

Health and Social Determinants in Brazil:  
A Study on the Influence of Public Participation on  
the Formulation of the Expanded Concept of  
Health and Liberating Practices

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## **INTRODUCTION**

This is a preliminary work, in two distinct senses. In the stricter sense, this paper provides a systematized description of the processes and forums of public participation and participatory management in health in Brazil. In the broader sense, it is an attempt to reveal aspects, not yet fully precise, of the relationship between the expanded concept of health as adopted in the 1988 Brazilian Constitution and its impact on the practices and content basic to the organization of health care networks.

In contrast to several other countries in Latin America, Brazil has worked towards assurance to all people of the right to health. This course of action, in opposition to current neo-liberal precepts, has two essential mainstays: (1) an expanded concept of health, which overcomes the restrictive interpretation of health as a synonym of non-disease and regards health as central to the rights of a citizen; and (2) public participation, institutionalized as health councils and conferences, and encouragement of dialogue between directors of health services and systems on the one hand and parliamentarians, members of the Judiciary and civil society on the other.

Throughout the sixteen years that the Unified Health System (Sistema Único de Saúde, SUS) has been in effect, health councils and conferences have become arenas of mediation, participation and intervention for different interests and different values. However, the performance of these forums, as well as the effective guaranteeing of the right to health, have been significantly affected by fiscal and political obstacles. Economic adjustment policy and concentration of social policy in specific areas have been accompanied by underfinancing and non-priorization of health in government agendas. Thus public participation forums, which generally would play a leading role in a universal and just health system, are now either embroiled in discussions of case-by-case allocation of financial resources, or in disarray in the face of a long series of general problems concerning health.

As a result, health councils and conferences have been displaced from their original tasks of formulating and monitoring health-system guidelines. These forums have now become points of resistance to fiscal restrictions on health in public budgets and arenas where unresolved health problems have been reintroduced in a cumulative manner. Under these conditions, the decision-making role of the public participation forums has become less consequential than their role as arenas for discussions and formulation of strategies for protecting the principles of SUS. In fact, due to the gap between the high relevance of health problems to the Brazilian population (demonstrated, for example, in the Survey on Political/Administrative Matters carried out by IBOPE in December 2006, in which the results showed health alone to be the top priority that should be taken into consideration by the government) and the non-resolution of problems of access and quality of care, problems that could have been resolved in administrative tribunals of the health sector have been transferred to public participation forums and to judicial bodies and the Public Prosecutor.

At present, the tensions incurred in the reestablishment of the State in its role of proponent of economic and social development in the various countries of Latin America, including Brazil, have provided the background for a new scenario for discussion, formulation, and implementation of health policies. The appointment of the hygienist José Gomes Temporão as health minister –inspired by the need to extend jurisdiction governing health problems to cover social determinants– and expectations on possibilities for and limits to citizenship rights over and above electoral rights, based on full exercise of social rights including the right to health, have brought back the original tasks of implementing the Unified Health System, which include (a) guarantee of resources for increasing and redirecting the overall supply of health activities and services; (b) decentralization and regionalization of health services compatible with development, distribution of revenue, and implementation of social policies by the States and the Federal

District; (c) timely, humane and high-quality access to health services; and (d) revitalization of participatory health forums.

At present the field of health has inspired the development of public participation forums for policies in other public sectors in Brazil, fully demonstrating the wisdom of including social control among SUS principles. The capacity to translate the principle of public participation into representative and flexible forums which include a variety of interests, approaches to health and sickness, and alternatives for formulating policies constitutes a major advance in the acquisition of the right to health in Brazil. However, preoccupation with reiterated fragmentary demands on the agendas of the councils and conferences and the consequent relative reduction of the impact of their deliberations on the course of the health sector and of SUS are shared by all those who, through more than thirty years, have consistently been developing these new arenas of social interaction, harmonization of values and ethical interests in the area of health.

The challenges cannot be bypassed. What is to be avoided is a "hyperactive paralysis" (a plethora of demands resulting from prioritization of parochial/individual interests over national objectives) which has affected other institutions and obstructed their capacity to develop and underwrite projects – so that a clear course can be traced for stabilizing the SUS as an institutional means of making the right to health a more effective right.

In order to give substance to reflections on the topic of relationships among sectors and health, this study focuses on public participation in the field of health and its impact on the expansion of the concept of health and social emancipation in Brazil. Its objective is to describe in systematic form the implementation, consolidation and present developments of public participation forums in health, and the impact of these forums on formulation and application of policies consistent with the expanded concept of health.

This study is divided into three sections. The first section gives an overview of the health situation and the organization of the SUS. The next section offers an historical perspective on the status and concept of public participation in order to provide a backdrop for a clearer understanding of its function in Brazil. Finally, the course of social movements, public participation and establishment of the SUS are described in a systematic manner.

### ***1. Outline of the Health Situation and the Health Services System in Brazil***

Brazil is characterized by severe social inequality, in terms of not only income, colour, race and sex, but also in terms of access to employment, the workplace and housing. Health indicators such as infant mortality and life expectancy have historically shown falling and rising trends, respectively. Yet these indicators vary widely from one region to another in Brazil and even among different areas within the same city. With an area of 8.5 million km<sup>2</sup>, comprising nearly one-half (47%) of the physical area of Latin America [actually, of South America alone - *transl.*], Brazil is home to 20% of the world's biodiversity, its richness exemplified in the Amazon Tropical Forest, 3.6 million km<sup>2</sup> in area.

Brazil ranks fifth in population among the countries of the world, with nearly 190 million inhabitants in 2007. Based on data from the census carried out in 2000, 81% of its inhabitants live in urban areas. The high concentration of the population in urban centres due to increased migration from rural areas leading to a higher rate of urbanization, with the southeast region as the centre of attraction; this characteristic is central to understanding the challenges to be faced as social policy is developed. Up to the 1960s, the majority of the population lived in rural areas. In the 1970s the rate of urbanization reached 73%. The age pyramids corresponding to the three most recent population censuses reflect the impact of this change on

the reproductive patterns of Brazilian women. The successive reductions in the population component consisting of children and adolescents and the increase in proportion of adults demonstrate an aging trend in the Brazilian population. Life expectancy at birth was estimated to be 71.9 years in 2005. In 1990-2000, the country registered its smallest increase in population in recent decades –1.6% per year– and while the southeast region is still the most populous, internal migration has been more intense within the state or region of origin (IBGE 2006).

Economically, the country accounts for three-fifths of the industrial production of South America and participates in various economic blocs such as Mercosur, G-22 and the Cairns Group. Its scientific and technological development, linked to a diversified and dynamic industrial base, has attracted business from abroad. Direct investments have generally been in the order of US\$20 billion per year, compared with US\$2 billion per year in the previous decade. Brazil has developed trade relations with more than a hundred countries, and 74% of its exports consist of manufactured and semi-manufactured goods. Its major partners are the European Union (with 26% of the trade), the USA (24%), Mercosur and Latin America (21%), and Asia (12%). Among the most dynamic sectors in this trade is agribusiness, which for two decades has placed Brazil among the most productive countries in this field. Brazil has technological expertise in specific sectors, including aerospace research and aircraft manufacturing, and has been a pioneer in deep-sea petroleum research, from which 73% of its reserves are drawn.

The political and administrative structure consists of three branches (the Judiciary, the Executive and the Legislative) and follows the principle of autonomy between the Federal Union, the Federal District, the 26 states, and the 5,564 municipalities as of 2005 (IBGE 2005). In the government structure of Brazil, the exercise of powers is attributed to distinct and separate bodies, each with its own function, but still subject to a system of control among themselves so that none can contravene the laws and the Constitution. Typically, the legislative branch is empowered to formulate laws; the executive branch to administer, i.e., to achieve State goals, adopting concrete policies for this purpose; and the judicial branch to oversee compliance with the law and resolve conflicts among citizens, legal entities and the government. The Court of Accounts of the Federal Union, the states and the municipalities do not form part of the judiciary branch: these are auxiliary bodies providing a guide for the legislative branch, and their purpose is to carry out accounting, financial, budgetary, operational and property auditing of federal agencies and corporations. In addition, the 1988 Constitution created the Public Prosecutor, a member of the executive branch (with independence with respect to this and other branches) to maintain law and order and enforce the law, as well as the Offices of the Public Advocate and the Public Defender.

### **1.1 Redemocratization, Social and Political Participation and the Course of the Economy: The Gap Between Formal Rights and Reality**

There has been some commitment to encouraging democratization of the federal public administration. Dialogue with all segments of civil society and with the states and municipalities has provided a guideline for government activity and constitutes a new mode of governance whereby, through dialogue, conflicts may be resolved democratically and unity established among all Brazilians. This effort, however, has not been translated into full exercise of one's citizenship. The gap between acquired political rights and social rights has resulted in the so-called "low-intensity" citizenship. A conflict has evolved between political advances and retention of socio-economic and institutional structures which underlie social inequalities. As O'Donnell (1996) stated, individuals in countries with informally institutionalized democracies may be citizens with respect to one single institution: the elections.

The expectations of changes made in the course of resistance to the military regime and the beginnings of redemocratization shaped the directives of the Brazilian Health Reform. The atmosphere of enthusiasm and hope for the future, shared by many social groups and players including the health movement, was

underlain by the certainty that democracy would be accompanied, sooner or later, by well-being and development as demonstrated in the experience of developed countries. The 1988 Constitution is a declaration of commitment to establishing a democratic state governed by law, grounded in citizens' rights among which the universal right to health is enshrined.

The question of health in our country, previously relegated to the market and to labour relations, was the object of one of the most lavish projects in Brazil in the 1988 Constitution. Given marginal status and neglected up to the 1960s, the health sector has become of increasing importance in the provision of services and development of the work force, and has become a focal point of accumulation of capital. Most recently, health has been raised to the status of a citizen's right.

However, the course of Brazil's redemocratization, begun in 1989, has been marked by inflation and has led to a massive public debt – in the wake of an increasingly globalized world economy free from the regulations and barriers which were created in Bretton Woods. The increase in gross domestic product, which was 6.17% and 8.63% during the 1960s and 1970s, was drastically reduced to 1.57% and 2.65% in the 1980s and 1990s, respectively. In addition, the social structuring underlying the inequalities in Brazilian society has remained almost immune to the projects of social inclusion and modernization in administration.

Changes brought about by a wide range of social movements and government sectors, enabling intergovernmental relationships that would be open to joint action, decentralization, and public participation, were required before the SUS could be established, however incompletely, without financial or political constraints. In addition, SUS itself was transformed into a site of constant and dynamic social-service innovation and management processes, impelled by interrelationships between a technologically competent bureaucracy, public participation forums and government institutions.

In its turn, the constant "agitation" revolving around SUS –certainly an essential factor for mobilizing it towards new advances– is a result of the formation of a strong national health intelligence network consisting of health counsellors, technicians in various areas, health professionals and politicians. At the same time, these social entities supply the underlying foundations of the SUS and its participatory forums and are its *raison d'être*.

## **1.2 SUS and Legislation**

Among the principles established in the 1988 Constitution is the right of all people to health and the obligation of the state to guarantee universal and equal access to services and activities which promote, protect, and restore health. In stating that health services and activities are of public relevance, the Constitution established the Unified Health System (SUS) by way of regionalized and hierarchically organized networks of public health services and activities, following decentralization directives with a single point of administration at each level of government, responsible for integrated preventive care and assistance, and with community participation.

Subsequent to the Constitution is the formulation and approval of laws subjected thereto - the "Laws Regarding Health Organization," which specify principles, directives and conditions for the organization and operation of the health system.

Law 8080 of 1990 set forth the basic organization of health services and activities with respect to its direction, management, areas of jurisdiction and powers at each level of government. Law no. 8142 of 1990 complemented it, specifying community participation in the management of the system and the manner and conditions of transfer of resources across governments. Two principles characteristic of the

SUS have thus evolved: social control (the participation of the public in management and oversight) and regionalization (giving municipalities major responsibility for local administration of health services).

Decentralization of SUS management has been regulated by Basic Operational Regulations 91, 93 and 96, and by the Operational Health Care Regulation of 2001 and the Health Protection Agreement of 2006.

SUS is thus responsible for providing assistance to persons through activities which promote, protect and restore health, with combined preventive and restorative care, including hygienic surveillance, epidemiological monitoring, health in the workplace and integrated therapeutic care, and including pharmaceutical care. There is only one SUS directorate at each level of government, its functions exercised by agencies such as the Federal Ministry of Health, the State Health Secretariats and the municipal health departments or equivalent bodies.

### **1.3 Health Indicators**

The country's health system has undergone constant change in the past century, in step with the economic, sociocultural and political changes in Brazilian society. Four historical trends may be identified in health policy in Brazil: (1) "sanitarismo campanhista" (campaign-style health measures) (from the beginning of the twentieth century to 1945); (2) transition (1945 to 1960); (3) private care, stabilized in 1980; and (4) extension of the right to health to all persons, characterized by tensions between public-sector reasoning and the expanded concept of health on one hand and private-sector reasoning still strongly oriented towards specialized treatment. It should be kept in mind that, generally, collective action (also referred to as preventive) has been linked to public health institutions, and, until quite recently, individual (or therapeutic) activity was associated with the welfare system. The SUS intends to change these perceptions on health and illness, health practices and the tenor of health activities.

SUS is therefore responsible for expanding health care and guaranteeing the quality of services provided. In this sector, preventive and outpatient/inpatient care is combined, in Brazil, with sanitation and food safety measures and with care given to children, women and the elderly. In addition to basic care, the country is promoting and investing in an extensive research network whose discoveries are being shared and marketed through a system of state and private pharmacies which distribute medication free of charge or at reduced prices. The marketing of generic medication (sold on the basis of the active ingredient, with elimination of costs for advertisement or patents) and the stoppage of licensing for medication (such as for antiretroviral medication) have been included in health policy.

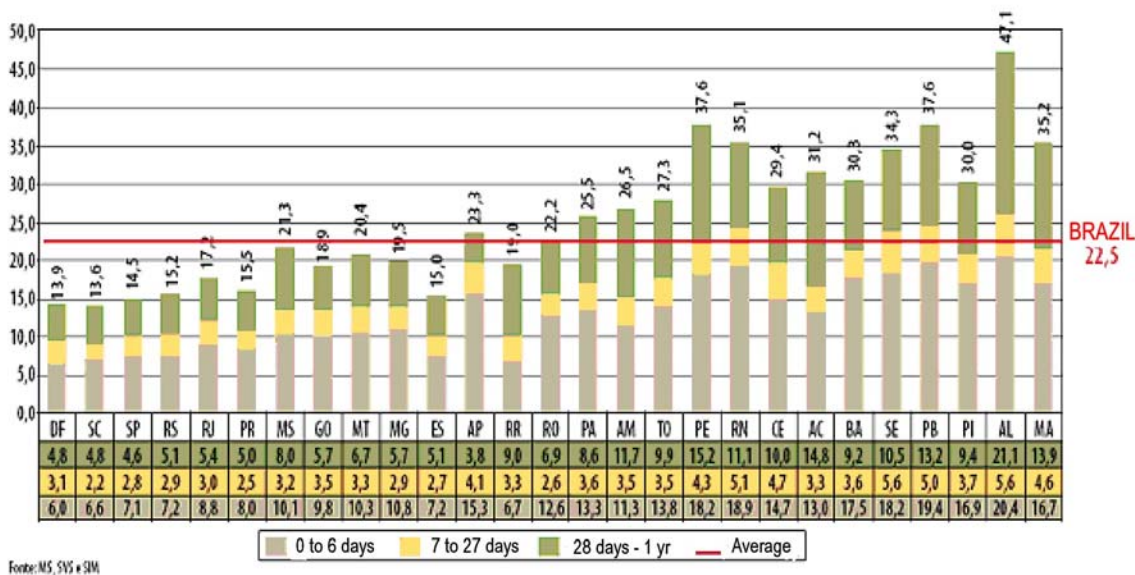
Since the 1990s, organization of the service network has been focused on the Family Health Program. The network of public and community agents, whose activities encourage links between different sectors, has begun to reduce infant mortality rates and has proven to be effective against epidemics and endemic conditions. States and municipalities have been enabled to provide specialized outpatient and inpatient care. Notable examples of the application of the expanded concept of health include the Brazilian Psychiatric Reform, based on the deinstitutionalizing of mental patients.

#### **1.3.1 Mortality, Morbidity and Life Expectancy**

The reforms of the Brazilian health system have had an impact on health indicators. However, they have not substantially changed the inequalities occurring within or between regions. Graph 1 shows infant mortality rates, broken down by state. We note that the rate of infant mortality (47.1 per thousand in 2004) in Alagoas (AL), a state in the Northeast, is much higher than the average in Brazil and is more than three times that in the Federal District (DF), the capital of Brazil.

Graph 1

Infant Mortality Rate by State in Decreasing Order of the Human Development Index, Brazil 2004



A comparison of Brazil's health indicators with those of developed countries and of Argentina and Cuba shows the effect of inequities on life expectancy, infant mortality, maternal mortality, and incidence of tuberculosis (Table 1).

Table 1

Health Indicators in Selected Countries					
Selected Countries	Life Expectancy 2005		Infant Mortality* 2005	Maternal Mortality** 2000	Incidence of TB*** 2005
	Male	Female			
Brazil	68	75	28	260	60
Argentina	72	78	14	70	41
Canada	78	83	5	5	5
Cuba	75	79	5	33	9
USA	75	80	7	14	5
UK	77	81	5	11	14

\* Infant mortality per 100 [actually 1000 - transl.] LB  
 \*\* Maternal mortality per 100,000 LB  
 \*\*\* Incidence of Pulmonary Tuberculosis per 100,000 inhabitants

Source: World Health Organization. LB = live births, TB = pulmonary tuberculosis.

**1.3.2. Resource Indicators. Access to and Use of Health Services**

Health expenditures in Brazil are much lower than those in developed countries, and until the beginning of the twenty-first century were lower than those in countries such as Argentina. In addition, while the public-expenditure component has increased in the course of time, it is still not compatible with the universal right to health. The evolution of public and private health expenditures is shown in Table 2. We note that Brazil shows an increasing trend in health expenses per capita and in public participation in these expenditures. In comparing the evolution of health expenses among six countries, we have used "international dollars" as a measure for converting the exchange rates, taking into consideration the "buying power" of the dollar in each country and reducing secondary variations in price differences between countries.

**Table 2**

Changes over time of per-capita health expenses in selected countries, in international dollars			
Country/Year	1996	2000	2005
<b>Brazil</b>			
Total per-capita health expenditure	499	789	1603
Public health expenditure per capita	201	323	861
% public exp./total exp.	40.28	40.94	53.71
<b>Argentina</b>			
Total per-capita health expenditure	916	1121	1427
Public health expenditure per capita	528	621	670
% public exp./total exp.	57.64	55.4	46.95
<b>Canada</b>			
Total per-capita health expenditure	2058	2505	3381
Public health expenditure per capita	1459	1762	2353
% public exp./total exp.	70.9	70.33	69.59
<b>Cuba</b>			
Total per-capita health expenditure	154	212	258
Public health expenditure per capita	126	182	228
% public exp./total exp.	81.82	85.85	88.37
<b>USA</b>			
Total per-capita health expenditure	3 812	4584	6543
Public health expenditure per capita	1 741	2015	2930
% public exp./total exp.	45.7	43.96	44.79
<b>United Kingdom</b>			
Total per-capita health expenditure	1465	1859	2724
Public health expenditure per capita	1 215	1503	2372
% public exp./total exp.	82.9	80.87	87.06
Source: World Health Organization			

With respect to physical resources, the Survey on Medical and Sanitary Assistance recorded in 2005 a complement of 83,379 health establishments. There was an increase of 17.8% with respect to the year 2002. Health facilities without beds accounted for approx. 72.0% of the total of establishments surveyed and, during the period between 2002 and 2005, these increased in number by 19.2%. In confirmation of the trend observed in previous surveys, facilities with beds decreased in number, specifically in the private sector, and a slight increase was noted in the public sector in all regions. As a result, bed capacity in public facilities showed a slight increase, though lower than the increase in population, and the number of beds in private facilities dropped at an annual rate of 3.2% from 2002 to 2005. This increase in participation of the public sector in establishments with beds is due not only to the reduction of the private sector, but also to the increase of the public sector itself, which has been intensifying in recent years. The number of beds included in the AMS 2005 Survey was 443,210, with 148,966 beds in public facilities (33.6%) and 294,244 beds in private facilities (66.4%). Among public facilities, 17,189 beds are in federally operated facilities, 61,699 beds in state-operated facilities, and 70,078 beds in municipal facilities: these statistics point to decentralization of management of the services. Of all the beds in the private sector, 82.1% belong to facilities that have indicated that they are providing services under the SUS.

Bed capacity per capita has thus diminished in the course of time. This fact is compatible with the fact that various clinical and surgical procedures are being provided on an outpatient basis in lieu of hospitalization. We also note that between 1996 and 2005 there was a major readjustment in the number of beds per 1,000 inhabitants so that the numbers became more uniform among regions, except for the northern region where number of beds remained below the national average throughout the period (Table 3). Among facilities registered in 2005, 6,403 (89.5%) reported that they had their own diagnostic and therapeutic support services.

**Table 3**

Change over time in number of beds per 1000 inhabitants in Brazil										
Region	1996	1997	1998	1999	2000	2001	2002	2003	2005	Total
Brazil	3.2	3.15	3.05	3.02	2.88	2.84	2.65	2.48	2.03	2.49
North	2.13	2.1	2.05	2.11	1.98	1.94	1.87	1.8	1.59	1.72
Northeast	2.9	2.9	2.83	2.81	2.75	2.73	2.59	2.55	2.19	2.4
Southeast	3.42	3.35	3.23	3.17	3	2.94	2.64	2.43	1.93	2.57
South	3.44	3.3	3.21	3.17	3.04	3.01	2.95	2.68	2.22	2.67
Central-West	3.76	3.7	3.57	3.53	3.36	3.34	3.19	2.78	2.06	2.87

Source: Datasus

In 2005, 14,521 exclusive facilities with diagnostic and therapeutic support services were registered, an increase of 63.7% in the public sector and 23.7% in the private sector in comparison with 2002. The private sector accounts for 13,419 diagnostic and therapeutic support service units surveyed. The annual growth rates were greater in the public sector (17.9%) than in the private sector (7.4%). These units increased their percentage among the total number of establishments from 17.6% to 18.9% between 2002 and 2005.

The medical care offered by outpatient facilities consists mainly of care in the basic specialties (75.0%), while care in other specialities is offered only in 24.4% of these facilities. Only 4.5% of these outpatient units report that they provide psychiatric care.

The problem of access to health services has been evaluated in surveys among the population. The National Household Sampling Survey (PNAD) of 2003 indicated that serious limitations still exist in Brazil; however, a more favorable outlook was found between 1998 and 2003 in a number of access indicators evaluated. Approximately 80% of the Brazilian population mentioned having a regular-use service. The existence of regular-use health services indicates that persons have a service which they use on a routine basis as a point of entry to the health system. The existence of a regular-use service is a positive indicator of access to health services. In 1998, 71.2% reported that they had a regular-use service.

The most common regular-use service was the health clinic, and its level of participation as a regular-use service increased perceptibly between PNAD 1998 and PNAD 2003 (41.8% and 52.4%, respectively). Over the same period, there was a slight drop in level of use of private offices as a regular-use service (19.7% in 1998 and 18.0% in 2003), but there is indication that first-aid clinics or emergency clinics are being increasingly used as a regular-use service (4.8% and 5.8%). These latter are not suitable regular-use services.

The type of service used as point of entry into the health system varies according to age, gender, and family monthly income. The health stations have most frequently been cited as regular-use services among persons less than 19 years of age, females, and persons in the lowest family monthly income bracket. Between 1998 and 2003, there was an increase in proportion of persons who had had at least one doctor's appointment in the year preceding the survey (54.7% and 62.8%, respectively). While this increase occurred among both rural and urban residents, it was greater among residents of urban areas. Again, while the increase occurred in all income levels, the difference between the highest and the lowest income groups remained high.

The proportion of Brazilians who reported never having gone to a dentist remains very high (15.9%), and is greatest among rural residents and among the poorest population. However, there was a drop of 2.8 points in this proportion between 1998 and 2003, and this reduction was more marked among residents in rural areas (4.0 percentage points) and among persons in the monthly family income bracket below the minimum wage (5.6 percentage points). There has thus been some improvement in accessibility to a dentist, in addition to a reduction of the social inequalities in this area.

In 2003, clinical breast screening in the previous year covered 37.6% of women 40 years of age and older. In addition, 34.4% of women in this age bracket had never undergone a clinical breast examination by a health professional. In the previous two years, mammography examinations covered 41.2% of women 50 years of age and older. In addition, 49.7% of the women in this age bracket reported that they had never undergone a mammography screening. In the previous three years, preventive screening for cervical cancer covered 68.7% of women 25 years and older; 20.0% of the women in this age bracket reported that they had never undergone a preventive screening for cervical cancer.

The main reason for requesting services was illness, followed by vaccination or other preventive measures. In this respect, there was an important change compared with the survey carried out in 1998, when the most frequently cited reason for requesting medical services was routine care and prevention or vaccination. The change in the question, which involved removal of the option "routine examination or prevention" and its replacement with "child care" and "other preventive measures," may have influenced this result.

Primary care services accounted for approximately 40% of the care provided in the two weeks preceding the interview. At the other extreme, pharmacies accounted for 1.5%.

In the year preceding the survey, seven out of a hundred persons were hospitalized. The coefficient of hospitalization did not vary between urban and rural populations and was higher among women, seniors 65 years and older, and children up to 5 years of age. There is a strong association between hospitalization and self-evaluation of one's state of health, with persons reporting poorer health conditions presenting higher coefficients of hospitalization. Unlike the case for use of services in general, where there were marked social inequalities unfavourable to the poorest stratum, it is this stratum which has been hospitalized the most.

The statistical profile of hospitalizations remained practically unchanged between 1998 and 2003. The services in the SUS network accounted for 67.6% of hospitalizations, a slightly higher proportion than that found in the PNAD of 1998 (63.1%), and health-plan companies paid partially or fully for 24.3% of the hospitalizations, a percentage practically equal to that observed in 1998 (24.6%). The percentage of persons who made some payment in the course of hospitalization was similar to that observed in 1998 (10%).

## **2. *Public Participation in Health, Social Determinants, and the Process of Developing the SUS***

Brazilian legislation institutionalized participatory practice with Law no. 8.142, which regulates "the participation of the community in the management of the Unified Health System as well as inter-government transfer of financial resources, and makes other provisions." It also establishes, "without prejudice to the powers of the Legislative Branch," collegial participation forums, health councils and health conferences, giving them deliberative and supervisory roles. Such roles have been fulfilled to the extent that the participating forums provide for representation of parties that are concerned with health policies in the case<sup>1</sup>, at the same time that they provide for direct exercise of citizens' rights by the public.

Public participation in health –more precisely, the immense, constantly active contingent of personnel who comprise the councils and attend municipal, state and national health conferences– is one of the highlights of the Brazilian health system. Together with universal programs such as control of AIDS and of menu updating and coverage for immunopreventable diseases, it is a source of national pride.

A recap of the history of the institutions and personnel who gave rise to public participation in the health system gives us a brief review of the conceptual categories and subsequent institutional previews of proposals on public participation current at the time of development of Health Reform and those raised at the present time. Proposals for community/public participation in health preceded the formulation of the rules of the Brazilian Health Reform. According to Carvalho (1995), the idea of community participation, both ideological and pragmatic, accompanied the strategy of placement of community health centres<sup>2</sup> in

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<sup>1</sup> "In order to receive the resources mentioned in Art. 3 of this Law, the Municipalities, the States and the Federal District must have (I) a Health Fund; and (II) a Health Council, with parity composition in accordance with Decree no. 99.438 of 7 August 1990..." (Law no. 8.142). This Decree provides for representation of the government, service providers, health professionals and users to formulate strategies and control implementation of health policy in the corresponding jurisdiction.

<sup>2</sup> According to Mário Magalhães da Silveira (1979), after the First World War,

the U.S. at the beginning of the twentieth century. Later, in the 1950s, the idea of "community development" formed part of the policy of foreign aid to underdeveloped South American countries in the context of the Cold War.

An alternative indicator, one which is indispensable for understanding public participation and its evolution in the area of health in Brazil, is a product of deliberations made during the Alma Ata Conference of 1968 – a landmark of international discussion on health policy. The motto "Health for All in the Year 2000", expressed in the strategy of extending primary care to health, the responsibility of national states, and the linking of fulfillment of health goals to social development and to reducing the gap in health conditions between developing countries and developed countries, served as a guideline for multilateral agencies such as WHO and PAHO in the 1970s and 1980s. International recommendations on public participation associated with extension of coverage to populations found their echo in Brazil. The Fifth National Conference on Health, held in 1975, "had the effect of justifying, on a sufficient and necessary basis, proposals which involved health care for marginal populations, with the participation of these populations" (Escorel 1998, 61).

## **2.1 Public Participation and the Health Movement**

The interpretation given in this country of "people's participation in the health system", which acquired formal status in the 1988 Constitution, is drawn from concepts expressed in the Health Movement<sup>1</sup> which took definite form during the 1970s in the context of the so-called "opening" of the military regime and the emergence and growth of social movements. The activities of the social movements, in step with the electoral victories of the opposition party (MDB), gave high priority to social questions which were previously relegated to second place in the conservative modernization program of the military regime. The Movement Against High Prices, a student movement; the stand for democratic freedoms taken by bodies representing liberal professionals such as the OAB and the ABI; the Amnesty Movement; the resurgence of a labour movement among factory workers; and the mobilization of unions and associations of engineers, teachers and doctors brought to the surface problems related to the conditions of life of the Brazilian population. In this scenario, in which new academic, political, social and institutional spaces were occupied by professionals and students in the area of health and by technicians engaged in a critical reflection on health conditions and the health-care model, the health movement took on the form of a "collective player", or of a "new political force" (Escorel 1998).

Viewed more in detail, the social movements developed clearer forms in the course of formulation of health policies during the period of transition to and strengthening of democracy. The people's movement for health (MOPS)<sup>2</sup>, the medical movement, the development of critical thinking on health in academic institutions and the discussions and experiences based on "community medicine" were vectors of the opposition to the health system current at the time and to the predominating medical model.

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"(...) the United States emerged as a richer, more powerful nation. Brazil began to turn away from Europe towards the United States, and public health physicians were the first to begin completing their courses there. In 1919, when Johns Hopkins University created the first course for public health physicians, a number of Brazilians from São Paulo and Rio were there. They returned extremely enthusiastic about American public health (...). Other physicians called these new doctors "young Turks". (...) The American system was a system of health centres. (...) In 1926, the first health centre was created in Brazil, the Inhaúma Health Centre, directed by Dr. [José Paranhos] Fontanelle [one of the "young Turks"].

<sup>1</sup> Teixeira *apud* Escorel (1998) considered the Health Movement to be characterized as (1) being a space for the buildup of knowledge; (2) being an ideological movement; (3) being political in practice.

<sup>2</sup> MOPS generically designates all associations of neighborhood and *favela* inhabitants which are concerned with demands for better health conditions.

Keeping in mind the purpose of identifying the proposals on public participation, we need to examine the origins and the links of critical reflexion and alternative health-related practices to the nonsectoral political and social movements which influenced the debate and the rebuilding of relations between the state and society in this period. The indissolubility of the people's movement with their experience of church-based communities, the medical movement with changes in professional practice as characterized by loss of autonomy due to increased intervention by the state and conversion of medical practice into private businesses, the Communist inspiration of the association between health and democracy, and the Health Reform, has been fully recorded.

The origins and motivations of the social movement and the medical movement are fairly distinct, though in both there is a predominant tendency towards the left.

In its origins, the social movement for health [MOPS] was located principally in the states of Rio de Janeiro, Minas Gerais and São Paulo. It was made up of medical hygienists, students, religious, Catholic militants, members of political parties and destitute people grouped around neighbouring associations and with Catholic community experience in neighborhoods at the edges of cities and in favelas. (Gerschman, 1995: 71)

(...) physicians suffered a loss of autonomy. (...) The resistance of the doctors to changes in work procedures, massive engagement on a salary basis and proletarianization of the category was not long in coming, and in the 1970s the medical corporation grouped under the title Medical Renewal Movement (Movimento de Renovação Médica, REME), which had just taken charge of the medical bodies, began to take on particular importance within the medical field (idem: 105).

The critical approach to the health/sickness process and institutionalization of health care, in turn, not only tended towards ransoming of health (as a scientific object) from treatment –characteristic of biomedical logic– of the health/sickness process in naturalist and biological terms for public health, but was also the result of combined theoretical and politico-institutional disputes within the prevention movement. Criticisms on conceptualization of "the public", linked with the prevention movement –for whom "the public" is viewed as a combination of individual attributes such as education, occupation, income, etc.– and with proponents of a rationalizing model based on the extension of coverage and on the cost/benefit analysis of health activities, favoured a conception of the collective as a structured field of social practices (ibid.).

The controversy over conceptions of "the public" spread into discussions on community participation during the Seventh National Health Conference in 1980<sup>1</sup>. Two positions were recorded:

[The "functionalist"] who hopes that community participation will resolve the question of groups which remain marginal in the process of growth of the country, with the social question remaining intact. [The "participation as instrument of democratization"] which seeks new channels of expression and opportunities to confront other social groups with the intention of influencing

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<sup>1</sup> The agenda of the Eighth Conference concentrated on three central points: "Health as a Duty of the State and a Right of the Citizen", "Reformulation of the National Health System", and "Sector Financing".

the process of continuing change to which social life is subject. (Seventh National Health Conference, 1980: 188)

The exposure of these controversies to academic discussion and the agenda of social movements reaffirmed the technical and political bases of the health movement. The compilation of "a social theory of medicine,"<sup>1</sup> its dissemination and the formulation of proposals for change by the movement consisting of medical groups, associations of resident physicians and associations of inhabitants (neighborhood movements), produced the base for the health movement or, as Paim (1987a) would prefer to call it, the movement for health democratization. The movement which proposed the Health Reform in Brazil successfully translated "medico-social" discourse into political and institutional practice through action which cut across political parties and corporate entities. Defined as a politico-cultural project, the Health Reform presented an integrated platform for expansion of the concept of health; recognition of health as a right for all and a duty of the State; creation of a Unified Health System as a component of an expanded and universal system of social protection; public participation; and creation and expansion of a social security budget.

## **2.2 The Eighth National Health Conference**

During the Eighth National Health Conference in 1986, the prognosis for changes in the new law-based order following the extended stay of the military in power coloured speeches from government authorities from the new coalition. The keynote –"Clean Up the History of Health in Brazil" (Paim 1987b)– put public participation on an equal footing with decentralization and autonomy as a "remedy for the abusive and ever-increasing concentration of political, economic and administrative power exercised by the previous government" (Roberto Santos, Minister of Health, 1986). Among the social and research movements in the area of collective health, public participation was linked predominantly to democracy and to citizens' rights. Extracts of the presentations given by representatives of the health movement expressed an understanding of the importance of public participation.

(...) Expand the channels towards democratization of health so that the impoverished of yesterday and the consumers of today can fight tomorrow, as citizens, for their rights and have the political organization to obtain them (...) (Jairnilson Paim<sup>2</sup>, professor at Federal University of Bahia, Report of the Eighth National Health Conference, 1986).

[Public participation is a] strategy in which the state fully assumes the responsibility for guaranteeing health for the population. It is up to us, here, to develop a strategy based on mobilization of the population and on the concept of participation not only as a characteristic or attribute of the new model of health, but also as a strategic element for de facto assurance of health as a right for all, to be assumed by a democratic state which would guarantee

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<sup>1</sup> Based on the structural historical vision of society, but also on the "medical institutional question" (expression used by Luz, 2000), which after the 1970s was a rallying point in Europe for intellectuals such as Michel Foucault.

<sup>2</sup> Jairnilson Paim is now an honorary professor at the Institute of Collective Health, Federal University of Bahia.

participation of the population (Antonio Ivo de Carvalho<sup>1</sup>, Representative of the Federation of Residents of Rio de Janeiro, idem, 1986).

A variation of this interpretation of "public participation" as participating in the development of the health system and in the fight for democratization of health is distinguished by delimitation of the composition of the participants and its effects on access to health services and care. Considerations on the participation of "excluded and marginalized populations" and the consequences for acquisition of access by these population groups were also presented at the plenary session of the Eighth National Health Conference. "Participation is the principal instrument for advancement towards true acquisition of rights for destitute populations (João Yunes<sup>2</sup>, Health Secretary of the State of São Paulo, Ibid., 1986). However, the majority opinion on public participation interpreted it as "participation by all", i.e., "by all segments", in "all" areas of the system: formulation and definition of policies/priorities, planning, management, and evaluation. That is, the prevalent idea of participation was as a principle, a right whereby society decides on its future, and not as a mere requirement for increasing health care resources for excluded population groups.

The Final Report of the Eighth National Health Conference alluded to public participation in all topics discussed and submitted for approval of the delegates. It was noted that the priority given to specific aspects of public participation was a function of the specific nature of the topics discussed. Under the topic Health as a Right, evidence was given of "the weakness of the organization of civil society, with insufficient public participation in the process of development and control over health policies and services; participation of the population in the organization, management and control of health services and activities", and there was a recommendation for "participation of the population, through representative groups, in policy formation, planning, management, performance and evaluation of health activities," as well as for "encouragement for the organized public to participate in decision-making cores, at different levels, assuring social control over the activities of the State." Under the topic Reformulation of the National Health System, the institutional format of the participation was stressed: "Health councils must also be created at the local, municipal, regional and state levels, composed of representatives elected by the community (service users and providers), which allow full participation of the public in the planning, implementation and monitoring of health programs. There should be a guarantee of elections of the managements of health-system units by persons working in these locations and by the community that is being served." Under the topic of Financing, emphasis was placed on the manner of management/monitoring of public funds: "Health funds shall be managed at different levels jointly with the collegial participation of public bodies and organized society."

Thus, effective public participation in the development of the Health Reform platform and confirmation of its indispensability in the formation of the SUS in the Constitution confirmed the leading role of the health movement in fostering proposals for changes to the Brazilian health system. The capacity to combine the concept matrices leading to an understanding of the health/sickness process with an institutionalized format which is open to changes with the formation of political alliances beyond party lines to substantiate them allowed for bringing the Health Reform directives into line with the ongoing politico-democratic changes.

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<sup>1</sup> Antonio Ivo de Carvalho is now a researcher with the Oswaldo Cruz Foundation and Director of the National School of Public Health.

<sup>2</sup> In 1986 João Yunes was State Secretary of Health of São Paulo. After his term of office as Health Secretary, he was representative of PAHO and WHO in Cuba (1987-1989). Later he assumed the office of Program Coordinator for Infant and Maternal Health of PAHO in Washington. Upon his return to Brazil he became an honorary professor in the Faculty of Public Health/University of São Paulo and assumed the duties of Interim Director of BIREME-PAHO until 1998. He passed away in 2002 when he was Director of the Faculty of Public Health at the University of São Paulo.

### **2.3 Public Participation in Health, Setbacks in the Social Protection System, and the Legal Framework**

Shortly after approval of the 1988 Constitution, the consensus on priority of the issue of health and its introduction into a universally applicable social services system was defeated. The so-called "reform of the reform of social welfare" brought back the old proposals (but in new clothing) of welfare capitalization and focusing on specific social policies. As a result of this turnaround in the official conception of the system of social protection, the rate, depth and extension of changes in the health system were deeply affected.

Regulations on public participation in the SUS were promulgated amidst uncertainty on whether the principles of the Constitution would take effect. Legislation subordinate to the Constitution which was directed towards emphasizing and detailing the participation of the community in public administration, such as the Law on Health Organization, no. 8.080/90, was established as one of the principles and directives of SUS (Article 7, VIII).

But it was Law no. 8.142/90 which actually introduced the outlines of community participation in the management of SUS –detailed by subsequent legislation– creating health conferences and councils and specifying that each level of government –federal, state and municipal– must have a health council. The same law attributed the characteristic of collegial body to the health councils, giving them the following definition:

Article 1 (...)

Paragraph 2. – The Health Council, as a permanent and deliberative collegial body composed of representatives of government, service providers, health professionals and users, works in formulating strategies and monitoring the implementation of health policy in the corresponding jurisdiction, including economic and financial aspects; its decisions shall be ratified by the head of the legally constituted power at each level of government.

At the federal level, the National Health Council (Conselho Nacional de Saúde, CNS) is responsible for social control. The Council was created by Law 378 of 13 January 1937 which restructured the Ministry of Education and Public Health; it discussed only internal issues. With the separation of the Ministry of State and Education, the CNS was regulated by Decree 34.347/54 and had the function of helping the Minister of State in determining the general bases of health protection programs<sup>1</sup>. From that time on, it retained its modified powers and mandate until it achieved its present form. In addition to Law 8.080/90 and, particularly, Law 8.142/90, CNS's powers and mandate have been governed by Decree 99.438/90, partially rescinded by Decree 4.878/03 in its bylaws, approved by the Council in plenary assembly in 1999 and also in CNS Resolution 333/03, which establishes directives for the structuring and reorganization of health councils.

The majority of state and municipal health councils have been created by state or municipal law (as the case may be). Creation by law has been a constant recommendation, previously stated in Resolution 33/92 and now given expression in National Health Council Resolution no. 333/03. We must note that creation by law may lend greater legitimacy and autonomy to the health council, since its creation is the

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<sup>1</sup> <http://conselho.saude.gov.br/apresentacao/historia.htm>

responsibility of the Legislative Branch. This has reduced the possibility of interference from the Executive Branch (whose powers have been either distributed or monitored by the health council) in the organization, functions and composition of the council.

The health councils thus have their origins in the Constitution and are regulated through laws and, at a lower level, through regulations. They are bodies of the Executive Branch, which include –at their respective government levels– the Ministry of Health, the State Secretary of Health, and the Municipal Secretary of Health and, thereby, elements of direct public administration.

The promulgation of legal rulings on public participation and what it consists in gave rise to controversy within the people's movement. The legal nature of the health councils, considered a type of internal division of the federal, state or municipal government, plus the absence of a legal character, have been pointed out as obstacles in implementing public participation. For Gerschman (1955), democratization lends a distinct significance: that of "people's mobilization", typifying an organization in favour of demands. The dynamics of the relationships between social movements and government authority have changed to the extent that arbitration from the outside has been given up in favour of development by players involved with one another and involved in relationships with others.

Disagreements over the manner in which public participation is being institutionalized and bureaucratized have led to divisions in the people's movement for health. In Rio de Janeiro, a MOP faction has defended creation of a People's Health Council as an autonomous forum to replace the State Health Council. In the national context:

The dilemma of the union movements and people's movements in playing the role of State's opponent while interacting with the State, which existed through the 1970s and 1980s and manifested itself at the time when the councils were created, when some movements, upon being called, refused to have institutionalized participation (Correia 2000)

In 1992, at the Ninth National Health Conference, social movement members decided to create and maintain autonomous forums in order to preserve their independence and avoid the possibility of the forums being treated as instruments.

Another set of problems is related to the territorial nature of the councils. According to authors such as Cohn (2003), a new type of stimulus for mobilization was engendered due to the fact that Law 8142 linked the creation of health councils to transfer of resources. Given the precariousness of resources, municipalities, regions, states and the federal district began to compete for resources. This attitude of defence of territorially-defined interests placed difficulties in the way of the people's movements, which had been raising banners for improvement of life conditions for all.

The third legal ruling which touched upon the effectiveness of public participation is related to the requirement that health councils be created by law as a requisite for acquisition of resources. The organizing of health councils in nearly all Brazilian cities and in all states and the Federal District, whose clearly defined function is "approval of accounts", redefined the end purpose and scale of public participation, which was previously ambiguous. Faced with the function of monitoring of the public funds, public participation acquired a supervisory aspect.

Unlike the people's movement, the participation of the medical movement was not compromised through the institutionalization of the health councils and conferences. After a brief period of adherence to the

themes of the Health Reform which attributed to these professionals salaried employment with fair pay in the public sector, the chief medical bodies of the country opted for autonomy in medical practice. According to Campos (1986), the leadership who replaced those who had contributed towards formulation of changes to the health system proposed a work agenda which combined private property, the autonomy of medical practice, and government intervention based on accreditation of individual doctors.

At the beginning of the 1990s, the debate over whether the health councils and their composition should be deliberative in character began to take as a reference point an agenda for monitoring public expenditures. The preponderance of interpretations and practices related to direct monitoring by civil society of the management of government affairs was reflected in the deliberations of the Ninth National Conference. Since then, the term "social control" has been preferred, certainly for its more direct connotation of "power" of the social movement to approve or censure government acts.

#### **2.4 Health Councils and Council Members. Health Conferences, Delegates and Topics**

Brazil has 4,390 municipal health councils and 27 state health councils in addition to the National Health Council, with a sizeable membership (at least 100,000 council members). Most of the municipal health councils were created in 1991, as provided for in legislation (Annex 1). The composition of these councils is paired for voting purposes, with 50% users, 25% health professionals and 25% managers (public and private). Council members include representatives of churches, the women's movement, the aboriginal movement, the black movement and the student movement; representatives of carriers of specific pathologies or persons with physical defects, scientific institutions, etc. The National Health Council consists of 48 council members. It holds monthly plenary meetings, organizes commissions and work groups on special topics, and has an executive secretary.

The National Health Conferences exert an influence, to a greater or lesser degree, on Brazilian health policy. Since 1937 when they were established, the conferences have exhibited different compositions and have adapted to different political contexts<sup>1</sup>. The Eighth National Health Conference in 1986 was a landmark conference in that it laid the foundations and guiding principles for the SUS, which would be created two years later in the 1988 Constitution. Since then, health conferences have been held every four years at each level of government, and the composition of these conferences is established in the bylaws with approval from the National Health Council.

At the Ninth Conference, held in 1992, discussions primarily revolved around participation of society in the management of the Unified Health System (SUS). The Tenth National Health Conference, held in 1996, occurred at a time when the SUS was undergoing severe budgetary constraints. The Tenth Conference was marked by the need to evaluate the current structure of the system and the efforts to refine it, particularly the financing mechanisms which were identified as the main obstacle to strengthening and consolidating the SUS throughout Brazil. The Eleventh National Health Conference in 2000 was attended by 2500 delegates, who participated actively and enthusiastically in the group work. Major discussions in this conference centered around strengthening social control in the SUS, with approval of issues related to the health councils. The Twelfth National Health Conference, held in 2003 on the theme "Health is a Right for All and the Duty of the State – the Health We Have and the SUS We Want", was attended by nearly 5,000 people, including 3,500 delegates. At the conference, ten broad themes were examined as guidelines

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<sup>1</sup> The original purpose of the conferences was to encourage exchange of information, assuring monitoring of the federal government of activities carried out in the states in order to regulate financial flow. There was no mention of deliberative processes. For example, the first conference, held in 1941, was attended by only seventy participants, and only after 45 years did the legendary Eighth Conference take place with the presence of more than 4,000 persons.

for the National Health Plan. (The programs of the twelve National Health Conferences are detailed in Annex III.)

Now, in 2007, the Thirteenth National Health Conference is about to be held, for the purpose of evaluating the twenty years of existence of the SUS and its main problems and proposing solutions so that the SUS as approved in the Eighth National Health Conference can serve as an element of State policy without fluctuations in its performance from one administration to another. The intention is also to draw up an agenda of activities to consolidate the system in order to meet current challenges in the quest to guarantee human rights and quality of life.

### **3. Present Challenges to Public Participation and the Implementation of Intersectoral Policy**

These days we are seeing a profound change in forms of public participation. Throughout the 1980s, public participation centered mostly around disputes of public power. At present, the search to increase direct participation of society in municipal administration and to increase the efficiency and efficacy of public policy has become an effort to convert participation into a tool of public management, now understood and designated under certain conditions as participatory management. "Participatory management" is a widespread term covering a range of types of participation.

In the field of health, participatory management has been viewed as a theoretical and practical challenge. The restructuring and creation of more flexible, responsive and effective forums and tribunals to meet complex social demands is consonant with evidence of limitations in the traditional manner of contacts between government and society. On the other hand, the attachment of promises of participatory management to government reform projects, widely distributed by international organizations, viewing decentralization as a means of confronting the processes of social exclusion, discloses its intended use as an instrument. In addition, criticisms of the notion of governability, which gives sense to participatory management in keeping with its presumed strategic character and normative content of principles and criteria allied to a market logic, marks the existence of contradictions which cannot be ignored (Fiori 1995, Oliveira 1998 *apud* Santos Jr. *et alii*. 2004).

With respect to what occurs in the arenas of participation, the idea of governance in terms involving scenarios of tensions and conflicts, is certainly more visible at the local level, where social players relate to one another more directly and restructuring of regrouping strategies and power struggles have a greater possibility of being observed. The experience of developing an arena for explicit expression of interests based on the democratic rule of recognition of the right for all to participate in public life has increased the need for monitoring and surveillance of public powers: this is the role of the Public Ministry, the prosecutors' offices and the special magistrates newly installed in health services and health administration institutions.

The forums of public participation in health have been an important arena of representation of social interests, both from the institutional point of view and from the point of view of the practices of each group involved and the social agents. In a more optimistic analysis, the diversity of social players in the forums may suggest that conditions for representing the interests of the sectors and segments in the public sphere are basically reasonable enough, considering their recent institutional status. However, research has tended to show groups and agents involved in public participation in health as coming from a type of social elite to distinguish them from the total population from the point of view of social and political participation (Monteiro dos Santos, 2004).

On the other hand, there is no longer any doubt regarding the importance of public participation forums for including demands from population segments excluded from the health agenda. Constant tensions between social movements which propose programs for the health care of specific population groups defined by gender, colour, race, and ethnicity, and a type of thinking which levels differences, is poorly receptive of differences and those who are different, and which serves as a principle for the formulation of public policy, contribute to expansion of the concept of health.

The active presence of these social movements and the activities of non-government organizations (NGOs) which centre on discussion and implementation of policies expanding public participation (including determination of the entire budgetary cycle), as well as the creation of public institutions such as the Special Secretary of Policies for Promotion of Racial Equality and the Special Secretary of Policies for Women, have established a favourable atmosphere for the discussion and development of intersectoral activities based on social determinants of health.

However, the intense debate on health in society and the significant forms that it has been taking in executive bodies, in legislative bodies and even in the courts have not been enough to absorb to the fullest the real importance of health in the daily lives of people. We have arrived at the twenty-first century and have not yet found a definite solution for building a comprehensive, reliable health care system based on social determinants and affordable in Brazilian society. A series of surveys on present and future trends can be formulated to evaluate the possibility of safeguarding the advances obtained and bending the social and political processes which hinder the full implementation of the SUS. What changes will be required in Brazilian society to assure solidarity and emancipation as constructive values?

In order to translate into concrete measures policies for reducing inequality and guaranteeing the right to health, mechanisms of participation, control and transparency in public management must be strengthened. Tribunals of direct democracy –such as the people's legislative initiative, participatory budgets, health councils, management councils and the deliberating forums– must be called upon to participate in further discussion of the social determinants of health. Along these lines, we will need to increase the presence of representative groups of Brazilian civil society and government agencies in order to obtain a standpoint on a review of macroeconomic policies which act against full implementation of the SUS and the capacity to carry out intersectoral policies impacting on social determinants in health. We must also consolidate, expand and plan for advances obtained through specific health programs such as women's health, health of the black population, health of the elderly, mental health, and health of aboriginals as vectors of the acquired universal right to health.

The creation of the National Commission on Social Determinants of Health (Comissão Nacional sobre Determinantes Sociais da Saúde, CNDSS) in 2006 encouraged debate and social mobilization on the issue of health and living conditions. The proposal of centrality of the concept of equity –defined as the absence of unfair, avoidable or remediable differences in the health of populations or groups defined by social, economic, demographic or geographic criteria– reopens the agenda of reflections on this topic. Once the social determinants of health and the social determinants of inequities in health are seen as not necessarily the same, we will need to make ethical and political commitments. Thus, a close analysis of social determinants may lead to the conclusion that structural changes in various contemporary societies will be necessary in order to reduce significantly the degrees of differences in health.

Equity, intersectorality and the promotion of these concepts in the field of health have become more seriously considered as policy objectives in international health agencies and by formulators of national policies. However, these agencies and policy formulators designate distinct concepts and forms of strategy to cope with inequalities in health. The three great visions which link the health/sickness process to health-care models are once more at the centre of debate: (1) improvement of the health of disadvantaged people

through target programs; (2) reduction of disparities in health care between persons exposed to poorer social circumstances and groups that are better off; and (3) a proposal for complete treatment of all phases of health, i.e., association between socio-economic conditions and health within a complete population. These three visions require action on the social determinants of health; they have effective potential to alleviate the weight of disease borne by socially disadvantaged persons. Nevertheless, these visions differ significantly in terms of the values of justice, autonomy and social emancipation.

The social movement has been called upon to review reality and its various possible interpretations. The creation of the SUS, its implementation, and resistance to its dismemberment have been effective by reason of our ability to propose changes. As Paulo Freire stated, "being of the world and with the world" means not only learning how to understand reality but also how to change it. "Being of the world" means not avoiding problems or underlying causes: hunger, unemployment, precarious housing conditions. Separating the subjects from the circumstances in which they live only means that you have lost commitment to them. And one can never have a social movement without commitment.

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Annex I																		
CREATION OF MUNICIPAL HEALTH COUNCILS, BY YEAR, IN EACH STATE AND IN THE FEDERAL DISTRICT																		
State	Total	NI	Before 1991	91	92	93	94	95	96	97	98	99	2000	2001	2002	2003	2004	2005
	41	3	5	5	3	3	9	2	1	7	1	-	1	-	-	-	-	1
Acre	22	4	-	2	-	3	1	2	2	2	-	3	-	-	1	-	-	2
Amazonas	49	8	-	5	1	4	9	-	2	6	5	4	1	3	-	1	-	-
Roraima	10	3	-	-	1	-	-	-	-	4	1	-	-	1	-	-	-	-
Pará	59	6	-	4	6	8	5	4	6	12	4	2	-	-	-	2	-	-
Amapá	14	1	1	1	1	-	4	1	2	2	-	-	-	-	1	-	-	-
Tocantins	47	1	1	8	1	7	7	2	-	10	2	-	1	5	-	1	-	1
Maranhão	128	12	1	12	4	11	10	7	4	47	7	3	3	1	-	-	-	6
Piauí	104	14	1	29	1	4	14	-	2	30	5	-	-	2	1	1	-	-
Ceará	170	18	34	34	21	20	14	5	3	11	3	1	2	3	-	-	-	1
Rio Gde. do Norte	83	11	1	18	2	13	11	5	2	11	5	3	-	-	-	-	1	-
Paraíba	110	20	1	11	1	11	18	4	2	32	-	2	-	4	-	-	-	4
Pernambuco	145	13	7	34	8	18	21	8	4	25	-	2	1	1	-	2	-	1
Alagoas	85	12	2	17	1	24	14	2	1	5	2	-	-	3	-	1	-	1
Sergipe	68	3	3	10	1	9	9	8	5	15	1	-	1	-	2	-	-	1
Bahia	305	24	9	54	3	37	13	14	10	87	15	8	2	15	1	-	4	9
Minas Gerais	781	63	18	161	74	127	68	24	21	126	17	15	9	26	2	5	4	21
Espírito Santo	63	3	6	33	1	4	5	-	1	7	1	1	-	1	-	-	-	-
Rio de Janeiro	80	13	8	24	5	12	3	3	-	8	-	2	1	1	-	-	-	-
São Paulo	622	29	21	274	23	58	29	12	12	80	26	7	5	28	6	1	4	7
Paraná	328	34	21	134	22	45	12	3	3	29	1	8	1	4	3	3	-	5
Santa Catarina	219	21	19	47	22	34	5	7	3	36	2	6	2	6	2	1	2	4
Rio Gde. do Sul	442	15	15	117	15	55	28	18	28	81	24	7	8	29	1	1	-	-
Mato Grosso do Sul	64	5	5	18	5	15	2	-	1	7	3	-	-	1	-	1	-	1
Mato Grosso	122	9	17	20	3	29	10	3	4	12	2	-	-	9	-	2	-	2
Goiás	229	19	5	14	8	49	17	5	4	43	11	2	3	35	4	1	1	8
Total	4390	364	201	1086	233	600	338	139	123	735	138	76	41	178	24	23	16	75

Source: Profile Research on the Health Councils of Brazil. National School of Public Health/Fundação Oswaldo Cruz 2006

Annex II

History of the Health Conferences in Brazil

The law establishing the health conferences was promulgated in 1937 during Getúlio Vargas' first presidency, at a time characterized mainly by lack of political freedom. Thus the initial idea of the conferences was explained as serving only as a meeting of technicians and administrators of the ministry and the states to advise the minister in the fields of education and health. Historical events such as the 1937 coup and the Second World War served even more to abort any initiative for discussion of health policies. During the Second World War, close relationships of the Brazilian government with the United States yielded a series of agreements, among them the Public Health Special Service [Serviço Especial de Saúde Pública, SESP], which lasted to the 1990s. During this time, the National Services (of Tuberculosis, Leprosy, etc.) were created, whose sole purpose was treatment of the diseases and not prevention. It was during this period that a second extensive ministerial reform was carried out in the field of health. The First Conference, in spite of being a nonpolitical meeting, was a landmark in the history of Brazilian health due to a number of demands, such as, for example, for a health minister, which position has existed since the beginning of the Republic; and another demand for changes in relationships among the federated entities, leading to centralization due to lack of technical capacity in almost all municipalities to resolve their sanitation problems. The Second Conference did not take place until 1950, and was distinguished by the enactment of laws on hygiene and safety in the workplace, as well as provision of medical and preventive assistance to workers and pregnant women. The year 1953 saw the creation of the Ministry of Health, a proposal that had been under discussion at the two national health conferences. The Third Conference, in 1963, had a difference: democratic movements emerged in the area of health, there was expanded room for discussion, and the first effective proposal for decentralization in the area of health was raised. Brazilian health problems appeared on the agenda for the first time and were pointed out and discussed. Proposals pointed to the need for a national plan which involved the three levels of government. The four conferences that followed took place during military governments and again were predominantly technical and bureaucratic in nature. At the Fourth Conference, the central issue was human resources and the need to identify the type of professional that would satisfy the demands of the country. At the Fifth Conference (1975), the national health system, the mother/infant health program, the system of epidemiological surveillance, the control of widespread endemic conditions, and the expansion of health-care activities to rural populations were topics that were discussed. The Sixth Conference (1977) concerned control over widespread endemic conditions and introduction of health services in the interior of the country. In the Seventh Conference, discussion was oriented towards the proposal to create the National Program of Basic Services in Health (Prev-Saude), but also touched on matters relating to health services in federal universities and the linkup of basic services with specialized services in the health system. The Eighth Conference was first and foremost the result of an extensive, nation-wide movement in defense of health. Social and political forces, together with the "health movement", joined together in a commitment for change. Thus several meetings were held to discuss health and the National Council of State Secretaries of Health [Conselho Nacional de Secretários Estaduais de Saúde, CONASS], and the first demonstrations took place in defense of the Unified System of Health (SUS), previously vague and inconsistent but which now was taking shape as concrete proposals arising from different strategies. The preparatory process of the Eighth Conference was then released through encouragement and support of preliminary conferences in the states and full disclosure of the agenda for discussion in society in general. This form of organization strengthened the proposal for democratic discussions, making it possible for representatives of organized civil society to sit at the same table with technicians, health professionals, intellectuals and politicians in representative discussion forums, counting always on the participation of more than a thousand persons and approving final reports contributed by many as a supplement to the national debate. This organization thus made all the difference and provided the tone of the Eighth Conference. Exceeding all expectations and previous estimates, the conference was attended by more than

four thousand persons. The Eighth Conference accomplished two tasks: one, the immediate one, of clarification and consolidation of government policy in the sector; the other of affirmation of a concept on the Health Reform, which then was the subject of efforts to render it viable and release it with the Constituent Assembly.

Annex III

Programs of the National Health Conferences (CNS)

*1st CNS – November 1941*

TOPIC: Structural reform for combating specific diseases (tuberculosis and leprosy)

*2nd CNS – November 1950*

TOPIC: Conditions of hygiene and safety in the workplace and provision of medical, sanitary and preventive care for workers and pregnant women.

*3rd CNS – 9 to 15 December 1963*

TOPIC: Provide a sketch revealing the state of Brazilian health starting from the premise that health is incompatible with poverty; distribute powers among the three levels of government; and discuss the transfer of health services to the municipalities.

SUBTOPICS:

- Health situation of the Brazilian population;
- Distribution of medical and sanitary activities among federal, state and municipal jurisdictions;
- Transfer of health services to the municipalities;
- Determination of a national health plan

*4th CNS – 30 August - 4 September 1967*

TOPIC: Human Resources for Health Activities

SUBTOPICS:

- The health professional needed in Brazil;
- Mid-level and auxiliary personnel;
- Responsibility of the Ministry of Health for training and upgrading health professionals and mid-level and auxiliary personnel;
- Responsibility of the universities and higher-education schools in the development of a health policy

*5th CNS – 5 to 8 August 1975*

TOPIC: Formulation of a national health policy to be submitted to the Social Development Council

SUBTOPICS:

- National health system;
- Mother/infant program;
- Epidemiological surveillance;
- Control over widespread endemic conditions;
- Extension of health activities to rural populations (Network of basic units and HR)

*6th CNS – 1 to 5 August 1977*

TOPIC: Process of control over widespread endemic conditions and introduction of health services in the interior

SUBTOPICS:

- Present situation of control over widespread endemic conditions
- Validation for use of new basic legal regulations, approved by the Federal Government for health purposes
- Introduction of health services in the interior
- National health policy

*7th CNS – 24 to 28 March 1980*

TOPIC: Extension of health activity through basic services

SUBTOPICS:

- Regionalization and organization of health services in the states and in the Federal District
- Sanitation and housing in Basic Health Services (PLANASA) and simplified sanitation
- Development of human resources for Basic Health Services
- Supervision and continued education for Basic Health Services
- Responsibilities and links between institutions (federal, state and municipal levels), development of institutions and the infrastructure of support in the states
- Food, nutrition and Basic Health Services
- Dentistry and Basic Health Services
- Mental health, chronic degenerative diseases and Basic Health Services
- Epidemiological information and surveillance and Basic Health Services
- Community participation - Basic Health Services and the communities
- Links of Basic Services with Specialized Services in the health system

*8th CNS – 17 to 21 March 1986*

TOPIC: “Democracy and Health”

SUBTOPICS:

- Health as a duty of the state and a right of the citizen
- Rebuilding the national health system
- Sector financing

*9th CNS – 9 to 14 August 1992*

TOPIC: “Health: Transfer to the municipalities is the way”

SUBTOPICS:

- Implementation of the SUS
- Social control in the system
- Democratization of information
- Financing

*10th CNS – 2 to 6 September 1996*

TOPIC: “SUS – Constructing a model of health care for quality of life”

SUBTOPICS:

- Health, citizens' rights and public policy
- Management and organization of health services
- Social control in health
- Financing of health
- Human resources for health
- Total health care

*11th CNS – 15 to 19 December 2000*

TOPIC: “Making the SUS effective: access, quality and humanization in health care with social control”

SUBTOPICS:

- The SUS as social policy
- Management of the SUS
- Access SUS services
- The social assistance model of the SUS
- Financing of the SUS
- Human resources
- Social control over the SUS
- Information, education and communication policy
- Responsibilities of the legislative and judicial branches and of the Prosecutor to guarantee access, quality and humanization

*12th CNS – 7 to 11 December 2003*

TOPIC: “Health: a right for all and a duty of the State - The health that we have, the SUS that we want”  
(Social control is a topic whose discussions were to cut across all ten broad themes)

SUBTOPICS:

- Right to health
- Social security and health
- Intersectorality of health activities
- The three levels of government and the development of the SUS
- The organization of health care
- Participatory management and social control
- Employment in the health field
- Science/technology and health
- Financing of the SUS
- Information and communication in health

Source: Escorel, S; Bloch, RA. *The National Health Conferences in the Development of the SUS [As Conferências Nacionais de Saúde na Construção do SUS]*. In Lima, NT; Gerschman, S; Edler, FC; Suárez, JM (eds.) *Health and Democracy - History and Perspectives of the SUS [Saúde e Democracia – História e perspectivas do SUS]*. Rio de Janeiro: Editora Fiocruz, 2005. pp. 83-119