Municipal Health Council Compositions in the State of São Paulo

CONFIGURAÇÕES DOS CONSELHOS MUNICIPAIS DE SAÚDE DE UMA REGIÃO NO ESTADO DE SÃO PAULO

CONFIGURACIONES DE LOS CONSEJOS MUNICIPALES DE SALUD DE UNA REGIÓN DEL ESTADO DE SÃO PAULO

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ABSTRACT

This article discusses the legal structure of the municipal Health Councils in a Health County in the state of Sao Paulo comprising six municipalities. This descriptive and exploratory study was based on documental research according to federal laws for the creation, organization, structure and routine work of the health councils. Results were presented and discussed in categories. The health councils were created in 1991, and four of them have changed their legal instruments, two of them have innovated in some procedures, such as election of the director, administration non-coincident with local majors, administrative structure and commissions. Some council regulations are in disagreement with local and federal laws, such as the deliberative character, parity representation of users, internal regiment, municipal staff in charge of council directory, and no guarantee of administrative and financial support for routine work. It can be concluded that it is necessary to improve and correct regulations to guarantee a suitable performance of health councils and also to improve the discussion about social participation in the nursing curriculum.

DESCRIPTORS

Health Councils
Social Control Policies
Unified Health System
Social participation
Education, nursing

RESUMO

Este artigo discute o panorama das bases legais dos Conselhos de Saúde em uma região com seis municípios do Estado de São Paulo. A abordagem metodológica, cujos resultados foram apresentados e discutidos em categorias, é descritiva e exploratória, sustentada por pesquisa documental baseada nas normas nacionais, considerando aspectos de criação, estruturação, organização e funcionamento dos conselhos, criados em 1991. Quatro deles alteraram seus dispositivos legais sendo dois deles com inovações, tais como: eleição do presidente, mandato não coincidente com executivo, estrutura administrativa e comissões. Algumas leis dos conselhos têm inconsistências quanto às normas locais e nacionais em relação ao caráter deliberativo, paridade dos usuários, regimento interno, gestor como presidente nato e não garantia de estrutura administrativa e financeira para funcionamento. Conclui-se que, para garantir que os Conselhos de Saúde exerçam de forma adequada seu papel, é necessário buscar aprimoramento dos dispositivos legais e também enfatizar o aprimoramento do tema *participação social* nos currículos de Enfermagem.

DESCRITORES

Conselhos de Saúde
Políticas de Controle Social
Sistema Único de Saúde
Participação social
Educação em enfermagem

RESUMEN

Este artículo discute el panorama de bases legales de Consejos de Salud en una región con seis municipios del Estado de San Pablo. El abordaje metodológico es descriptivo, exploratorio, sustentado en investigación documental, basado en normas nacionales, considerando aspectos de creación, estructuración, organización y funcionamiento de consejos. Resultados presentados y discutidos en categorías. Los consejos nacieron en 1991; cuatro alteraron sus dispositivos legales, dos de ellos con innovaciones como elección del presidente, mandato no coincidente con el ejecutivo, estructura administrativa y comisiones. Algunas leyes de los consejos presentan inconsistencias respecto de normas locales y nacionales referidas al carácter deliberativo, igualdad de usuarios, régimen interno, gestor como presidente nato y falta de garantías de estructura administrativo-financiera para su funcionamiento. Se concluye en que, para garantizar que los Consejos de Salud ejerzan adecuadamente su papel, debe buscarse optimización de dispositivos legales y enfatizar la *participación social* en los currículos de Enfermería.

DESCRIPTORES

Consejos de Salud
Políticas de Control Social
Sistema Único de Salud
Participación social
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INTRODUCTION

The ideology of the Unified Health System (SUS) resulted from society's desire, which was made clear in the movement of the Brazilian Health Reform in a time when the country was under a dictatorial regime and the State exerted strong control over the society. The direct participation of the community, proposed in this movement, emerged in the face of a crisis of legitimacy of conventional ways to represent interests, given pressure from social movements, and was inspired by recommendations of international agencies[1].

The Magna Carta resulted from this movement and was enacted in 1988, called *Constituição Cidadã* [Constitution Citizen], it ensured the creation of the SUS, which includes various aspects guaranteeing the participation of the community in government decision-making, and is one of the organizational principles of the system along with decentralization and integral care[2].

The regulation of community participation in SUS was possible through the Organic Health Law nº 8,142/90. In consonance with the decentralization principle, this law determines that there will be participative boards in each sphere of the federal, state and city governments, conferring to the health councils

> a permanent and deliberative character acting in the control of public policy implementation in the corresponding body, including its economic and financial aspects[2].

The process of establishing health councils was intensified in the country through the Operational Standards edited by the Ministry of Health in 1991. According to a study[3], the 5,564 Brazilian cities have a City Health Council (CHC) implemented, though only information from 5,553 CHCs is found in the database of the National Record of Health Councils[4].

The health councils are *one of the main and most interesting innovations of the contemporaneous Brazilian health organization* and has increasingly become an object of investigation and the theoretical reflection of researchers[5]. In the context of organizations, traditionally vertical structures are giving way to more democratic concepts, configured through networks, groups, teams and professionals, who demand a greater voice in decision-making processes[6].

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Such a fact has led nurses, in addition to improving their leadership skills, also to occupy various positions of representation in these participative spaces. Nurses have an important role in strengthening the social control of SUS through the exercise of their functions[7] as health workers, managers or service providers, in addition to promoting the participation of users.

The Brazilian Curricular Guidelines of Nursing Undergraduate Programs[8] indicate in its 5th Article that the education of nurses should enable these professionals to hold specific competencies and skills, among which are: understanding health policy in the context of social policies and acknowledging epidemiological profiles of populations; health as a right; participation in the establishment of advisory and deliberative structures of the health system and acknowledgement of nurses' social role to work in health policy and planning activities.

Initiatives to review undergraduate nursing curricula are in progress, filling in the gap between educational and work processes[9], which corroborates the need to introduce themes related to the Brazilian health policy in teaching, including instances of SUS social control[10].

The Essential Public Health Functions in the education of nurses, a recommendation of the Pan–American Health Organization (PAHO), represent the base on which "the programs can be constructed and improved" and include social participation in health[11].

This theme in such a context, while essential for public health, needs to be emphasized in curricula, considering that SUS provides social participation in its organizational principles with the participation of users and health professionals in health councils and conferences[12].

OBJECTIVE

This study analyzes the CHC of a Health Region in the state of São Paulo, Brazil and addresses aspects related to the creation, structure, organization and functioning of these bodies based on recommendations of the National Council of Health (NCH).

METHOD

Considering the objective of presenting a perspective on CHC, the health region that includes the city where the researchers' institution is located and its surroundings with distinct population sizes was chosen. It was called Region *Coração* [Heart] of the Regional Department of Health III (RDH) in the process of regionalization of the State of São Paulo that was initiated in 2007. The study has a descriptive and exploratory approach and is based on a documental search performed between June and December 2008 in the RDH III in Araraquara, SP, Brazil.

This study was approved by the Ethics Committee concerning research involving human subjects at the Federal University of São Carlos (Protocol nº 237/2008).

The organization and analysis of data consisted of identifying, in the CHC legislation, issues based on Resolution NCH nº 333 from 2003 and on other legal devices of SUS[2,13], which are then discussed in the following categories: creation of health councils, definition of councils and their deliberative characters, composition and representativeness of

health councils, number of counselors by segment and parity, how the health councils' members and chairs are chosen, the health councils' administrative and financial structure, existence of committees, plenary meetings of health councils and the participation of the population in such meetings.

The cities are coded from 1 to 6 according to the alphabetical order of their names in data presentation and discussion.

RESULTS AND DISCUSSION

Creation of Health Councils

The CHCs were established in 1991, a result of specific laws in Cities 1, 2, 4 and 5 and by Executive Decree in City 3. In City 6, the creation of the council occurred through the Law of the City Health Fund[a].

This data are compatible with national data and those from the state of São Paulo, respectively 86.24% and 87.75% of the CHCs were created through laws[4] according to Resolution NCH nº 333 de 2003[13].

The national inductive policies were instrumental for the creation of these bodies in 1991 because they conditioned their existence on the reception of federal financial transfers. Consequently, 92% of the CHCs in Brazil were created in this period[5].

The review process of existing laws, which regulate the health councils in the region, is presented in Table 1.

Table 1 - Legislation of City Health Councils in the Health Region Coração of the RHD III - São Carlos, SP, Brazil - 2008

City	Year of creation	Law amendment	What was changed?
1	1991	No	-
2	1991	April 5th, 2001	• Election of the president, termination of mandate does not coincide with the executive, insurance of administrative structure, existence of committees, etc.
3	1991	May 21st, 2002 March 9th, 2005	• Plenary sessions are settled with the presence of 1/3 of its members, who shall decide by majority vote; • Creation of the CHC by law with some innovations: election of the president, insurance of administrative and financial structure, existence of committees, etc.
4	1991	July 9th, 1991 April 12th, 2005	• 1991: number of the participants of the CHCs representations; • 2005: with other changes, but no significant breakthroughs.
5	1991	No	-
6	1991	July 25th, 2003	• Election of the president, termination of mandate does not coincide with the executive, insurance of administrative structure, existence of committees, etc.

Source: City Laws and Decrees.

Changes in the legislation did not occur uniformly over time in the cities; significant innovations are observed only in the Cities 2, 3 and 6. The laws of the CHCs of the Health Region define that the functioning of these bodies shall be governed by internal rules to establish the *rules of the game*, regulating the procedures of the councils and guiding the decision-making process[14]. Such a device does not exist in the Cities 4 and 5, which is contrary to Resolution nº 333.

Definition of councils and their deliberative character

The definition of the CHC in the Health Region is presented in various forms in the legal apparatus as are their basic characteristics, shown in Table 2. With the exception of City 5, which presents the council as an advisory body, and City 4, which does not make clear its deliberative nature, the remaining are in agreement with current legislation.

Table 2 - Definition and Characteristics of City Health Councils in the Health Region Coração of the RDH III - São Carlos, SP, Brazil - 2008

City	Definition of Council	CHC Characteristics
1	Body member of the basic structure of the City Health Department or Secretariat.	Does not make clear its deliberative status though mentions that decisions shall be formalized through legal document.
2	Higher participative body, responsible for SUS in the city.	Deliberative, legislative, supervisory and advisory status.
3	Permanent, deliberative and legislative body of SUS at the city level.	Deliberative and legislative character.
4	Body member of the basic structure of the City Health Department or Secretariat	Does not make clear its deliberative status though mentions that decisions shall be formalized through legal letters.
5	Not defined.	Does not make clear its deliberative status though mentions that decisions shall be formalized through legal letters. The City Organic Law confers to it a consultative status.
6	Instância colegiada deliberativa e de natureza permanente, vinculada à Secretaria Municipal de Saúde.	Deliberative status.

Source: City Laws and Decrees.

[a] The City Health Fund is a legal instrument of accounting, budgeting and a financial nature that manages the city's health resources.

Some cities do not clearly acknowledge the deliberative nature of community participation in decision-making concerning health policies, which shows the need for a review on the part of local governments and the councils themselves.

Composition and representativeness of health councils

According to Resolution nº 333, the health council is composed of representatives of the following segments: users, health workers, government, and health service providers.

Table 3 presents the entities or representations by category and subcategories of counselors contemplated in the city laws of the Health Region under study.

Table 3 - Composition of City Health Councils in the Health Region Coração of the RDH III - São Carlos, SP, Brazil - 2008

Categories	Subcategories	Cities
Government	City Health Department	1, 2, 3, 4, 5, 6
	State Health Department	1, 4, 5, 6
	Other City Health Departments	4, 5, 6
Health Services Providers	SUS Contracted Services or not	1
	Public, Philanthropic and Private Services	2,4, 5 e 6
	Medical Group	4
Health Workers	Un-named professional entities	1, 2 e 6
	Public or private health entity	3 e 4
	Medical Entities	6
	Dental Surgeons Entities	4, 6
	Nursing Entities	6
	Education of human resources in health entity	6
Users	Labor organizations	2, 4
	Social and community movements	2, 3, 4, 6
	Employers and private entities	2, 3
	Disease carriers	2, 3, 4, 6
	Elderly individuals, retirees, etc.	2, 3, 4
	Community councils of health units	2
	Entity's users	5
	Users from the Health Region	6

Source: City Laws and Decrees.

There is no representation at the state level in the category 'government' in 33.3% of the CHCs, which is specified in the foundational legislation. Hence, we conclude that the cities have acquired a more autonomous and independent posture in this process in relation to this sphere of the government.

Another relevant fact is that social areas such as Social Promotion, Education and Culture are represented in some city councils, which seems to reflect the valorization conferred on inter-sectionality in health issues. It corroborates the claim that the presence of representatives from other fields shows the commitment to establish inter-sector cooperation, which is *intrinsic to the view of the health disease continuum embedded in SUS*[5].

Health service providers are represented in the CHCs in the Region, except in City 3. Resolution nº 333 indicates that this segment should include under-contract private or nonprofit health services providers.

Health workers are represented in the CHC and aggregate various associations or professional councils with the exception of City 5. The Cities 3 and 4 define their representations as originated from the local public and private health services themselves as provided in the cities' legislations. In this segment there is also the participation of representatives of educational institutions of human resources in health (City 6). The participation of nursing is highlighted. This profession has, in one city, participation below what is ideal given its numerical importance among health workers.

The representatives of users are from many entities in the society in addition to representatives of Health Regions or Local Councils Managers. City 5 does not specify in its legislation which entity represents users.

In general, with some exceptions, the segments are represented in the health councils as recommended by Resolution nº 333, and with the composition established in local laws.

Number of counselors by segment and parity

The parity of users in relation to the remaining components is considered an important indicator of the level of democratization and autonomy of Health Councils[15,16]. According to law nº 8,142, the health councils shall be equally composed of health services' users in relation to the set of all the other segments represented[2]. Resolution nº 333 recommends the following distribution of seats: user entities=50%; health worker entities=25%; government and health services providers =25%.

Table 4 presents the quantity of health council members existing in the studied region and their respective categories of representation.

Users are equally represented in the councils, that is, there are 50% of these in relation to the remaining members of the council (health workers, providers and management) with the exception of the City 4.

When the distributions of councilors are verified, the users and health workers are below the percentage of participation recommended in 50% of the CHCs, conferring to providers and government a participation of 30% of the total of councilors.

These data are similar to a national study[15], which verified that 68.5% of the CHCs respect the parity of users in relation to the remaining segments and only 25% fully respect the recommendation of the NCH resolution. The over representation of managers in the health councils may compromise social control, thus the composition of such councils needs to be reviewed[14].

Table 4 - Number of Health Councils and percentage of participation by category in the Health Region of Coração of the RHD III - São Carlos, SP, Brazil - 2008

City	User	%	Health workers	%	Service providers	%	Management	%	Total
1	8	50	4	25	2	12.5	2	12.5	16
2	9	50	3	16.6	3	16.6	3	16.6	18
3	8	50	4	25	0	0	4	25	16
4	8	44	3	16.6	3	16.6	4	22.2	18
5	6	50	2	16.6	2	16.6	2	16.6	12
6	12	50	6	25	2	8.3	4	16.6	24
Total	**51**	**49**	**22**	**21**	**12**	**12**	**19**	**18**	**104**

Source: City Laws and Decrees.

How the health council's members and chair are chosen

The CHC, with exception of City 6, have their councilors chosen by their peers, in agreement with the recommendation of Resolution nº 333. It enables the choice of a council member linked to the bases of entities of representation and discourages directed and biased processes that result from the lack of organization of civil society[17].

The text found in City 5 in which counselors *are named by the City Mayor according to criteria to be established in Decree* is highlighted. City 6 in turn determines that the *users of the regions shall be elected by their peers* and representative entities of users and professions *in widely disseminated assemblies*.

In relation to the selection of the CHC coordinator or chair, 50% of the cities (2, 3 and 6) include election among peers, while the election of the council's chair is a responsibility of the Health Secretary in the remaining cities, which is contrary to what is established in Resolution nº 333[13].

Even though election processes are held to choose chairs in some CHCs, the health secretary is the chair, except in City 2 where one user occupies this position. It is reported that in 50% of the CHCs (Cities 1, 3 and 4), the secretaries who are the chairs are nurses.

Similarly, studies conducted at a national level identified a prevalence of managers as chairs of CHCs at 67.1%[15] and 63.8%[17]. Such a fact *possibly occurs when a sense of obligation crystallized in city's laws that created the Health Councils* and *managers are not the chairs of most of CHC when the vote is secret*[15].

The prevalence of the centralization of power in the local executive with the coordination of councils exerted by health managers, even where they are chosen through election, may be an indication that civil society has not yet accomplished this achievement.

The health councils' administrative and financial structures

According to resolution nº 333, the *Governments shall ensure autonomy for the full functioning of the Health Council, budget allocation, Executive Secretary and administrative structure*, which are defined by the health councils themselves as *the administrative structure and personnel staff...*[13] required for their activities.

The studied cities present a diversity of situations established in their local legislations, which are presented in Table 5.

Table 5 - Administrative and Financial Support to the City Health Councils in the Health Region Coração of the DRS III - São Carlos, SP, Brazil - 2008

City	Administrative and Financial Support	Executive Secretary
1	Not defined.	CHC secretary: a local server designated by the chair.
2	City Health Department: Administrative Support services	Executive secretary is chosen among councilors.
3	City Health Department: may provide administrative and financial support; The Council shall propose allocation to meet its needs.	Executive secretary is subject to the chair, with exclusive room, basic equipments and at least one city's employee with compatible qualification.
4	Not defined.	Secretary: CHC member, elected by peers
5	Not defined.	Executive secretary appointed by the chair
6	City Health Department: infrastructure required to the CHC functioning, financial and material resources; Budget allocation appropriate for the needs.	Executive secretary subject to the chair, with exclusive room, basic equipment and at least one city's employee with compatible qualification

Source: City Laws and Decrees.

In general, the CHC laws of Cities 2, 3 and 6 present some type of administrative and financial support, while it is the role of the city health agency to provide such support. In the remaining cities, the lack of clarity concerning

administrative and financial support may generate vulnerability, impeding the health councils' attempts to appropriately perform their functions.

It is verified through information available in the National Registration that 33.9% and 39.2% of the councils are structured to have an executive secretary in the state of São Paulo and Brazil, respectively. The indices of budget allocation correspond to 11.0% and 17.6% of the CHCs, respectively, in the state of São Paulo and Brazil[4], which makes apparent the poor infrastructure of these participative instances.

Another study[5] shows that only 26% of the CHCs had an executive secretary. Another more recent study analyzing the entire country reveals the situation has not changed, and indicated that only 24.86% of the CHCs have a structured executive secretary, while 8.91% do not have financial resources[17].

To verify the vitality of councils, the existence of an executive secretary indicates the level of an agency's structure; this support is essential to ensure functioning conditions[5].

Similar to issues previously discussed, the CHC's poor guarantees of administrative and financial infrastructure show a lack of acknowledgment on the part of local governments.

Existence of committees

To exercise their responsibilities, the health councils can establish internal committees composed only of councilors of a temporary or permanent character, as well as other intersector committees and work groups for transitory actions[13].

The committees have a *propositional character* with their main responsibility being to prepare analysis and advice concerning themes that are submitted to plenary meetings, enabling members to have the *opportunity to deepen the addressed themes* and encourage and qualify the work of its members[18].

With the exception of City 5, these spaces are differently provided and receive diverse names in the CHC legislations: transitory or permanent and sector or inter-sector special committees.

In a study carried out at the national level[17], only 8.9% of the CHCs had permanent committees and 3.7% had other types of committees. The absence of committees weakens local social control as it does not support or provide analyses, disqualifying decisions concerning public health policies[18].

Plenary meetings of health councils

Health councils' meetings should ordinarily be held at least once a month and otherwise held as provided in internal regulations, in addition to being open to the public. Such requirements ensure the continuity of *debates concerning themes and issues related to social control, to the definition of guidelines of policies and the administration of public health management*[15].

The meetings in the studied CHCs should be ordinarily held once a month and additionally held when convened by the chair or members, except in City 5, where the frequency of meetings is every six months, contrary to the NCH resolution.

Data from the Health Councils National System[4] show that 85.09% and 90.70% of the CHCs in the state of São Paulo and in Brazil, respectively, regularly hold meetings at least once a month. Another national study showed that 83.5% of the CHCs held ordinary meetings at least once a month and 15% held meetings in intervals greater than a month. In 0.7% of the councils, the frequency of meetings is once every six months, *which allows us to conclude that these councils do not interfere in the decision-making of local health policies*[15].

A simple way to verify whether a health council works is to identify the occurrence of regular meetings and whether they have some administrative structure. The author of this study asserted that *the performance of meetings is certainly the most elementary manifestation of the organic life of councils […] It is a direct indication of the* active *character of the Council*[5].

Participation of the population in meetings

Legislation from Cities 1, 2 and 4 does not address the participation of the population in meetings. Plenary meetings are open to the population in the remaining cities though with different possibilities of manifestation:

> […] shall be open to interested people who may have the right to speak by deliberation of the plenary (Cities 3 and 6);
>
> Meetings will be public unless otherwise required by some councilor; the suggestion shall be the object of decision on the part of councilors… (City 4).

A study of national scope revealed that all the State Health Councils and 89% of the studied CHCs have meetings open to the population. It also showed that CHCs whose chairs are mainly from the management segment do not give people the right to speak[15].

Adjustments in such arrangements would ensure greater democratization in these spaces enabling increased social participation.

CONCLUSION

It is possible to verify the advancements achieved in the 20 years SUS has been established in relation to national laws that support the participation of the population through health councils. This study portrays these advancements in the studied Health Region. It is, however, important to note that despite advancements, many cities still maintain restrictive laws that limit a more autonomous, democratic and effective participation in these bodies, indicating there is hegemonic maintenance of power on the public health policy in local governments.

Even though nurses occupy the chair of various health councils and also represent workers from the sector, this professional has not yet fully appropriated the space of social control within SUS.

The theme *Health Councils* has seldom been addressed in the scope of nursing, which allows the emergence of important discussions from the point of view of education and the practice of professionals from this field in the country. This study contributes to the production of knowledge as it examines the structure and dynamics of the functioning of these participative spaces. Hence, it is essential to include such a topic in the curricula of nursing programs to improve the exercise of social participation within SUS.

It is worth noting that the study in a specific context of a Health Region can provide evidence for the different advancements achieved in terms of social participation in the cities. It also permits the generation of a fruitful exchange of experiences among health councils, including all the involved actors and intensifies processes with the necessary adjustments to improve social control in the regional spaces for discussions such as Participative Management established by the Health Pact in 2007.

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