the world after being considered by the World Health Organization (WHO) in the conference arranged in Alma Ata in September 1978, to be one of the most important principles of primary health care (PHC).[2] It was set up as a strategy, to achieve the objective of "health for all" by the year 2000, through the adopting of a model of PHC. Among other points, the Conference's report states the following: *"Primary health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation, and control of primary health care, making fullest use of local, national, and other available resources"* (OMS; 1979: 4).[3]

Despite being considered by the WHO an important element in the search for solutions to the health problems of peoples, the significance of the term community participation (CP) in health, resting on political, economic, social and cultural features, can be interpreted in various ways. One of the most frequent views depicted by Morley *et al*.[4] as "direct participation" sees it as a mobilization of resources, such as: manpower, money, materials, ideas, etc., spontaneously provided by the community in order to carry out health programs. According to Morley *et al*. (1983: 190)[4] *"This view is based on the assumptions that community has certain capacities*

which have been hidden under apparent passivity or resistance to change."

There is, on the other hand, a point of view that is in some sort opposed to the previous one and perceives community participation as a process of increasing popular control over the (social, political, economic and environmental) factors influencing the health status of a community. This concept, designated by Morley *et al*.[4] as "social participation" presupposes that it is not enough for the communities merely to involve themselves in health activities and programs in a voluntary way, the intended changes in this sector require participation to extend to other social activities (transport, education, home, etc.) *"... these two opposing views reflect a different analysis of society, especially of the distribution of wealth and power among the different social groups"* (Morley *et al*.;1983: 191).[4]

Other ideas related to community participation can be found in contemporary literature, Rifkin *et al*.,[5] while favoring geographical and epidemiological aspects, regards community participation as *"... a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these need"* (Rifkin *et al*.; 1988: 933).[5]

However, in the final analysis, starting from the two initial interpretations of the concept of community participation in health, various studies and conclusions as regarding recent experiences have been elaborated. These vary from negative views like that of Ugalde[6] who, in analyzing community participation in Latin American health programs, states that *"... health participation programs in Latin America, in spite of promotional efforts by international agencies, have not succeeded ... through symbolic participation, international agencies had two purposes in mind: the legitimization of low-quality care for the poor, also known as primary health; and the generation of much needed support for the masses for the liberal democracies and authoritarian regimes of the region"* (Ugalde; 1985: 41),[6] to other more optimistic positions like that of Bhaduri and Rahman (1982: 12)[7] who conclude, *"... participation makes demands upon those in control. The dominant structures, economic or political, will have to adjust if such demands are to be accommodated. Therefore, participation is at best an evolving process, whose tensions and contradictions are created and resolved through stages of demands and accommodations."*

In the Brazilian case, both in the sociological literature as well as in political discussions and technical documents, we can find expressions other than 'community participation', such as 'popular participation', 'social participation', 'participative democracy', 'community development', 'social control' and many others, available for dealing with the same theme or explaining similar phenomena.

Of those terms cited above, the one that was first introduced and popularized in the Brazilian health sector was "community participation" in the context of community development. Goulart *et al*.[8] directed justified criticism against that concept of participation. That study makes no attempt to examine it in depth, however, some points arising from it constitute limitations to participative practice: a view that conceals the inherent conflicts to social life as, for example, those between antagonistic social classes, different cultures, group and minority interests, etc., implying in an artificial way, a harmonious and balanced society; participation is reduced to a mere associativism devoid of political content and linked to public power and the appeal to immediatist activities of the "mutirão" (communal work) type strong, in which consideration is not directed to reflection and actions about the structural problems of society; its local character which favors a detached microvision of the global decision-making process of a political nature.

Overcoming these critical points is not an easy task. In many ways it requires a theoretical effort in order to take effect, and especially a disposition to systematically confront theory with the concrete reality of the social conflicts. The principle of democratization of the National Health System, originating in the eighth National Health Conference in 1986,[9] consolidated in the Federal Constitution of 1988 and reaffirmed by the States Constitutions, defines the need for a Unified Health System able to face the serious national health situation. In these new circumstances, participation should appear as an eminently political phenomenon, in which active social actors define their course, far from the previous technical, passive, instrumentalist picture.

From this standpoint, for the purposes of this article, a concept of participation that presupposes a real dislocation in the structure of power will be adopted, in such a way as to enable the formation of new political subjects. Participation understood in this way must be, above all, a continuous learning process, in which the actors/citizens can build the bases of an effectively democratic society.

Different Approaches to Community Participation

Despite the relative consensus about the usefulness of community participation in the development of programs and health activities, it is important to identify the various approaches and expectations in its operation originating from some social actors responsible and involved in this process. We here refer to health professionals, doctors, planners, managers and policy makers.

Rifkin,[10-11] after analyzing experiments in community participation in health planning in South East Asia, identified three different types of approach: *"... 1. he medical approach....based on the view that health is essentially the absence of disease ... 2. the health planning approach ....based on the view that health is essentially the result of the appropriate delivery of health services ... 3. the community development approach ... viewing health improvements as a response to an education process by which community members begin to take control and responsibility for their own health care"* (Rifkin; 1986: 157).[12]

In a more recent publication this author states that these three approaches can be translated into two frames of reference that might sum up the thinking about health improvements and have guided the actions of health planners and managers, since the end of the second world war. These are: "target-oriented frame" and "empowerment frame".[2]

The first, also called the "top-down" approach, follows a line of reasoning based on the logic of traditional western science and on the biomedical determination model of the health/disease process. According to this manner of confronting the problem, improvements in the health status of the population will occur in keeping with advances in science, as discoveries are made, and communities accept and incorporate these innovations into their reality. In this frame of reference decision-making is always in the hands of the professionals, the outcomes of the programs are quantified as products and the community participation is an instrument for achieving an objective.

In its turn, the empowerment frame also referred to as the "bottom-up" approach, is based on the notion that the reason for poverty and its consequences in the health status of the majority of the population, stems from the profound inequity in access to existing goods and services or in the unfair distribution of wealth produced world-wide. If that is true, it will not simply be the technological advances caused by an elite which will put an end to it. This approach, in which the work of some non-governmental organizations (NGOs) in various countries has been mentioned, starts from the principle that people cannot be considered as objects, in fact the fairest thing, from the point of view of current thought, is that the communities, through gradual access to education and information, assume power and control of the system and are subjects of the social changes most suitable to their interests.

Advantages and obstacles to community participation in the health sector

The advantages of community involvement in the decision-making process are varied with regard to the form and types of public services provided for it. There are more than a few justifications for encouraging participation, particularly in health, management and planning. Even the traditional ruling elite of some third world countries are aware that there is little hope of effective planning for development without popular support. The quest for mass involvement is the central tenet of "democratic planning".[13]

The reasons are varied, Conyers[14] cites at least three: in the first place, community participation is an efficient way of obtaining indispensable information and data about the real needs and habits of the target population. In the second, insofar as the members of the community feel themselves participating in the planning of the project or program, they also perceive it as "theirs" and, apart from identifying themselves with it, increase the possibility of it being accepted and implemented. *"The third reason for encouraging popular participation is that in most countries it is considered to be a basic democratic "right" that people should be involved in their own development"* (Conyers; 1982: 103).[14]

Collins[15] recognizes that community participation, apart from being a powerful instrument for the effectiveness of health plans and programs, at the same time as it increases the perception of the health needs of the population and guides it towards the programming of decisive actions more appropriate to their situation, the involvement of the community also makes their self-reliance, learning for health and consequently the sustainability of the health plans and programs, increase.

Examples of the advantages and utility of adopting community participation in health systems can be found in different parts of the world. Frieden and Garfield,[16] when analyzing the case of Nicaragua, after the Sandinista revolution of 1979, stated: *"By giving community groups a role in planning and ad-*

ministration, the health system maintains the flexibility essential if health services are to be brought to Nicaragua's geographically and demographically diverse population" (Frieden and Garfield; 1987: 162).[16] Molina-Rodrigues *et al*.,[17] on considering the experience of social participation in health in the municipality of Simojovel, Chiapas, Mexico, observed that the participation of the community at levels such as diagnosis, planning, programming, control and implementing health activities, had produced positive changes in the local health situation, while the mere presence of the state, in these activities through social programs, encouraged dependence and paternalism.

However, in accordance with Collins[15] and Rifkin,[18] there exists a set of obstacles to the implementation of real community participation in the health sector and these can be recognized as much in the dynamic of the management process as within the community itself or in the existing social/political/economic system. Walt[19] reasserts that an analysis of the political system can be extremely useful in an evaluation as to how much participation can be encouraged or permitted. Historical, cultural and other aspects of a structural nature, such as ideological values, ethnic heterogeneity, the country's geography, etc., can also form powerful barriers to the mobilization of the community.

In the properly so-called area of the management process the problem of decentralization assumes a strategic dimension. Collins (1994: 252)[15] warns that *"In the absence of significant decentralization, community participation can be nothing more than a political facade for the legitimacy of political regimes."*

Another difficulty to its implementation arises from the threat that its adoption represents to the status quo of the professional controlling groups already integrated into the system. Clearly, this problem has implications in the form of communication between the community and the personnel, holders of the existing technical information, *"Personnel tend to communicate among themselves and not with the community, in addition to using jargonized and incomprehensible language"* (Collins; 1994: 252).[15]

Conyers[14] advances several problems deriving from the community itself which can create difficulties for community participation, one especially concerning the low level of information, education and consequent lack of clarity, on the part of some communities, as to what is really best for its situation, *"... the average citizen in a developing country - particularly in the rural areas - has very little idea of the range of options open to him or of the implications of these various options. Consequently, it is not surprising that he will often ask for the impossible or for what others have told him he should want"* (Conyers; 1982: 125).[14]

Westphal[20] illustrates this assertion in a case-study about community participation in the management of the health system of one of the municipalities of the metropolitan region of São Paulo, Brazil, and concludes that the lack of access to information and of reflection about the health situation, on the part of the community representatives, has hampered real participation in that locality.

Other obstacles identified by Conyers,[14] are related to representation and inequality. Internal conflicts invariably exist in communities with a high degree of inequality, as can often be seen in Latin America. Combined with a need for participation, these are not infrequently caused by the choice of representatives This offers a risk to the picture of the community as a whole or at least the majority of its members is not being adequately represented. *"In such situations, the danger is that those people who are selected to represent the community are those who are economically and socially better off, and then they use their position as community representatives to further their own interests, thus merely increasing the existing inequalities"* (Conyers; 1982: 129).[14]

Because some planners and managers consider it inefficient, they defend the non-inclusion of the community in the process of policy-making and this has often proved an obstacle to its adoption. The fact is that the process of involvement of the community demands a larger share of the resources, like time, money and manpower, than a more "top-down" approach. According to this point of view, it acts in such a way that it is not justified. However, as Conyers (1982: 134)[14] contends, *"The purpose of participatory planning is not to make the planning process simpler or more efficient ... but to make sure that local conditions and needs are taken into account and to allow people to have more say in their own deve-lopment."*

Participation and health policy: modalities of the state-society relationship

As was noted in the previous section, the notion of participation has a long tradition in the field of health policy and in the organization of services. This has, nevertheless, assumed various meanings depending on the context where it is introduced.

In fact, the various concepts and practices relative to the idea of participation in health are likewise historically ascribed with regard to different social-

economic-cultural contexts, involving different forms of understanding of the state, of social groups, of state-society relationships, of the health-disease process and of ways of intervening therein.

This being so, Carvalho[1] identifies three modalities of participation in health, according to different technical-political practices and rationales: complementing the state, opposing the state and controlling the state. These will be discussed as follow.

The community complementing the state

The idea of community participation emerges at the beginning of this century in the United States, as an evident and strategic tool of the community health centers movement in that country.

In the area of health care for individuals and groups, this movement originated with the aim of providing an answer to the serious and increasingly important problems deriving from the relationship between poverty and disease. It was based on the discovery that the existing health policies in the USA were not responding to the needs of those who were under-privileged by the social-economic system.[21]

"In fact, the proposal for community medicine appears from the moment when public health activities happen to depend, technically, on the assent of the population for their implementation and efficacy; that is, they are important with regard to the people in the health units and involve their agreement with directives and recommendations of individual application. The population ceases to be an inert target of a controlling and normative action in the field of health and goes on to be called upon to fulfill a minimally active and conscious role in the endeavor to seek public health. Health activity would no longer depend merely on coercion, but it would have to win the agreement of the people" (Carvalho; 1995: 14).[1]

The view that guided this practice embodied a new logic in understanding the health-disease process, since there is a dislocation of the focus of attention in the actions directed towards environmental hygiene and towards actions aimed at intervening in the relationship, now understood more dynamically, between man and the environment.[1] For that reason the most important thing does not consist in seeking to modify individual behavior through impositions, what would be really important for the efficacy of health activities would be to modify the milieu, including social and cultural factors, in which the community was living; that being so, the most efficient and 'shortest' way would be to persuade that community itself, if not alone, to help the state in the realization of this task.[22]

However, as was promptly suggested by Goulart *et al*.[8] in the previous chapter, this view of participation does not consider fundamental aspects of the circumstances of the communities, since it stems from a concept that does not take into account its characteristics of heterogeneity, which the conjunctural and structural factors determine. community here is understood as homogeneous, whether from the social or cultural point of view, the problems to be faced are of a technical order. *"It is thus a question of an autonomous concept of the community that allows its inclusion in the widest social-economic context. The community will be able to combat poverty and disease depending on its ability to unite, organize and exert itself, in a collective version of the idea of the self-made man. Participation is made into a fetish, as the passport to social progress"* (Carvalho; 1995: 17).[1]

In spite of this restricted view of what 'community' means, this pattern of state/society relationship in the USA example, insofar as it expanded the awareness and need of organization of the community to confront health problems, occasioned considerable advances in that society, regarding technical and political fields.

On the other hand, in political-social situations with an authoritarian tradition and few social and participative cultural organizations, like those that were found in the majority of the countries of Latin America, this model allowed the infiltration of *"... agents and designs protesting against the political and health status quo - and ended by setting themselves up as laboratories, not as an official alternative argument, but as actions of a community organization and politicization from the position of an anti-establishment health plan"* (Carvalho; 1995: 19).[1]

The people opposing the state

For the reasons mentioned earlier, in the case of the majority of the countries of Latin America, the political and technical results produced by the model of community participation as a 'collaborator' in the execution of health practices, were either aborted for ideological reasons or were below the health needs of the less favored classes.

Van Stralen[23] explains that, the times when this practice signified some threat to the *status quo*, or canalized popular demands to governmental institutions, the experiences were interrupted and the specialists were institutionally marginalised. This being

the case, a new modality of the social practice emerged as a radicalization of the political practices of opposition to the dominant system:"popular participation".

"The deepening of the criticism is taken as the adoption of a new theoretical reference system, in which the category 'Community' is replaced by the category 'People', here denoting that section of the population excluded or subordinated in their access to goods and services. In a clear doctrinaire approximation to Marxism, the problem of social segmentation is introduced not merely as a descriptive element of the distribution of health problems, but as a key to its explanation" (Carvalho; 1995: 21).[1]

This radicalization whose strategy is to widen participation in the universe of the social dynamic, uses as a tactic every form of confrontation and the organization of popular classes.[23] Consequently, the space for participation exceeds the limits of the health sector and extends to the whole of the society and the state; and it is in this plan that its new objectives are defined: the democratization of health, designating the demand for universal and egalitarian access to the services and also by access to power.

Unlike the view of "community participation" that explained the origin of the health problem starting from a technicist viewpoint, on the model here described the reasons for the deficiencies of the health system are attributed to the political problem or to its class character,[24] as well as inequity, which can only be overcome by an interruption in the logic of capitalist accumulation which the system produces. The way of explaining the health-disease process in spite being modeled on ecological aspects emphasizes the social dimension of the environment and the social circuit of the natural history of the illness. The health risk is permanently associated with social vulnerability and is thus politicized.[1]

If for community medicine participation had an instrumental character in relation to the technical-sanitary objectives, here it is health and health practices that become instrumental in relation to the political objectives. Whether in the direction of the so-called 'popular learning', in which participation is seen as an end in itself, whether in the line of popular organization returned to the confrontation with the state.[25,26]

In some countries of Latin America, including Brazil, these radical experiences of political confrontation between the social movements and the State aiming to abolish discrimination and abolish privilege in the access to goods and services of health, ultimately became democratic, assumed a particular dynamic and dialectic of transformation. In proportion as the state, for reasons that will be identified later, widen its accessibility to those social demands, institutional spaces are opened for representatives of this movement, thus conditions for overcoming radical Manichaeism are opened up and the possibilities of interaction are born, as an alternative to confrontation.[1]

The citizen controlling the state

While the plan for popular participation turns itself into a social practice characterized and dominated by a notion opposed to the existence of an established power, represented by state, the process of democratization brings new actors to the stage and places on the agenda new questions in the sphere of state-society relations. From society's point of view, the presence of an increasing diversity of actors and interests makes itself felt, disputing space for the implementation of its projects. On the State's part, its characteristics of space for representation and its seeking of a consensus begin to crystallize.

At this moment, it can be seen that the nature of the state can no longer be understood simply as a Marxist vision, remaining unalterably the committee for bourgeois affairs. The state can no longer represent the interests of the dominant classes alone; the 'pressure from below' also obliges it to accommodate interests deriving from other classes. Oslak[27] states that, in this new scenario, the old understanding of the role of the state was replaced by another broader one that interprets it as an arena of political conflict where contradictory interests struggle to prevail over socially important problems.

Coutinho[28] states that the expansion of political and social citizenship leads to an important transformation in the liberal order, in the capitalist state: it opens political space for representation of new interests.

If this is true, this new character and understanding of the role of the State confers on the practice of participation the dimension of a legitimate exercise in citizenship.

"The central category ceases to be the community or the people and becomes society. The intended participation is no longer that of groups excluded by a dysfunctioning of the system (communities), nor that of groups excluded by the logic of the system (marginalised people), it is rather that of the totality of individuals and social groups, whose diversity of interests and plans integrates the citizens and contests space and care by the state apparatus with equal legitimacy" (Carvalho; 1995: 25).[1]

Carvalho[1] also indicates that one of the characteristics of this model of participation is its tendency towards institutionalization, a process of inclusion in the institutional juridical framework of the state, of structures of representation direct from society, invested with some level of governmental responsibility.

This does not mean that the tensions and contradictions that dynamize the real political process disappear, they only assume an institutional dimension and become more transparent. The "game" in this pattern of social participation aims at the necessary seeking of consensus, of the guarantee for a determined interest or group of interest to become capable of legitimately influencing the actions of the government.[28] Yet this practice of participation adds another 'novelty' to the political process: the 'collapse' of the Manichaeian logic in which people are 'good' and the bureaucracy is 'wicked', since as can be seen in its now explicit dynamic, the political actors are shaped in the process of persuasion.[29]

In the Brazilian case, social participation is institutionalized during the process of democratization of the country, dedicated to transforming the state, overcoming its politically authoritarian and socially exclusive character. The idea of social control is here marked by a double bias: the hard reality of social exclusion and the age-old patronage and privatized character of the Brazilian State. As if the state, initially suspect, needs to be watched, contained, corrected, in its habitual practices.[1]

Participation in the Brazilian health system

This section will identify, in the context of Brazilian health policy, the background and social practices that shaped the proposal of the health councils as an instrument of social participation in the health system.

The crisis and emergence of participation: the health reform movement

The first stage of the Brazilian military regime (1964/1974) was characterized by the "Brazilian Miracle" whereby, through rapid centralization, an extensive readjustment in the State administration, including the health sector, was brought about. The central logic of the dictatorial government, apart from destroying the autonomy of the states forming part of the federation, imposed reforms of an institutional nature that confirmed the model of individual medical care as the health standard.[30] This policy of medical welfare gave rise to an enormous increase in the number of medical acts with resultant investment, financially subsidized by the public sector, in the building of hospitals and private diagnostic services.[31]

In 1975, by means of law nº 6.229, the jurisdiction, allocation of space and rules for the relations between the public and private sectors in the area of health were defined. In objective terms, they may be explained in the following way: less cost-effective public health activities, proposed by the Ministry of Health, would be the province of the public sector, and cost-effective medical treatment, mediated by the newly-created Ministry of Welfare and Social Security, would fall to the private sector.

In the second half of the 70s, with the creation of the National Welfare System (SINPAS), the National Institute of Medical and Social Welfare (INAMPS) and the incorporation of the Central Office of Medicine (CEME) into the first, the basis to allow the dominance of the private medical care model was established. As Mendes[32] shows, that was subtended by the following three principles: a) the state as the great financier of the system through social security; b) the national private sector as the largest provider of medical care services; c) the international private sector as the most significant producer of supplies, especially biomedical equipment and medicines. It is in this context of aggressive commercialization of medicine, with the backing of the authoritarian government that an anti-establishment idea, critical of this model and also a form of social movement began. From within the departments of preventive medicine of some Brazilian universities, the health reform movement, would later establish itself on the politico-ideological basis of Brazilian health reform.[29,32-34]

Starting from an analysis of the work processes and the key concept of the social organization of medical practice,[35] such a movement gives rise to a socializing interpretation of the issues, demonstrated by the crisis in commercialized medicine, as well as its inefficiency, at the same time as the possibility of organizing a health system capable of responding to prevailing demands, organized in a democratic way in its management and administered on the basis of rationality of planning.[36]

The end of the "economic miracle", in the second half of the 70s, was followed by a state financial crisis with repercussions in the financing of social security, if on the one hand, the private model led to a crisis of no-return, once its curative emphasis was

incapable of altering the existing morbimortality and its increasing costs had made its expansion non-viable; on the other hand, it forced the regime: to introduce a slow and gradual political "openness", which brought new social actors into the political arena, until then excluded from the decision-making process of government actions, and to create compensatory social policies directed towards marginalised groups, mainly those located on the urban outskirts and in rural areas.[32]

And it was at this juncture that the initial experiments in community medicine in Brazil emerged, first as a compensatory low-cost policy, then through government initiatives and within its agencies.

These initiatives, which sought to adopt the principles of Primary Health Care (PHC), recommended by the WHO in the Alma-Ata declaration, were limited to a kind of extension program covering basic health activities directed towards the less favored. These, in spite of being weak in relation to community participation and health improvements for the target populations,[1] were extremely productive from the political point of view, since they created a favorable atmosphere for the acceptance of thought, and of a number of experts making up the health reform movement, into the State apparatus.

This view of the economic crisis and of legitimacy of the regime, at the same time as it introduced health reform movement actors into the federal bureaucracy, widening the debate and the technical-political argument among the governmental structures, made the emergence of health worker movements feasible throughout the country, especially the doctors through trade unions and councils which, in their opposition logic, were demanding democracy and popular participation in the management of the country.

Health consciousness increased within society, and the incipient process of democratic "openness" aided the debate. Publications and symposiums flourished in the health sector. A broader outlook regarding the national health policy was gradually incorporated into the professional movements, the doctors began to note the connection between the causes of their professional problems and the health conditions of their patients.[36] Thus, *"... historic alliances were formed between the medical movement, the health reform movement of academic origin and the popular movement for health, which were capable of transcending the corporative limits of the professionals, the elitist culture of the scientists and the absence of a more comprehensive vision of the popular movement"* (Fleury; 1988: 199).[36]

In this way, an alternative proposal was systematized for the private medical care model which, as well as aspects of centralization, hierarchisation and regionalisation of the health services, proposed the question of participation as a fundamental component. This was established in the form of what came to be called the Brazilian Health Reform.

Basically, it is through the clash between these two interest groups that various plans, and reformulation and reorientation proposals for the health system came about, between 1979 and 1985. On the one hand, there was the decreasingly dominant private medical care, ever striving to modify itself, represented by social actors such as the profitable and powerful Brazilian Federation of Hospitals (FBH), and the Federation of Philanthropic Institutions, providers of non-profit making medical services and some trade unions linked to large economic interests; on the other, the health reform movement increasingly favoring the strategy of occupation of governmental spaces.

Thus it was that in 1986 the most important event in the history of Brazilian health policy took place: the VIII National Health Conference (CNS), which introduced the institutional participation of representatives of civilian society into the process of defining health policy.

The expansion of participation: the VIII National Health Conference

With the end of the military regime and the setting up of a civilian government in 1985, a period of redemocratization of the country began, with a consequent expansion of the institutional spaces of social participation. In addition, the new government emphatically maintained that its main objective was the redemption of the social debt accumulated during the two decades of the dictatorship. The motto and order of the day of the newly established power was: 'All for the Social (People)'. The political conditions for sectoral changes which the health reform movement was hoping for, began to appear. The time to square up to opponents and attempt to institutionalize the health reform, had indeed arrived, because the basis of social consensus existing at that moment encouraged it in the direction of confrontation.

The first step in that strategy was the holding of a broad national debate, which began at a municipal level, with the municipal health conferences, moved on the State health conferences and culminated in a grand national event: the VIII National Health conference (VIII CNS).

This Conference convoked by the President of

the Republic in July 1985 and held in Brasilia in March 1986, was attended by the country's President, the Minister of Health and assembled almost five thousand representatives from almost all the social forces interested in the health question. The presidential decree that set it up defined as delegates:[37]

- The heads of technical organs of the Ministry of Health and of its decentralized bodies as well as other officials designated by the Ministry;
- Representatives of the Ministry of Education, the Interior, Social Security and Welfare, Urban Development, Science and Technology, the Department of Planning, the President of the Republic, and the General Staff of the Armed Forces, as well as representatives from each of the other Ministries;
- Parliamentarians nominated by the Health Commissions of the Federal Senate, Chamber of Deputies and State Legislative Assemblies;
- Representatives of rural and urban workers trades union organizations, as well as nation-wide managerial bodies;
- Representatives of Federal Councils, national Associations and Federations of health professionals;
- Representatives of State and Municipal Health Departments;
- Representatives and bodies, including legal entities providing health services;
- Observers nominated by international organizations linked to the health sector with representation in this country;
- Representatives of other institutions of civilian society at the discretion of the Organizing Committee;
- Other people or institutions specially invited by the Minister of Health.

These representatives discussed a number of subjects tackling questions related to all the aspects of health sector reform needed by the country and basically concluded that:

- *"Health is not an abstract concept. It is defined in the historic context of a specific society and at a given moment of its development, needing to be embraced by the population in its daily struggles"* (Anais...; 1987: 381).[9] In its broadest sense, health is the outcome of the conditions of nourishment, habitation, education, income, environment, work, transport, job, leisure, freedom, access to and ownership of land and access to health services. And thus, above all, the result of social organization of production, which may occasion great inequalities in living standards.
- Health is an inalienable right of the human being and therefore of citizens, and this being the case, it should be a responsibility and duty of the State to guarantee it.
- In order to assure this right, the National Health System should be reformed, as the private medical care model is unable to make it practicable. The system should be a single one "Sistema Único de Saúde" and guided by the principles of universal access, comprehensiveness, decentralization with a single authority in each federal jurisdiction and popular participation in the formulation, execution and control of health policy.

Participation in the law: the Constitution of 1988

The extent of the political importance of the VIII CNS can be measured by the speed with which its proposals were translated into action by the government. Already in August 1986 an interministerial directive was published and signed by the Ministers of Education, Health, Welfare and Social Security who, among other deliberations, decided, *"... on considering the conclusions and recommendations of the VIII CNS .... to set up a National Commission for Health Reform (Comissão Nacional da Reforma Sanitária, CNRS), with a view to: analyzing the difficulties identified in the performance of the national network of health services, and to suggest options for a new organizational structure for the system; ..."* (CNRS, 1987: 25).[38]

This Commission, consisting of representatives of governmental bodies, the National Congress, various syndicates and other organizations of civil society, in carrying out what was required of it, came up with a proposal: the subject matter of a new law for the National Health System which, as well as taking into account the basic conclusions of the VIII CNS, regarding the concept of health and its importance as a citizen's right, in what it says with regard to the theme of this article (participation), makes the following observation: (CNRS; 1987: 21).[38]

- *"As a basic principle, the management of the national network of health services (RENASSA) should be participative, involving government, users, through their representative bodies, and providers of services, through their representative bodies.*
- *Participation should involve effective power of control at the level of decision, planning, management, control and evaluation of the activities and services provided by the RENASSA.*
- *At national level, there will be a National Health Council linked to a new Ministry of Health, with the task of formulation and control of carrying out na-*

tional health policy; at the state and municipal levels, there will be State and Municipal Councils with corresponding powers.

- *The hierarchical levels of organization of the National Health System will have an administrative Council, made up of service managers and employees, with the participation of the users.*
- *The National, State and Municipal Finances will be respectively under the control of the new Ministry, the State and municipal departments, and will have their administrations voted and appointed by the corresponding Health Councils"*

The proposals set out in this document became the political and ideological basis that prevailed in the process of drafting the chapter on health in the Brazilian Constitutional Charter, promulgated in October 1988. Its suggestions as to the form of the organization and structure of social control of the health system, through the participation of representatives of society, was established as the model for the Health Councils (HC) later organized.

Thus, Art. 198 of the Federal Constitution[39] states that: public health practices and services form a regionalized and hierarchical network and constitute a single system, organized according to the following directives:

I. Decentralization with a single management in each level of government

II. Comprehensiveness, with priority to preventive care, not disregarding higher complex services

III. *Participation of the community* (our italics)

Together with the Laws 8080[40] and later 8142,[41] they regulate the constitutional order, defined as a participation jurisdiction, as well as the Health Conferences, the health councils in the three governmental spheres, national, state and municipal.

In accordance with this prevailing legislation, these collegiate organizations should take on the following characteristics:

- Character: permanent and deliberative.
- Composition: representatives of the government, providers of health services, health professionals and users; this last social section must have the same number of representatives as the total of all the other sections, in such a way as to guarantee the principle of parity between the state, providers and society, the users.
- Objective: to implement the formulation of strategies and control of the execution of the health policy in the corresponding jurisdiction, including economic and financial aspects having to be ratified by the executive power of the respective areas of government.

Conclusions

The democratization of the Brazilian political system, with the introduction of new constitutional framework, begun during the second half of the 80s, produced reforms in the existed structures of power and allowed the emergence of new forms of administration for social policies, which helped to rekindle expectations about better public services offered to the public. As far as health was concerned, the proposal for decentralization, combined with the institutionalization of community participation in the management and control of the system through the Health Councils, not only established the possibility of an occupation of the political space of social representation within the State apparatus, but also offered the opportunity to reduce social exclusion and render the existing health picture less unfair.

However, the literature review applied to the experience of the Health Councils, seems to show that this task is by no means easy to accomplish; participation is not introduced by administrative organization alone; real alterations in the political, economic and social structures need to be undertaken; positive changes need to take place in the State/society relationship, which are reflected in new links between the government and the citizen. When these fundamental changes do not happen, participation can be transformed into an escape valve for the existing structures to accommodate emerging interests[42] or into an instrument of legitimization for a particular governmental policy.[15]

The fact that Brazil forms part of the universe of those countries in which the capitalist model of development was late to arrive, it being a society with an already high level of inequity and profound social disparities,[43] where, up till now, the role of the State has always been exercised, with a view to protection, supervision and control, the adopting of democratic mechanisms of community participation in the drawing up and regulating of policies cannot be implemented from day to night. In this context, whether from the point of view of the traditional structures of power, which always try to revive ways of maintaining the status quo, or whether because of the poor organizational and political participatory culture of the community, various limitations are imposed on its full operational implementation.

In accordance with Maciel Filho,[44] the actual limitations to the functioning of the HC, have origins of a political and cultural nature and are related to the fact that Brazilian society is still getting accustomed to the democratic exercise of participation.

That being the case, ways of overcoming the obs-

tacles identified must be sought. Certainly, no predefined formulas or recipes exist. Participation should be understood and constituted as a process of apprenticeship concerning new forms of management. It is through this process that new groups will be included in the decision-making process, by way of trials, mistakes and successes, bringing health practices nearer to the real needs of the population and, as a result, increasing its legitimacy and efficiency.

Perhaps, an important step to cope with it might be to make the specialist area aware of the importance of broadcasting and receiving information and training the community representatives in some necessary skills for joint action - training that introduces basic information about budgeting and resource management, for example, could be extremely helpful in the decision-making process of the HC.

In this respect, the experts should abandon their position of being the unique repositories of knowledge and be disposed to accept the information that the population has about its situation, to listen to and analyze its proposals and treat it with respect like a partner in the resolution of health problems. On the other hand, the people need to qualify themselves so as to escape from the position of those who only make demands, adopting a more active stance and being able to propose suitable solutions to a specific situation.

Another positive step would be the setting up of specialist committees permanently linked to the HC and composed of advisers specifically contracted for that purpose. These professionals would facilitate the expert analysis of different themes and topics in the strategic areas to its operation, such as: the legal and economic ones and those related to social communication, thus providing a streamlining of the role of the HC, while at the same time, they would produce an educational spin-off of apprenticeship for all its members.

At the end of this article, it is clear that in a country with the political, social and economic characteristics of Brazil, the task of transforming the Health Councils into real agencies of social participation in the administration of public health policy, depends on the ability of the country to build a new spirit of citizenship.

References

1. Carvalho A. Conselhos de Saúde no Brasil: participação cidadã e controle social. Rio de Janeiro: Fase; 1995.
2. Rifkin S. Paradigms lost: toward a new understanding of community participation in health programs. Acta Tropica 1996; 61:79-92.
3. Organização Mundial da Saúde (OMS), Fundo das Nações Unidas para a Infância (UNICEF). Declaração de Alma-Ata. In: Cuidados Primários de Saúde: relatório da Coferência Internacional sobre Cuidados Primários de Saúde; 1979 Sep. 6-12; Alma-Ata, Kazakhstan. Brasília: UNICEF; 1979.
4. Morley D, Rohde J, Williams G. Practising health for all. Oxford: Oxford University; 1983.
5. Rifkin S, Muller F, Bichmann W. Primary health care: on measuring participation. Soc Sci Med 1988; 26: 931-40.
6. Ugalde A. Ideological dimensions of community participation in Latin American health programs. Soc Sci Med 1985; 21: 41-52.
7. Bhaduri R, Rahman MA, editors. Studies in rural participation. New Delhi: Oxford; 1982.
8. Goulart F, Baratta T, Trindade C. Conselho Municipal de Saúde: diretrizes para implantação. Rio de Janeiro: Instituto Brasileiro de Administração Municipal (IBAM); 1991.
9. Anais da VIII Conferência Nacional de Saúde. Relatório Final; 1986 março 17-21; Brasília, DF, Brasil. Brasília, DF: Ministério da Saúde; 1987.
10. Rifkin S. Primary health care in South East Asia: attitudes about community participation in community health programs. Soc Sci Med 1983; 17: 1489-96.
11. Rifkin S. Health planning and community participation case studies in South East Asia. London: Croom Helm; 1985.
12. Rifkin S. Health planning and community participation. World Health Forum 1986; 7: 156-62.
13. Myrdal G. Asian drama: an enquiry into the poverty of nations. London: Harmondsworth Penguin; 1968.
14. Conyers D. An introduction to social planning in the Third World. London: John Willey; 1982.
15. Collins C. Management and organization of developing health system. Oxford: Oxford University; 1994.
16. Frieden T, Garfield R. Popular participation in health in Nicaragua. Health Pol Plann 1987; 2: 162-70.
17. Molina-Rodrigues JF, Daquilena M, Gomez-Batista C. Social participation in health: an experience at Simojovel, Chiapas. Salud Publica Mex 1992; 34: 660-9.
18. Rifkin S. Primary health care, community participation and the urban poor. A review of the problems and solutions. Asian Pac J Public Health 1987; 1: 57-63.
19. Walt G. Health policy: an introduction to process and power. London: Witwatersrand University Press; 1994.
20. Westphal M. Gestão participativa dos serviços de saúde: pode a educação colaborar na sua concretização? Saúde Debate 1995; 47: 41-5.
21. Rosen G. Da polícia médica a medicina Social. Rio de Janeiro: Graal; 1980.

22. Bodstein R, Fonseca C. Desafio da reforma sanitária: consolidação de uma estrutura permanente de serviços básicos de saúde. In: Costa N, Ramos C, Minayo M, Stotz E, organizadores. Demandas populares, políticas públicas e saúde. Petrópolis: Vozes; 1989. v. 1. p. 67-90
23. Van Stralen CJ. Movimentos sociais urbanos e a democratização dos servicos de saúde. Rev Adm Pública Fund Getúlio Vargas 1983; 17: 46-67.
24. Barker C. The health care policy process. London: Sage; 1996.
25. Carvalho A. Saúde e educação de base: algumas notas. Saude Debate 1979; 6: 6-6
26. Costa N. Transição e movimentos sociais: contribuição ao debate da reforma sanitária. In: Costa N, Ramos C, Minayo M, Stotz E, organizadores. Demandas populares, políticas públicas e saúde Petrópolis: Vozes; 1989. v. 1, p. 45-65.
27. Oslak O. Políticas públicas e regimes políticos: reflexões a partir de algumas experiências latino-americanas. Rev Adm Pública Fund Getúlio Vargas 1982; 16: 17-60.
28. Coutinho CN. Representação de interesses, formulação de políticas e hegemonia. In: Fleury S, organizador. Reforma sanitária: em busca de uma teoria. Rio de Janeiro: Cortez; 1989. p. 47-60
29. Fleury S, Mendonça MH. Reformas sanitárias na Itália e no Brasil: algumas comparações. In: Fleury S, organizador. Reforma sanitária: em busca de uma teoria. Rio de Janeiro: Cortez; 1989. p. 193-232
30. Luz MT. Notas sobre as políticas de saúde no Brasil de "Transição Democrática" - anos 80. Physis: Rev Saúde Coletiva 1991; 1: 27-45.
31. Noronha J, Levicovitz. E. AIS - SUDS - SUS: os caminhos do direito a saúde. In: Guimarães R, Tavares R, organizadores. Saúde e sociedade no Brasil anos 80. Rio de Janeiro: Relume-Dumará; 1994. p. 73-112.
32. Mendes E. As políticas de saúde no Brasil nos anos 80: a conformação da reforma sanitária e a construção da hegemonia do projeto neoliberal. In: Mendes E, organizador. Distrito sanitário: o processo social de mudança das práticas sanitárias do Sistema Único de Saúde. São Paulo: Hucitec; 1993. p. 19-91.
33. Escorel S. Reviravolta na saúde: origem e articulação do movimento sanitário [dissertação mestrado]. Rio de Janeiro: Escola Nacional de Saúde Pública da Fundação Oswaldo Cruz; 1987.
34. Araújo JR. Decentralization in the health sector: the Brazilian process, issues and problems 1988-1994 [master dissertation]. Leeds: Nuffield Institute for Health, University of Leeds; 1994.
35. Nogueira RP. Medicina interna e cirurgia: a formação social da prática médica [dissertacao mestrado]. Rio de Janeiro: Instituto de Medicina Social da Universidade Estadual do Rio de Janeiro; 1987.
36. Fleury S. O dilema da reforma sanitária brasileira. In: Berlinguer G, Fleury S, Campos G. Reforma sanitária: Itália e Brasil. São Paulo: Hucitec; 1988.
37. Brasil. Decreto nº 91466 de 23 de julho de 1985. Convoca a VIII Conferência Nacional de Saúde e dá outras providências. In: Anais da VIII Conferência Nacional de Saúde; 1986 mar 17-21; Brasília, DF, Brasil. Brasília: Ministério da Saúde; 1987. p. 399-400
38. CNRS (Comissão Nacional da Reforma Sanitária). Documentos I. Rio de Janeiro: CNRS; 1987.
39. Brasil. Constituição, 1988. Constituição da República Federativa do Brasil: Título VIII. Da Ordem Social. Seção II. Da Saúde. Brasília, DF: Congresso Nacional; 1988.
40. Brasil. Lei nº 8080 de 19 de setembro de 1990. Dispõe sobre as condições para a promoção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. In: Ministério da Saúde. Gestão municipal da saúde: leis, normas e portarias atuais. Brasília, DF: Ministério da Saúde; 2001. p. 15-34.
41. Brasil. Lei nº 8142 de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde, e dá outras providências. In: Ministério da Saúde. Gestão municipal da saúde: leis, normas e portarias atuais. Brasília, DF: Ministério da Saúde; 2001. p. 35-37.
42. Motta PR. Participação e descentralização administrativa: lições de experiências brasileiras. Rev Adm Pública Fund Getúlio Vargas 1994; 28: 174-94.
43. Uga MA. Descentralização e democracia: o outro lado da moeda. Plan Pol Públicas IPEA 1991; 5: 87-104.
44. Maciel Filho R. Community participation in Brazilian health system: a case study on the hole of health council in Pernambuco state - 1995/1996 [master dissertation]. Leeds: Nuffield Institute for Health, University of Leeds; 1997.

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