Democratization and continuing education: perception of former QualiConselhos students about its contribution to the improvement of health councils

Democratização e educação permanente: percepção de egressos do QualiConselhos sobre contribuições aos conselhos de saúde

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ABSTRACT This article examines the extent to which the process of continuing education initiated by the Support Program for the National Policy of Continuing Education for Social Control in the Brazilian Unified Health System – QualiConselhos (Health Council Qualification) has contributed to the improvement of participation in health councils. The research focused on the profile and the context of the health councils, as well as on the knowledge and the daily practice of 1,859 advisors in 26 states. The data was collected through an on-line survey on the course's website. We have concluded that qualification processes are essential for health advisors to better comprehend and improve their performance in health policy decision-making.

KEYWORDS Health councils. Citizen participation. Education, continuing. Democracy. Health care reform.

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RESUMO *O presente artigo analisa em que medida o processo de educação permanente deflagrado no Programa de Apoio à Política Nacional de Educação Permanente para o Controle Social no Sistema Único de Saúde – QualiConselhos (Qualificação de Conselhos de Saúde) contribuiu para o aperfeiçoamento da participação nos conselhos de saúde. Foram estudados o perfil, o contexto dos conselhos, o domínio de conhecimentos e a prática cotidiana de 1.859 conselheiros(as) em 26 Unidades de Federação. A coleta dos dados foi realizada por meio de um questionário respondido na plataforma on-line do curso. Concluímos que processos de qualificação são fundamentais para que conselheiros compreendam melhor e aperfeiçoem o exercício de seu papel no processo decisório das políticas de saúde.*

PALAVRAS-CHAVE *Conselhos de saúde. Participação cidadã. Educação continuada. Democracia. Reforma de serviços de saúde.*

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Introduction

The creation of health councils in all of the country's states and cities represents the most daring institutional innovation of the Brazilian Unified Health System (SUS), and is capable of promoting the democratization of health policies, especially on account of the potential for support for the participation of representatives of organized civil society in the decision-making process.

Moreira and Escorel (2009), in the most recent national census survey on city and state health councils, demonstrated that, in 2007, there were more than 72,000 health advisors in the country, being that 50.8% represented the segment of SUS users. These come from 27,669 entities of organized society which, for its part, represent a myriad of local political actors that have historically had little or no opportunity to participate in the decision-making processes of public policies.

Therefore, in promoting this increase in social participation, the health councils insert into the decision-making process actors that do not have a historical trajectory of institutionalized political debate, which, for them, reduces the cultural, technical, rhetorical, processual, legislative, associative, and enunciative repertoires and resources that the traditional actors have built over the years and decades.

On account of this need for new actors inserted into the decision-making process, the sectorial debate has been giving an expressive emphasis to the qualification of advisor working practices as a factor of utmost relevance to increase not only their participatory potential, but also their effectiveness. In 2007, the National Health Council (CNS) and the Secretary of Strategic and Participatory Management of the Ministry of Health (SGEP/MS) approved the National Policy of Continuing Education for Social Control in SUS (PNEPSUS) (BRASIL, 2007), seeking to foster the expansion of already existent initiatives in educational institutions and stimulate states and cities to seek the qualification of their advisors.

This recent process has not been consolidated yet, there being few studies on its processes, results, and impacts (ALENCAR, 2012). This article seeks to contribute to filling this gap by reflecting upon the results of QualiConselhos (Health Council Qualification) – Support Program for the National Policy of Continuing Education for Social Control in SUS, based on an evaluative survey conducted with 1,859 former health advisors from the National Enablement Course for the Development of the Practice of Social Control in SUS, the first educational offering of the aforementioned program. The objective of this evaluative survey is to analyze to what extent the process of continuing education initiated by QualiConselhos contributed to the improvement of the participation and performance of health councils that participated in the National Course. Its results, therefore, are constituted in the empirical basis that structures this article. Before discussing them, the next section presents the theoretical references that will guide their analysis.

Democratization, social participation, health councils, and the role of continuing education

The participation of organized society in defining the directions of public policies is a recent phenomenon in the course of formation of democratic regimes and represents an effort to overcome the limitations of classical representative schemes. Santos and Avritzer (2002) argue that the emergence of ideas and proposals for community participation in State decisions occurred as a result of the crisis of democratic debate in the post-war period, which is characterized by three

tendencies: (a) the overcoming of structuralist theories devoted to explaining the possibilities for democracy's emergence in each national context, (b) the outdating of the landmarks that sought the universalization of traditional models of liberal democracy in the face of the new experiences of Eastern Europe and Latin America, and (c) the tendency to value local practices and existing variations in the sphere of nation states.

In the last decades of the 20th century, the center of debate shifted from the clashes between the emphasis on the individual rights of the citizen (liberal democracy) or on the sovereignty of the popular will (popular democracy) to the issue related to the quality of democracies, in the extent to which, with the fall of the Soviet Union, the expansion of institutions typical of Western democracy to a greater number of countries, covering wider population ranges, has produced the paradox of low intensity democracies: extension of the mechanisms and structures of representation accompanied by the reduction of the levels of citizen mobilization and the loss of the legitimacy of representatives (DALLMAYR, 2001).

Consequently, the valorization of participatory practices and forums was disseminated as part of a set of processes of redefinition of State/Society relations that occurred in the last three decades of the 20th century, driven both by the struggle of new social actors for recognition, political space, and rights in the sphere of movements for democratic opening and by the changes in the structure and performance of public administration introduced by strategies of State Reform.

In both movements, there was the recognition that the recuperation of mechanisms of representation or their restructuring and improvement alone would not be enough to give political quality and vivacity to national democracies and that it would be necessary to introduce more direct forms that made it possible for the various social actors to influence State decisions in a more direct manner. In this sense, the social participation of society in public policies emerges as a practice that is complementary to the classical format of representative democracy, seeking to increase State responsiveness, combat crony and patrimonial practices, diversify the possibilities of inclusion of new political actors and cultural identities, and guarantee rights (BOBBIO, 2004).

In the case of Brazil, the demands for greater society participation in government decisions were an intrinsic part of the struggle against the authoritarian regime established by the 1964 Military Coup (FEDOZZI, 2009). Throughout the process of redemocratization, the different political actors of the resistance, little by little, with 'liberalization,' began to coordinate themselves in organizational associations of a civil nature that pressed for a greater ability to interfere in government decisions, such as the popular movements of the urban poor, the movement for national urban reform, professional and class associations (lawyers, engineers, university professors, doctors, etc.), peasant movements (for example, the Landless Workers Movement – MST), labor unions in industry and commerce, and the black movement, among others. Such movements, although they adopted a position of autonomy in relation to political parties and the authoritarian State, eventually proposing forms of organization for public policies independent of the State, mainly sought to rupture the authoritarian bureaucratic model established by the military governments that insulated government decisions in the technocracy of the ministries (AVRITZER, 2012).

In the field of health, the Health Reform Movement (MRS) gathered the various sectorial forces around the banner of the guarantee of the right to State healthcare, coordinating popular movements, bureaucracies in the Health and Social Security Ministries, state and city managers, sectors of the Communist Party (PCB), and health workers. The MRS gained expression in

the second half of the 1970s, coordinating the mobilization of organized civil society, brought together in institutions such as the Brazilian Center for Health Studies (Cebes) and the Brazilian Association of Collective Health (Abrasco), the infiltration of frameworks in the public administration of the health sector in the three spheres of the federation, and the holding of social participation events aimed at building proposals to subsidize the intended reforms in the health system, which was considered to be exclusive and centralized (FALLETI, 2010).

Consequently, at the basis of the MRS' conceptions and strategies of political action there was a vision of change in State/Society relations, expressed in the slogan 'Health is Democracy,' which combined the increase in organized sectorial civil society, coordination with political leaders devoted to redemocratization, the opening of the decision-making instances and processes of public administration, and the decentralization of networks of health actions and services (FLEURY, 1997). Centered on State democratization, the MRS' vision guided the whole process of institutionalization of sectorial reforms, which ranges from the holding of the I Symposium of National Health Policy in the House of Representatives, in 1979, and the approval of the Organic Laws on Health, in 1990, to fundamental political moments with the implementation of the Integrated Health Actions (AIS) (1982), the VIII National Conference on Health (1986), a defining moment in the directions and theses that led to SUS, and actions in the Constituent National Assembly (1986-1988) (ESCOREL, 2008).

Social participation in health policies is a result, then, of a daring project of democratizing reform in sectorial public administration, the health conferences and councils being a material expression of this ideology of health reform.

However, the conception of health councils expressed in the Final Report of the VIII National Conference on Health, in 1986, is considerably different from that which prevails in the country today, structured by Law 8.142/90. In the former, health councils, mostly in cities and states, would be external to public authority, formed only by representatives of citizens and health workers. On account of this, their role would be to exercise the control of society over the State. This is one of the few, if not the only, key ideas of the VIII Conference that was not maintained in the legal framework of SUS, in which the councils became an organ linked to the city executive, which counts on the participation of government representatives and even of private service providers. This means that, from a controlling external organ, the councils became health policy decision-making institutions. That is why it can be affirmed that health councils institutionalized social participation (MOREIRA, 2009).

The implementation and improvement of health councils in defense of SUS throughout the 1990s also required the use of political capital accumulated through health reform, in the extent to which the creation of a council in each Brazilian city demanded the mobilization of thousands of citizens, health managers, and health workers (CARVALHO, 1995). This movement was not automatic and was conducted in way that was concomitant to the actual process of implementation and decentralization of SUS, being marked by constant political clashes in the national sphere.

On the national level, in a context marked by market reforms, economic crises, and restrictions to social funding, the mobilization of organized civil society in spaces such as the National Health Council (CNS) and national health conferences was fundamental to the defense of the right to health and to the guarantee of SUS implementation, as some moments of the 1990s illustrate.

In the second half of the 1990s, the role of national forums of participation was essential in the building of a discourse in the denouncement of the obstacles imposed by the economic policy and the State reform

strategy of Fernando Henrique Cardoso's government and in the monitoring of issues that were considered strategic to the SUS implementation process. A large part of the work of mobilization and coordination by actors and entities active at the CNS was concentrated in actions to protect and promote the advances obtained with municipalization in the period of 1993-1994 (OUVERNEY, 2015).

This form of action covered, on the one hand, the creation of thematic commissions to accompany and take a position on issues relevant to the implementation of SUS (funding and intergovernmental financial transfers, human resources, medicine policy, worker health, PSF – Family Health Program, DTS-AIDS – Sexually Transmitted Diseases-Acquired Immunodeficiency Syndrome, etc.), seeking to regulate and direct the actions of the Ministry of Health and provide state and city councils with information and positions in order for them to do the same in relation to the state and city health secretaries.

In addition, on the other hand, the action of organized civil society entities in SUS involved political coordination to influence important decisions and oppose government proposals considered contrary to the achievements of the 1988 Constitution and to the implementation of SUS, such as the possibility that the CNS would not be summoned at the beginning of President Cardoso's first term, the Proposed Constitutional Amendment (PEC) that changed Art. 196 of the Brazilian Federal Constitution (CFB), Minister Bresser Pereira's State Reform, the postponement of the implementation of the Basic Operational Norm – NOB 96, the SUS funding crisis, and the approval of the Provisional Contribution on Financial Transactions (CPMF) and EC 29/00, among others. In this period, the National Health Plenary Assembly, at first, and the National Health Council Plenary Assembly, later on, were essential spaces for coordination and mobilization of the councils with regional and local reach (FALEIROS *ET AL.*, 2006).

This context of expansion of the role of councils and other forums of social participation, in virtue of the demands coming from the SUS implementation process, led to the need for advisors to have a greater grasp of areas of knowledge and the various themes related to health policy. The performance of advisor roles came to require, more and more, minimum levels of qualification in order to adequately accompany and be able to influence the health policy decision-making process in the three spheres of government.

At the end of the 1990s, qualification initiatives are observed that were developed by training centers (collective health departments, public health schools, etc.). The theme gained space in the official agenda of national forums, since not only the scale and extension of the programs, but also the nature of the qualification process became a target of the debates. Recognizing the relevance of the theme, the CNS expanded the discussions that were already occurring, and, in 1999, published the National Directives for the Capacitation of Health Advisors, defining references to guide the qualification initiatives for advisors throughout the nation.

This process acquired additional momentum with the creation of the Secretary of Work Management and Health Education (SGETS), in President Lula da Silva's first term. This initiative represented a qualitative change in the policies devoted to the democratization of public administration in the health sector, since it came to have an exclusive space in the sphere of the Ministry of Health with its own budget and management structure devoted to the promotion of participation and equity policies (BRASIL, 2013). Advisor training, at this moment, became one of the main initiatives of the new secretaries, in the scope of the national expansion of the continuing education policy in SUS (CECCIM, 2005).

The expansion and transformation into the Secretary of Strategic and Participatory Management (SGEP/MS) fostered the

publication of the National Policy of Continuing Education for Social Control in SUS (PNEPSUS), a result of the debates held in the sphere of the CNS and of the qualification initiatives developed by several academic institutions and training centers since the I National Congress of Health Councils.

Following the National Directives of Continuing Education for Social Control in the Unified Health System, constants of CNS Resolution 354/2005 (BRASIL, 2005), PNEPSUS defined as an objective the building of strategies and actions to promote the democratization of the State, the guarantee of social rights, and citizen participation in health policy.

The institutionalization of PNEPSUS increased government support for a broad set of national extension initiatives in the field of health advisor qualification, increasing the volume of resources invested in training programs and fostering the emergence of didactic and institutional innovations. In this context, QualiConselhos – Support Program for the National Policy of Continuing Education for Social Control in SUS – was one of the initiatives that implemented PNEPSUS, constituting a pioneering experiment on a national scale that, until 2016, had qualified more than 8,000 health advisors (MAFORT; MOREIRA, 2014).

Elaborated in the years 2011 and 2012, QualiConselhos is the fruit of a partnership among the National School of Public Health/Oswaldo Cruz Foundation (Ensp/Fiocruz), the Fiocruz Health Channel, the SUS Network of Schools and Training Centers, the Secretary of Strategic and Participatory Management at the Ministry of Health, the National Forum of Continuing Education for Social Control in SUS, and the CNS. Its first pedagogical offering, concluded in 2013, was the National Enablement Course for the Development of the Practice of Social Control in SUS, implemented in all states, except Rio Grande do Sul.

In order to evaluate the results and impacts of the National Enablement Course and thus produce subsidies not only for its improvement, but also for the continuation of the continuing education process, an evaluative survey was conducted with former students. This is the research data that constitute the empirical basis of this article. Next, the methodological aspects of this evaluative survey are presented.

Evaluative survey methodology

The characteristics of the councils and the working dynamic of the advisors were studied based on an evaluative survey that analyzed the profile of composition and the working context of the councils, as well as the grasp of basic knowledge about social participation and the daily practice of advisors in their relationship with the segments that they represent and in their debate of themes considered nationally relevant for the advancement of SUS. *Chart 1* presents the dimensions and respective variables employed in the study.

Chart 1. Analysis dimensions and variables in QualiConselhos' evaluative survey

Analysis Dimensions	Variables
Advisor profile	Segment represented in the council Time active on the council (terms) Participation in elaboration of city health plan Role performed on the council
Context of practice	Perception of the level of council influence on health policy Council participation at the last city health conference Discussion frequency of the city health plan by the council Form of utilization of the city health plan by the council
Objective knowledge of the health plan and conference	Function of the city health plan Content of the city health plan Function of the city health conference Role of the council in relation to the city health plan Evaluation of the city health plan by the council
Council and advisor practice	Enablement for debate on the city health plan with their segment Enablement for discussion of Municipal Health Council (CMS) agendas with the represented segment Enablement for debate on regionalization (Decree 7.508/11) Enablement for use of the Public Health Budget Information System (Siops) as an instrument of social control Enablement to guide the debate at the CMS on intersectoriality Enablement to guide the debate at the CMS on networking with other councils

Source: Elaborated by author.

Data collection was performed through a questionnaire elaborated by QualiConselhos coordinators, which was composed of 20 closed questions, being that 4 allowed multiple answers, and 16, only one answer. The questionnaire was transformed into an electronic form and inserted in the Virtual Learning Environment (AVA), an on-line platform employed for the academic management of QualiConselhos, and the advisors, upon completing the course, were invited to respond to the questionnaire. Therefore, the information gathering technique applied in the evaluative survey was that of 'long-distance investigation.' This technique is recommended for surveys which, like that presented here, have many respondents distributed across an extensive territory, making the operational management and financial costs very high when techniques such as focal groups or open interviews are employed.

The data was collected in the period of July to November of 2013. 1,859 advisors responded to the questionnaire, the equivalent of 64.8% of the total number of course graduates. The set of respondents is distributed across the 26 Brazilian states where the course was completed, encompassing 908 cities, being that the average rate of return by state was 57.3%. The data was automatically exported from the AVA to an Excel spreadsheet and inserted in the Statistical Package for the Social Sciences (SPSS) software for tabulation generation. The results obtained are presented and discussed in the following section.

Perceptions of graduates of the National Enablement Course for the Development of the Practice of Social Control in SUS about the health councils in which they operate and the contributions of QualiConselhos to their performance

As presented in *table 1*, the majority of the responding advisors was formed by workers and users (66%) who were in their first or second term (64.5%) and had participated at most once in the elaboration processes of a city health plan (71.3%).

This data may indicate a movement of renovation in the composition of health councils. If this is verified, it may represent an expansion of the interest in social participation, which would be extremely healthy, at the same time that it would increase the challenge of the Policy of Continuing Education for Social control in SUS. It becomes necessary, therefore, to invest in studies on the composition of the councils in order to verify the real significance of this process.

Table 1. Distribution of advisors per segment represented, number of terms, participation in the elaboration of Municipal Health Plan (PMS), and role performed on the Municipal Health Council (CMS)

Segment Represented	%	Elaboration of PMS	%
Workers	35,4	Did not participate	40,5
Users	30,6	Once	30,8
No longer an advisor	15,9	Twice	12,4
Managers	13,4	More than twice	16,3
Service providers	4,8		
TOTAL	100,0	TOTAL	100,0
Number of Terms	**%**	**Role Performed on the CMS**	**%**
First	39,1	Didn't have a specific role	25,3
Second	25,4	Participated on committees	26,4
Third	6,5	No longer an advisor/others	18,0
More than 3 terms	9,6	President	11,8
Didn't respond	3,5	Executive Secretary	8,8
No longer an advisor	15,9	Vice-President	4,4
		Coordinates/directs committees	5,3
TOTAL	100,0	TOTAL	100,0

Source: Elaborated by author.

The perception that councils have the capacity to influence the decisions of the Municipal Secretary of Health (SMS) is an indicator of consolidation of councils as a space of social participation and reflects the mobilization capacity of sectorial actors. In general, as can be seen in *table 2*, part of these new advisors (41.4%) have the perception that the council has average influence on city health policy, although it is important to emphasize that the contingent of those who attribute low or no influence (24%) is proportionally greater than the group that attributes high influence (17.1%).

In relation to participatory planning, most of the advisors pointed out that their councils had low policy-making initiative and little capacity for association with organized civil society. More than half (52.4%) indicated that the council did not participate in the organization of city health conferences, having only created partnerships with the SMS or elaborated theses. The building of partnerships with social movements for the holding of conferences was cited by only 17.8%.

Table 2. Advisor perception of the influence of councils and their performance in policy formulation and planning activities

Influence of the CMS	%	Inclusion of the PMS in meeting agendas	%
High	17,1	At least once	26,3
Low	21,4	Twice	12,8
Average	41,4	More than twice	27,4
None	17,5	Never	8,6
No longer an advisor/didn't respond	2,6	No longer an advisor/didn't know how to respond / other	24,9
TOTAL	100,0	TOTAL	100,0
CMS Participation at the last conference	**%**	**Use of the PMS by councils**	**%**
Organized in partnership w/ SMS	44,3	Guides the action of the CMS	8,2
Organized in partnership w/ SMS and social movements	12,8	In the supervision of the SMS	9,3
Elaborated theses/organized by themselves	3	Coordinated with management reports	18,3
Organized in partnership w/ social movements	5	The three previous ways together	8,3
Didn't participate	4,4	Not taken into account	15
No longer an advisor/didn't know how to respond /other	30,5	No longer an advisor/didn't know how to respond / other	40,9
TOTAL	100,0	TOTAL	100,0

Source: Elaborated by author.

For the respondents, the councils also rarely discuss the elaboration processes of city health plans: almost half (47.7%) included it less than twice in the meeting agendas of the first semester of 2013 (the semester before the completion of the survey), being that only 27.4% of the councils included it more than twice.

The councils, in the perception of the respondents, have a reasonable mobilization capacity to monitor the execution of city health policy: 44.1% use the city health plan in conjunction with management reports, in the control of the SMS, or to guide advisors. However, a small but significant group (15.9%) of health councils do not take city health plans into account.

The existing contradictions in advisor perceptions of the councils' reasonable capacity for influence and its low involvement in the activities of policy formulation and planning might be related to an adaptive behavior that is strategic to the dynamics of sectorial public management, characterized by the formalism of notarial planning. Therefore, council action would be more effective if directed to the implementation stage, seeking to influence the decision-making process and the dynamics of resource allocation directly in the contracting of professional services, the construction of centers, the purchase of materials, etc.

This would explain the emphasis on the monitoring and supervision of executive activities in detriment to the processes and moments of discussion of city health plans. Therefore, this adaptive behavior allows for the building of a participation strategy that leads councils to develop supervisory powers and a more reactive and denunciatory position, confusing its role, even, with organs of external control such as audit offices. As a consequence, the councils came to make less use of its prerogatives of policy formulation and of coordination and representation of organized society entities and actors, which can lead to the reduction of its potential for political mobilization and democratization of the health sector.

The little attention given by councils to policy formulation activities seems not to be directly related to the basic knowledge of advisors in relation to the fundamentals related to the theme. Despite the recent sectorial trajectory and little experience, the respondents know well the fundamentals of the cycle of sectorial planning and monitoring of health policy execution. According to *table 3*, the great majority (70.9%) responded that the objective of health plans is to guide the definition of the annual schedule of health actions and services provided in their cities, adequately recognizing the essential role of this instrument in the system of sectorial planning.

More than two-thirds of the advisors indicated that the role of the council is to monitor the execution of the plan by the State Secretary of Health (SES) (86.4%), using the annual management report to evaluate the results obtained at the end of each fiscal year (70.7%). Finally, only in relation to the basis of plan formulation, a lesser percentage of advisors (57.2%) was observed who indicated the analysis of the population's health situation as a point of departure to project a more efficacious and effective health system in the future.

Table 3. Advisors' grasp of concepts and fundamentals related to the City Health Plan

Objective of the City Health Plan	%	Role of the CMS in relation to the City Health Plan	%
It guarantees the resources necessary to the health system	10,6	To fund it	0,8
It guides the annual schedule of health actions and services	70,9	To regulate it	4,8
It establishes rules for council action	3,1	To accompany and monitor it	86,4
It presents the achieved results	7,5	To execute it	3,2
Didn't know how to respond	7,9	Didn't know how to respond	4,8
TOTAL	100	TOTAL	100
Basis of the City Health Plan	**%**	**Instrument of Evaluation of the City Health Plan**	**%**
Multi-Annual Plan (PPA)	22,8	Annual Management Report	70,7
Meeting minutes of the council	4,9	Budget Directives Law (LDO)	6,4
Analysis of the health situation	57,2	Multi-Annual Plan (PPA)	8,1
Annual Budget Law (LOA)	7,9	City Health Conference	8,5
Didn't know how to respond	7,2	Didn't know how to respond	6,3
TOTAL	100,0	TOTAL	100,0

Source: Elaborated by author.

The tendency to have a good grasp of the fundamentals related to the cycle of sectorial planning might be something more specific to the advisors who had just passed through a qualification process or else be restricted to a set of basic knowledge. The elaboration of a good city health plan demands a grasp of knowledge of epidemiology, demography, economy, and budgeting, among others, requiring further and more extensive research to conclude that the majority of advisors possess these fundamentals.

Obviously, advisors can contract specialists and consultants to contribute this knowledge in the stage of plan formulation, despite the well-known operational limitations that are imposed on the advisors by city health secretaries, especially those related to budgeting and financial autonomy. These limitations also contribute to the advisors' seeking to focus their attention on the stage of execution in detriment to planning.

Finally, the main limitation observed in the survey's results consists in the enablement of advisors to perform the activities of representation in their segments and to concretely list and discuss relevant themes in their councils. The respondents presented an expressive sensibility/awareness to the issues tackled in the Learning Centers, however it was still difficult for them to produce concrete actions in their daily practice of social control. In order for council participation to contribute to democratization, the exercise of representation requires not only advisor identification with the demands of those represented, but also the capacity to pronounce and decide on various themes related to the management, organization, and funding of health policy.

As can be seen in *table 4*, most respondents (74.2%) declared that they recognized as legitimate the need to meet with their representative base to discuss the city health plan in the first semester of 2013, however only a small group (13.8%) had already scheduled meetings with their constituents.

Table 4. Enablement of advisors to debate with the segment that represents and to list relevant themes at the CMS

Debate on PMS with their segment	%	Debate of the CMS agendas with their segment	%
No longer an advisor	15,9	No longer an advisor	15,9
It isn't necessary	0,7	It isn't necessary	1,2
No, because this theme isn't on the CMS agenda	5,8	No, because nobody goes to these meetings	4,1
Other	3,4	Other	3,6
Yes and I've already scheduled the meeting(s)	13,4	Yes and I've already scheduled the meeting(s)	19,5
Yes, but I haven't scheduled the meetings yet	30,2	Yes, but I will schedule the meetings later	31,8
Yes, but I don't know when the meetings will be	30,6	Yes, but I don't know when the meetings will be	23,9
TOTAL	100,0	TOTAL	100,0
Debate on regionalization (Decree 7.508/11)	**%**	**Use of Siops as an instrument of social control**	**%**
No	24,4	No longer an advisor	15,9
No longer an advisor	15,9	I don't know what Siops is	5,8
Don't know how to respond	7,7	No, because it's very difficult to use	3,4
Other	2,4	No, because it isn't necessary	1,1
Yes, in two meetings	7,3	Other	3,3
Yes, in more than two meetings	20,1	Yes, I already use it	28,2
Yes, in one meeting	22,2	Yes, but I don't know how to use it	42,3
Total	100,0	Total	100,0
Debate at the CMS on intersectoriality	**%**	**Debate at the CMS about coordination with other councils**	**%**
No longer an advisor	15,9	No longer an advisor	15,9
It isn't necessary	1,2	It isn't necessary	4,2
No, the CMS has already tried and it didn't work	3,2	It isn't necessary because the CMS already coordinates with these CMS	11,7
No, because the CMS already coordinates	19,8	No, because the CMS has already tried to coordinate and it didn't work	4,7
Other	4,1	Other	4,2
Yes, and I've already listed it	13,9	Yes, and I've already listed it	7,7
Yes, but I will list it later	41,8	Yes, but I will list it later	51,6
Total	100,0	Total	100,0

Source: Elaborated by author.

In the same manner, the percentage of respondents who declared the intention to meet, in the first semester of 2013, with the entity that represents in order to discuss council agendas is extremely expressive (75.2%). Nevertheless, the portion of those who were effectively coordinated to produce debates on the City Health Plan (PMS) is much less (19.5%).

This pattern can also be found in the disposition of respondents to discuss themes of great relevance that compose the strategic agenda of SUS. In the same *table 4*, one notes that more than half (53.9%) belong to councils that discussed, at most twice, Decree 7.508/11 between the year of its publication and the completion of the survey. Only 20.1% of the respondents have already participated in more than 2 meetings in which the aforementioned decree was discussed.

The respondents also demonstrated difficulties in the use of SUS management tools, despite recognizing their relevance, and manifested an intention to appropriate them. A little more than 42% affirmed that they intend to use the Public Health Budget Information System (Siops), however they do not grasp the necessary knowledge. In contrast, only 28.2% declared that they already use Siops.

The difficulties in providing concreteness to the action of health councils also extends to inter-sectorial coordination in the sphere of social policies, as also deduced from table 4. An expressive quantity of respondents (41.8%) affirmed that they intended to list, in City Health Council (CMS) meetings, the relationship with other sectors of social policies over the second semester of 2013, but they had yet to schedule the meetings. In contrast, only 13.9% had already scheduled meetings to discuss coordination with other sectors of social security.

The difference between intention and action can also be observed in the coordination with other health councils. More than half of the respondents (51.6%) manifested an intention to debate with their peers the relationships with neighboring city councils in the second semester of 2013, however they had not yet performed any concrete action in this sense. On the other hand, only 7.7% had already listed the theme in CMS meetings.

Final considerations

The results of the evaluative survey support the reflection that educational and qualification processes are fundamental strategies in order for advisors to better comprehend and improve the performance of their role in the decision-making process of health policies, building political resources that allow them to debate with other political actors on levels of institutional equality.

The prospects that representatives of health users and workers will look for their constituents to discuss agendas and results of the meetings in which they participate at the councils, as well as the search for coordination with councils in neighboring cities, point toward the concrete possibility of development of political action by advisors, a vital process for the institutional growth of health councils.

Precisely for this reason, the data also demonstrates that the practice of continuing education is fundamental in order for these possibilities to be realized. The completion of a course is always important, but if it is isolated and is not inserted in a political-pedagogical strategy that connects its improvement and continuity, that covers the demands of advisors and uses them as a formative element, it will not likely achieve greater than occasional success.

Former student responses indicate that their perception of the political process was stimulated when they participated in a course, but they also showed that, in order for there to be a definitive change in their practice, educational processes need to be really permanent.

These responses authorize, therefore, the affirmation that investment in the National Policy of Continuing Education for Social Control in SUS is essential in order for health councils to be consolidated as instances in the decision-making process of health policy, which they have still not achieved, running the risk of having their efforts delegitimized.

Faced with this situation, PEC 241/16, which instituted limits to the expansion of investments in health and education linked to the inflationary revision of current amounts, represents a real threat both to the functioning of services provided by SUS and to the development of PNEPSUS.

In considering that current levels of public investments in health are not enough to build a universal system in a national situation marked by expressive regional inequalities, the insulation of the decision-making process and the reduction of investments can lead to the delegitimization of the policies and forums that promote them, with expressive impacts at the federal level. In the same manner, austerity measures tend to aggravate economic recession, repeating the recent European experience, leading to the intensification of the fiscal crisis in states and cities. Faced with less revenue, these will tend to reduce resources for the funding of policies of advisor qualification and to cut investments in council infrastructure, delegitimizing the role of councils and advisors in the sphere of SUS and the democratization of health policies. ■

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