CHAPTER TWELVE

PARTICIPATION AND PUBLIC POLICIES IN BRAZIL

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The 1988 Brazilian Constitution, which established the formal transition to democracy, sanctioned the decentralization of policymaking and established mechanisms for citizens to participate in the formulation, management, and monitoring of social policies. Hundreds of thousands of interest groups worked throughout the country as the constitution was being drafted and collected half a million signatures to demand the creation of participatory democratic mechanisms. Underpinning such demand was the belief that by opening spaces for citizens to participate, the policymaking process would become more transparent and accountable and social policies would better reflect the needs of the citizens.

This legal foundation promoted the development of an extensive institutional framework for participation by citizens, including management councils, public hearings, conferences, participatory budgeting, and deliberative mechanisms within regulatory agencies. Of the plethora of participatory mechanisms in Brazil, participatory budgeting and management councils gained the greatest momentum in the 1990s. These two participatory mechanisms are linked to the executive branch and stress transparency, local control, and the redistribution of resources to underserved areas.

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Since 1989, 250 of the 5,507 Brazilian municipalities have adopted the participatory budgeting process, which enables the participation of citizens in setting priorities for government investment in infrastructure and basic social services. Participatory budgeting is a local practice of public deliberation on budget issues. The participatory budgeting assemblies facilitate public scrutiny of government performance, and they provide a space in which citizens negotiate priorities on public investment. The final document of the participatory budgeting process is the plan of work and services; this plan is sent to the executive as an integral part of the budget, then submitted to the legislature for review and a final vote. In Porto Alegre, the city of 1.3 million inhabitants where participatory budgeting was first established, close to 100,000 people have taken part in the participatory budgeting process.[1]

Over 28,000 management councils have been established for health policy, education, the environment, and other matters. These councils are organized at all levels of government, from local to federal, and they provide forums in which citizens join service providers and the government in defining public policies and overseeing their implementation. Management councils enable citizens to have a voice in policymaking and provide a mechanism for greater downward accountability.

Of these two participatory mechanisms, the management councils are much more important, at least in terms of their scale. Previous research, however, has raised questions about how effective these councils are at promoting effective citizen participation. In this view, the democratic promise of these councils has been compromised by the authoritarian tradition within the Brazilian state and, more generally, a lingering authoritarian political culture, fragile associational life, and resistance from both society and state actors.[2] Even when councils are implemented, the poorest remain excluded and continue to lack sufficient resources to articulate their demands, while the costs of participation continue to be lower for those with more resources.

In this chapter, we take a different perspective. We acknowledge that a management council's organizational structure can reinforce existing inequalities among the actors involved, but they can be addressed, at least partially, through improving the deliberation that is part of the council process. Thus, it is necessary to review the process through which councillors are chosen and devise appropriate rules and procedures to ensure that those citizens with relatively little technical expertise and communicative resources are included as effective participants in the deliberative decision-making process.

In making our case, we focus on the Municipal Health Council of São Paulo, a council that works in a favorable environment with a strongly committed government and citizenry.[3] Health councils such as this one make for a good case study because they have been established for a longer period than most councils and are perceived as more consolidated. Before discussing the particulars of the São Paulo case, we review the legal context of health councils.

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The Legal Context of Health Councils

The 1988 constitution defined health as a right of all citizens and the responsibility of the state and established the Unified Health System (SUS)—the Brazilian public health system—based on the principles of universality and equity of health care provision. The SUS introduced the notion of accountability (*controle social*) and popular participation; it stated that the health system had to be democratically governed and that the participation of civil society in policymaking was fundamental for attaining its democratization.[4] Health councils emerged within the legal framework as the institutions responsible for enabling citizen participation in health governance. Health councils have been established at federal, state, and municipal levels of the government.

The health council is a permanent collective body that consists of citizens, health professionals, governmental institutions, and providers and producers of health services (Federal Law 8,142). There are currently more than 5,500 health councils involving almost 100,000 citizens and a vast number of associations. Health councils are political forums in which participants discuss issues and may make alliances to help the health secretariat plan and define priorities and policies. The strength of these councils largely lies in the law that grants them veto power over the plans and accounts of the health secretariat. If the council rejects the plan and budget that the health secretariat is required to present annually, the Health Ministry does not transfer funds.

Municipal health councils, such as the one in São Paulo, are of particular importance in health governance because one of the principles of the SUS was decentralization of the health system. Through the process of decentralization, both health planning and the provision of health services became the responsibility of municipal governments.[5] This process turned the municipality into a key political space for the definition of health policies and municipal health councils into an important arena for participation in policymaking. In order to implement this constitutional provision, enabling legislation was enacted to change the distribution of resources between federal, state, and municipal governments, greatly strengthening the municipal governments. The Basic Operational Norms, which regulate the SUS, make the transfers of resources within the health sector from the federal government—which manages 60 percent of the public health budget—to the municipalities, conditioned on the existence of the municipal health councils. The enforcement of this legal framework has led to the rapid institution of municipal health councils throughout Brazil. The Basic Operational Norms also stipulate that representation in these councils be based on a parity principle that states that the number of representatives of civil society (citizens) must be equal to that of service providers, health professionals, and government institutions added together.

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How the São Paulo Council Works

The Municipal Health Council of São Paulo is located at the headquarters of the municipal health secretariat in downtown São Paulo, a city of ten million inhabitants. The council is made up of three bodies: the Deliberative Assembly, the Executive Commission and the General Secretariat (Municipal Decree 38,576/99). Deliberative Assemblies, or plenary meetings, are held monthly (ordinary meetings) and every time the president or the majority of its members deem it necessary (extraordinary meetings) at the headquarters of the municipal health secretariat. Deliberative Assemblies are open to the public and make final decisions on council matters. The quorum required for the meetings of the Deliberative Assembly is half of its members plus one. The council has sixty-four members—thirty-two titular members and thirty-two substitutes. Councillors are elected for a two-year term and may be reelected for another term. The law establishes that they cannot be paid, because their participation constitutes a public service. The municipal health secretary is by law a member of the council and its president; he or she has the right to voice opinions but not vote in the Deliberative Assembly, except in cases where his or her vote is needed to break a tie.

The municipal decree that formally constitutes the council establishes the general profile of the associations and organizations within each of the four membership groups that have the right to be represented in the council and the number of seats they hold (see Table 12.1).[6] The responsibility of electing or otherwise choosing their representatives to the council lies with these four sectors.[7] The parity principle guarantees organizations from civil society half of the seats on the council. Health professionals make up one quarter of the seats, while representatives of governmental institutions, together with representatives of public and private providers of health services, account for the remaining quarter.

Previous research points out that in São Paulo, the majority of organizations from civil society that are represented on the council work closely with citizens who have historically been marginalized or excluded from the policymaking process and suffered discrimination from mainstream society. These marginalized groups include poor dwellers on the depressed peripheries of the city, the black population, disabled people, and the elderly.[8] Most of the seats reserved for citizen organizations (eleven out of sixteen) have been assigned to popular health movements and social movements, and an additional three are occupied by associations that represent disabled citizens (one seat) and people affected by diseases such as AIDS (two seats). The remaining two seats are reserved for representatives of trade unions. The role played by social movements in the transition to democracy and in the institutionalization of health councils explains the large number of seats they occupy on the council. In São Paulo in particular, popular health

TABLE 12.1. COMPOSITION OF THE MUNICIPAL HEALTH COUNCIL OF SÃO PAULO

Institutions Represented in the Municipal Health Council	Number of Seats
Civil society (16 total seats)	
Popular health movements	6
Social movements	5
Associations of people with pathologies	2
Associations of disabled people	1
General workers' unions	1
General corporate unions	1
Health professionals (8 total seats)	
Health professionals' unions	2
General unions	2
Supervisory councils of professionals involved in direct service to patients	2
Supervisory councils of professionals involved in the supervision and production inputs (such as blood banks or pharmaceuticals)	1
Associations for professionals such as physicians and engineers	1
Governmental institutions (6 total seats)	
Municipal health secretariat	4
Public universities and research institutes	1
Private universities and research institutes	1
Suppliers and producers of health products (2 total seats)	
Corporate entities supplying or producing health services or products	1
Nonprofit entities supplying health services	1

Source: Municipal Decree 38,576/99.

movements played an important role in the struggle for the improvement of the health and living conditions of poor and marginalized people.

Little is known about the process through which the council's member organizations choose their representatives. On March 2002, a councillor summoned an extraordinary meeting of the council, denouncing the "partisan appropriation" of the council on the part of the Workers' Party. The councillor alleged that the Workers' Party controls the process through which some of the councillors are

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chosen, especially those connected with social movements and unions. This issue generated a heated discussion within the council, but it did not result in any change.

To exemplify the process through which some of the councillors are chosen, we recount briefly the election of the representative of the Popular Health Movement of the Eastern Zone, which took place in July 2001.[9] The meeting was held on a weekday, in the afternoon, and was attended by sixty-four people from the thirteen health districts comprised in the Eastern Zone of the city, as well as a public official nominated by the municipal council.[10] There were three candidates for the post of councillor, and no explanation was given as to how these names had been chosen. After the candidates had presented and discussed their proposals, participants were asked to vote by raising their hands. The winner got thirty-nine votes. We were unable to obtain information on the identity of the participants and the organizations they represented; these details had not been documented. This description should not be taken as paradigmatic; it is likely that other organizations on the council (and other health councils in the country) adopt different methods for choosing their representatives. Nevertheless, it illustrates the dearth of information on the processes through which such choices are made, as well as the difficulties in shedding light on such processes.

Research on the socioeconomic and political profile of the council has found that 45 percent of citizen representatives began participating in social movements during the 1970s and 1980s, and the rest were connected to left-wing parties. Seventy-five percent of civil society representatives in the 2000–2001 term were women; 78 percent were over fifty years old; and many of the elderly councillors were retired. Citizen representatives have lower levels of education and are less well-off compared with the other groups represented on the council. Forty-three percent of citizen representatives declared that they earned an income equivalent to four or less minimum wages, which is much lower of that earned by representatives of the other groups.

Although being granted the right of membership on the council by decree is a prerequisite for the inclusion of citizens in policymaking, this in itself is not sufficient. Inclusion can only be secured to the extent that citizen representatives are able and willing to attend the meetings of the council. The meetings are scheduled on weekdays at two o'clock in the afternoon, which means that employed councillors need to take time off from work to attend. For the representatives of governmental institutions and most health professionals, this does not present a difficulty, for the nature of their employment facilitates their participation. In contrast, citizen representatives have to request permission from their employers and negotiate with them in order to obtain time off from work, and some of them do not get paid for the hours of work forgone. For them, therefore, attendance at council meetings entails a considerable opportunity cost.[11] In view of these considerations, it would

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not be surprising if only a few representatives of civil society were able or willing to attend the council meetings. However, a review of the lists of attendance at the Municipal Health Council plenary meetings during the 2001–2002 term reveals that the majority of citizen representatives *do* attend the council meetings. Moreover, because their level of attendance tends to be slightly higher than that of the other groups on the council, they always constituted at least half of the participants, and they often outnumbered the other groups.[12]

The data on the socioeconomic profile of the councillors and their level of attendance suggest that the Municipal Health Council has succeeded in opening a space for dialogue between social groups that do not usually meet in other forums and that have historically lacked the opportunity to debate and define health policies collectively. In spite of this achievement, it is important to not to lose sight of the fact that the poorest sectors of society are still not participating and that a significant number of citizen organizations represented on the council have historically been linked to the Workers' Party, while numerous other organizations that are working to improve provision of health services to the poor have been excluded from the formal composition of the council.[13]

This situation can be largely attributed to the council's internal regulations, which reserve seats for specific associations and organizations. The rules regulating citizens' access to the council mean that only some groups have access to it (that is, those that were mobilized when the rules were created), thus reinforcing the exclusion of social groups that lack representation. To counter this trend, it would be necessary to devise more appropriate ways to organize representation in participatory institutions so as to ensure the inclusion of less mobilized and more vulnerable groups. Several authors have proposed ways of doing so, and we expect that some of these alternatives will be tested in participatory forums in the coming years .[14]

Assessing the Impact of the São Paulo Council

The council's formal structure is horizontal, assuring the full freedom of its members to participate in face-to-face discussions and bring their own views and preferences into the debates. The council plenary meetings are chaired by an elected councillor, who plays the role of facilitator. It is expected that this horizontal structure will bring the voices of different social actors into health governance.

Our review of the minutes of the council plenary meetings shows, however, that fostering an exchange of information among participants can be difficult. Only some interventions succeed in provoking a response from other participants, thereby generating a debate, whereas other interventions are silently ignored. When interviewed, most of the councillors agreed that an argument that goes

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straight to the point and keeps to the issue under discussion, avoiding digressions, is an effective way to advance one's position within the council. Mastering the technical language of the health sector enables councillors to convey their views in a way that resonates with current policy discourses, thereby conferring greater weight and legitimacy to the positions they advance. The tendency of citizen representatives to construct their arguments in a way that is regarded as unstructured, combined with their focus on highly localized issues, makes their speeches appear unclear, emotional, disruptive, or irrelevant to most representatives of the other sectors. Moreover, this style of speech tends to be associated with poorer and less educated people, and it is regarded as not only ineffective but also virtually unintelligible.

When debates were about important political issues, such as changes in administrative rules or health programs, numerous councillors found that the arguments they advanced failed to modify in any meaningful way the proposals advanced by the government. Even when the majority of the councillors held views that were opposed to that of the government, the council proved unable to develop and put forward coherent alternative policy proposals. Interviews with the councillors reveal that they are aware of the limited influence that the council exerts within the health system. They say that they are always denouncing problems of the everyday functioning of the system but rarely find ways to organize themselves to solve them. This implies that although it is meant to be a mechanism for citizen participation, the council has failed to legitimize new concerns and practices, which puts it in a weak negotiating position vis-à-vis the government. In spite of these limitations, many councillors describe their experience as a member of the Municipal Health Council as rewarding. This is so for at least two reasons. First, being a councillor grants them access to new information that they previously did not have access to. Second, they find the council a friendly space where they meet other people who are committed to improving the health system.[15]

Our analysis of the dynamics of participation in the Municipal Health Council of São Paulo suggests that significant advances have been made in terms of institutionalizing a political space in which the views of hitherto excluded groups can be expressed. Nevertheless, much remains to be done if the voices of these groups are to be heard. One of the main challenges is fostering an inclusive dialogue between different socioeconomic groups. Relying on a councillor to facilitate the discussion during plenary meetings and to foster the participation of all participants has not proved to be an efficacious strategy because the councillors don't have the necessary skills to perform these tasks. Several authors argue that to enable underprivileged groups to express themselves effectively in participatory forums, specific methodologies aimed at fostering the abilities of participants with less technical expertise and communicative resources need to be devised and adopted.[16]

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On the other hand, the council's inability to exert influence over the policies and programs defined by the health secretariat calls for a more careful selection of the issues discussed in the council. Some areas are likely to benefit little from citizen participation because they require highly specialized knowledge or because citizens lack expertise and information.[17] On the other hand, significant benefits can be expected in those areas in which citizens have an advantage over politicians and administrators—that is, when local knowledge and citizens' preferences play an important role.

Reflections

The experience of municipal health councils is part of a movement that should be carefully examined—a movement in which civil society and political actors have joined forces to institutionalize political spaces for citizen participation in policymaking. As the experience of the Municipal Health Council of São Paulo shows, the challenges for attaining effective citizen inclusion in health governance are many, even in a favorable context. As we saw, these challenges arise from inequalities in the distribution of political and communicative resources between the actors involved, as well as from the rules that define how citizen representatives are chosen, how issues for discussion are selected, and how the process of deliberation is organized. Unless these challenges are addressed, they will reproduce and reinforce the exclusion of groups that lack political ties as well as communicative and technical resources.

A participatory institution such as a municipal health council is expected to provide resources to at least partially mitigate these inequalities. Our recommendation is that these resources be invested to make the selection of citizen representatives more transparent and democratic and to strengthen the council's organizational capacity so as to render the deliberation process more inclusive. It remains to be seen whether the actors involved will feel sufficiently capable and motivated to promote such changes. Whereas the response to these challenges is likely to come from the political sphere, the considerable efforts devoted to the promotion of participatory forums during the last few years suggest that a wide range of social, state, and political actors will contribute to its realization.

Notes

1. Souza Santos, B. (1998). "Participatory Budgeting in Porto Alegre: Toward a Redistributive Democracy." [http://www.ssc.wisc.edu/~wright/santosweb.html].
2. Brazilian Association of Collective Health.(1993). *Relatório final da oficina: incentivo à participação popular e controle social em saúde* [Final report: Popular participation and social control in health]. Série Saúde e movimento [Health and movement series]. Vol. 1. Brasília: Brazil-

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ian Association of Collective Health; Andrade, I. (1998). "Descentralização e poder municipal no nordeste: os dois lados da moeda" [Decentralization and municipal power in the North East: Two sides of the coin]. In J. A. Soares (ed.), *O orçamento dos municípios do Nordeste brasileiro* [The municipal budget in the Brazilian Northeast]. Brasília: Paralelo15; Carneiro, C. (2002, March). "Conselhos: Uma reflexão sobre os condicionantes de sua atuação e os desafios de sua efetivação" [Councils: Challenges for their implementation]. *Informativo CEPAM* [CEPAM Bulletin], *1*(3), 62–70. São Paulo: Fundação Prefeito Faria Lima; Carvalho, A. (1995). "Conselhos de Saúde No Brasil" [Health Councils in Brazil]. *Política, Planejamento e Gestao em Saúde*. Série Estudos [Study series: Politics, planning, and health management], no. 3. Rio de Janeiro: Ibam/Fase, 5–41.

3. The Workers' Party (*Partido dos Trabalhadores*) won the municipal elections for the 2000–2004 term. In the first two years of this term, the health secretary was Eduardo Jorge, an enthusiastic promoter of civil society participation.
4. Lobato, L. (1998, Sept. 24–26). "Stress and Contradictions in the Brazilian Healthcare Reform." Paper presented at the annual meeting of the Latin American Studies Association, Chicago.
5. Lobato, (1998). "Stress and Contradictions in the Brazilian Healthcare Reform." The federal government retained responsibility for developing national policies, controlling national regulation through the SUS, and providing technical and financial support to states and municipalities. The states became responsible for controlling the health network and hierarchy within the state and for supervising and providing technical and financial support to municipalities.
6. To our knowledge, no study has examined how or why these organizations and associations have been chosen instead of others. While it is highly likely that the list in Table 12.1 is the result of an intense process of political negotiation among a number of different actors, light has yet to be shed on the ways in which this negotiation took place.
7. To appoint councillors, a list of nominees is presented to the health secretariat, which in turn gives tenure to the new councillors during the municipal health conference.
8. Pozzoni, B. (2002). "Citizen Participation and Deliberation in Brazil." Unpublished master's thesis, Institute of Development Studies, University of Sussex, Brighton, U.K.; Coelho, V. (2004, Apr.). "Brazil's Health Councils: The Challenge of Building Participatory Political Institutions." *IDS* [Institute of Development Studies] *Bulletin, 35*(2), 33–39.
9. Pozzoni (2002), "Citizen Participation and Deliberation in Brazil." In São Paulo, there are six organizations associated with the popular health movement—one for each of the six regions of the city—and each of them holds one seat on the Municipal Health Council.
10. Health districts comprise a population of approximately 250,000 inhabitants each.
11. For citizen representatives who are either unemployed or retired, attending the meetings is an activity carried out on their own time. While this is not likely to entail an opportunity cost comparable to that paid by those who are employed, it does constitute an extra demand on their otherwise free time.
12. Pozzoni (2002), "Citizen Participation and Deliberation in Brazil."
13. Coelho, V. (2004). "Conselhos de saúde enquanto instituições políticas: o que está faltando?" [Health councils as political institutions: What is lacking?]. In V.S.P. Coelho and M. Nobre (eds.), *Deliberação e Participação no Brasil* [Deliberation and participation in Brazil]. São Paulo: Editora 34 Letras.
14. Fishkin, J. (1995). *The Voice of the People*. New Haven, Conn.: Yale University Press; Cornwall, A. (2004, Apr.). "New Democratic Spaces? The Politics and Dynamics of Institutionalised Participation." *IDS* [Institute of Development Studies] *Bulletin*], *35*(2), 1–10; Fung, A. (2003).

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"Recipes for Public Spheres: Eight Institutional Design Choices and Their Consequences." *Journal of Political Philosophy, 11,* 1–30; Font, J. (2004). "Participación ciudadana y decisions públicas: conceptos, experiencias y metodologias" [Citizen participation and public decisions: Concepts, experiences, and methodologies]. In A. Ziccardi (ed.), Participación ciudadana y políticas socials en el ámbito local [Citizen participation and social policies in local government. Mexico: Instituto Nacional de Desarrollo Social [National Institute of Social Development].

15. Interviews of the councillors who were in office in 2000–2001 and 2002–2003 were part of the "Participation and Social Inclusion in Brazil" project carried out by the Brazilian Center of Analysis and Planning with the support of the Citizenship Development Research Centre on Citizenship, Participation and Accountability, Institute of Development Studies, University of Sussex.
16. Carvalho (1995), "Conselhos de Saúde No Brasil"; Fung (2003), "Recipes for Public Spheres"; Gaventa, J. (2004). "Representation, Community Leadership and Participation: Citizen Involvement in Neighbourhood." In *Renewal and Local Governance.* Report prepared for the Office of the Deputy Prime Minister, United Kingdom. Available on the Logolink Web site; Cifuentes, M. (2002). "Political Legitimacy of Deliberative Institutions." Unpublished master's thesis, Institute of Development Studies, University of Sussex, Brighton, U.K.; Delli Carpini, M. X., Cook, F. L., and Jacobs, L. R. (2003). "Talking Together: Discursive Capital and Civil Deliberation in America." Paper presented at the meeting of the Midwest Political Science Association, Chicago.
17. Fung (2003), "Recipes for Public Spheres."