User Participation and Reform of the Brazilian Health System: The Case of Porto Alegre

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Abstract

Municipal health commissions have been key elements in the reform of the Brazilian health system over the past thirteen years. The reform made publicly financed health care, in principle, universally accessible, while the system became better integrated as well as decentralised. Municipal health commissions have become a widespread institutional feature of the health system. They have gradually increased their planning and supervisory roles over health services located within their territorial jurisdiction.

The participatory schemes of municipal health commissions can achieve better results in areas where they have the support of strong social and trade union movements. This is the case in the southern region of Brazil and, in particular, in Porto Alegre. This study analyses the ways in which users were involved in the municipal health commission of Porto Alegre, between 1985 and 1991, verifying which institutional-political factors have most influenced their involvement.

The study develops a "methodology" for the assessment of user participation in statutory fora. The attendance lists and minutes of meetings, interviews with regular participants in the forum, and other sources of information, were used to build up indicators of user involvement and of the factors that could influence the participatory process. Two main sets of variables are identified. The first set of indicators is concerned with the ways in which users participated in the commission. Two indicator-variables were created to assess this participation: the attendance of users at weekly plenary meetings of the commission (the decision-making division of the forum) and the types of involvement of user representatives in the decision-making process. The second set of indicator-variables refers to institutional-political factors that could have most influenced the participation of users. Among these are: (a) major policy changes in the institutional framework of the Brazilian health system, (b) changes in the organisation of urban social movements in Porto Alegre (since trade unions had not regularly participated in the work of the commission), (c) changes in the relationship between public health professionals and leaders of urban social movements, (d) the types of interest which municipal, state and federal health authorities had in promoting the participation of user representatives in the decision-making process, and, finally, (e) the types of issues discussed in the majority of plenary meetings.

Relationships were then established between both sets of variables to verify which factors most influence this involvement. The study concludes that, between 1985 and 1991, variations in the attendance of users at plenary meetings, as well as variations in the type of involvement user representatives had in the decision-making process of the forum, were strongly associated with important changes: (1) in the institutional framework of the Brazilian health system, (2) in the organisation of urban social movements in Porto Alegre and (3) in the relationship between public health professionals and leaders of urban social movements. The position of municipal health authorities on user participation has also influenced user involvement in the commission. The other factors, however, had apparently determined only short term changes in user involvement.

The study also highlights the role of Brazilian health system reformers as promoters or stimulators of these changes. This policy community had a central role in attracting urban social movement activists to become involved in these formalised fora. They can be regarded as policy formulators as well as as an active part of an alliance established between them and urban social movement activists.

In the case of Porto Alegre, it is possible to affirm that social organisations, particularly those representing shantytown populations, sustained consistent involvement of their representatives in the overt political spaces of the local and municipal health commissions. These commissions had limited power over health services in the city, mostly due to delays in placing these services under municipality control. However, the case examined indicates the gradual formation of an alternative type of political relationship in the health sector in Porto Alegre, in which the interests of the urban shantytown residents are represented formally and publicly. In this sense, the consolidation of participatory fora can assist in the democratisation of Brazilian institutions, giving voice to social sectors traditionally excluded from the political system. Through their involvement in the commission, these representatives were also increasing the responsiveness of publicly financed health services to the needs of users who, individually, lacked the political power to sustain their demands.

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Contents

Index of Acronyms

ABEN	Associação Brasileira de Enfermagem (Brazilian Association of Nurses)
AHRGS	Associação de Hospitais do Rio Grande do Sul (Hospital Association of Rio Grande do Sul)
AIS	Programa das Ações Integradas de Saúde (Programme of Integrated Health Action)
CAMP	Centro de Assessoria Multiprofessional (Multiprofessional Advisory Centre)
CAP	Caixas de Aposentadorias e Pensões (Retirement and Survivor's Pension Fund)
CGT	Central Geral dos Trabalhadores (General Confederation of Workers)
CIDADE	Centro de Assessoria e Estudos Urbanos (Advisory and Urban Studies Centre)
CIMS	Comissão Interinstitucional Municipal de Saúde (Inter-institutional Municipal Health Commission)
CLIS	Comissão Local Interinstitucional de Saúde (Inter-institutional Local Health Commission)
CONAM	Confederação Nacional de Associações de Moradores (National Confederation of Residential Associations)
CONASEMS	Conselho Nacional de Secretários Municipais de Saúde (National Council of Municipal Health Secretaries)

CONASP	Plano de Reorganização da Assistência à Saúde no Âmbito da Previdência Social (Plan for Reorganising Social Security Health Care Assistance)
CUT	Central Única dos Trabalhadores (United Confederation of Workers)
FAS	Fundo de Apoio ao Desenvolvimento Social (Social Development Support Fund)
FASE	Federação de Órgãos para a Assistência Social e Educacional (Federation of Social Assistance and Educational Organisations)
FETAG	Federação dos Trabalhadores da Agricultura (Federation of Rural Workers)
FIBGE	Fundação Instituto Brasileiro de Geografia e Estatística (Brazilian Foundation of Population and Geography)
FNM	Federação Nacional dos Médicos (National Medical Federation)
FRACAB	Federação Riograndense de Associações Comunitárias e Amigos de Bairro (Rio Grande do Sul Federation of Community and Neighbourhood Associations)
HSA	American Health System Agencies
IAP	Instituto de Aposentadorias e Pensões (Retirement and Survivor's Pension Institute)
IBAM	Instituto Brasileiro de Administração Municipal (Brazilian Institute of Municipal Administration)
IBGE	Instituto Brasileiro de Geografia e Estatística (Brazilian Institute Population and Geography)
INAMPS	Instituto Nacional de Assistência Médica da Previdência Social (Medical Care Institute of the Ministry of Social Security)

INPS	Instituto Nacional de Previdência Social (Social Security National Institute)
NHS	National Health Service
PAHO	Pan American Health Organisation
PC do B	Partido Comunista do Brasil (Communist Party of Brazil)
PCB	Partido Comunista Brasileiro (Brazilian Communist Party)
PDS	Partido Democrático Social (Democratic Social Party)
PDT	Partido Democrático Trabalhista (Democratic Labour Party)
PMDB	Partido do Movimento Democrático Brasileiro (Party of the Brazilian Democratic Movement)
PREVSAUDE	Programa Nacional de Serviços Básicos de Saúde (National Programme of Primary Health Services)
PT	Partido dos Trabalhadores (Workers Party)
PTB	Partido Trabalhista Brasileiro (Brazilian Labour Party)
SINPAS	Sistema Nacional de Previdência e Assistência Social (National Social Security System)
SUDS	Sistemas Unificados e Decentralisados de Saúde (Unified Decentralised Health Systems)
SUS	Sistema Único de Saúde (United Health System)

UAMPA	União das Associações de Moradores de Porto Alegre (Porto Alegre Union of Residential Associations)
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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Chapter 1

Introduction

The reform of the Brazilian health system, during the eighties, can be understood within the context of reforms underway at that time, in both developed and developing countries. Since the thirties, in the view of policy makers and academics, the State would be the main promoter of economic growth and welfare (Grindle and Thomas 1991, 2). More precisely, central governments would be the principal promoters of progress. Particularly in developing countries, the size of the gap between the goals of development and the reality had justified central planning and implementation as the best way to deal with social and economic problems. During the eighties, however, international donors and development agencies recommended reforms based on neo-classical economic theories, challenging the idea of the State inducing economic growth and social welfare. The new approach advocated

> *"a shift of power away from central government to the market and to more local levels of government"* (Grindle and Thomas 1991, 2).

Privatisation and devolution became key notions for many reform initiatives during this decade. This new approach on how to achieve development, combined with the idea of primary health care, had a strong influence on the reform of the Brazilian health system during the eighties.

The primary health care strategy redefined earlier views that were dominant in the health field. Criticism was directed in particular at the concentration of investment in a few complex health units, mostly hospitals, usually located in a few large cities (Walt 1994, 5,24). The idea was to make health care accessible to all, through a comprehensive network of basic health services, whose management would be decentralised and would count on community participation. The broad notion of participation, as it was initially conceived of by supporters of primary health care, would have distinct meanings according to the peculiarities of each country's political and social organisation. Particularly in developing countries it has often resulted in the extension of health care coverage to rural regions and to poor urban areas (Walt 1994, 5; Paim 1989, 19; Cattani and others 1988, 71-81).

The grouping within the same classification of developing countries, whose societies and historical backgrounds are so different, is not the most straightforward way of explaining their current political organisation or their prospects for the future. Nevertheless, there are some common characteristics, well analysed by many studies, that permitted the use of this general concept (World Bank 1990; Grindle and Thomas 1991, 43-69). One of these characteristics is the lack or weakness of civil society organisation able to counterbalance the political power of economic and military elites in alliance with State officials. Particularly in Latin America, policy-making is traditionally conducted through informal channels, where business and military interests would be represented within the State bureaucracy (Cardoso 1975, 165-86). In Latin American countries, non-dominant interests - such as trade unions, rural workers, urban dealers - would be systematically excluded from autonomous representation of interest. Their demands would be filtered by the clientelistic relations established by politicians and officials with obliging leaders or individual clients.

This is a rather limited picture of political life in Brazil during the eighties. The prescriptions of international economic and health advisors for less central government, and some sort of community, participation in the health services hit a Brazilian society undergoing parallel processes of *economic crisis*, of *unprecedented civil society organisation* and of *political liberalisation.* Signalling the beginning of the so called "lost decade", the *economic crisis* combined high inflation with negative or very low economic growth. The loss in government revenue due to reduced economic activity, as well as the draining of financial resources due to the payment of high interests on a huge external debt, virtually neutralised central government as the main agent of economic growth.

At the same time, there was a process of Brazilian *civil society organisation* taking place. Since the end of the seventies, the "new trade union movement" actively demanded pay rises and freedom of organisation, and openly opposed the military dictatorship (Keck 1989, 252-96; Almeida 1984, 191-214). For the first time since the early sixties, rural worker trade unions and the landless movement organised public campaigns demanding land reform, and the extension of social security benefits to rural workers, among other claims (Hall 1990, 187-232; Grzybowski 1987). In the urban field residential associations promoted campaigns demanding better services or even, sometimes, the occupation of empty residences or public buildings (Baierle 1992; Martes 1990). At the same time, new organisations were created, such as environmental associations or feminist groups. The common ground of these organisations and movements was the rejection of the authoritarian political regime. They did not reverse centuries of authoritarian and elitist domination in the country (Schwartzman 1982), neither was

the majority of the population involved in them. They potentially constituted, however, the embryo of a civil society organisation without precedent in the country.

The climax of *political liberalisation* during the eighties was the end of the military regime and the promulgation of a new Constitution in 1988. The new Constitution instituted a liberal regime of competitive oligarchies, in which all Brazilians were formally regarded as citizens (Weffort 1988, 16). The Constitution created new mechanisms of popular participation such as the referendum, plebiscite and popular initiative, and stated that there should be popular participation in the health sector (Moisés 1990, 33; Brasil 1988, art. 194/VII). The actual implementation of such mechanisms remains, however, to be seen. As O'Donnel has affirmed (1988, 42), one of the most serious problems for the democratic transitions of South American countries was not only the incapacity of democrats to implement suitable strategies for the construction of democracy. There was also the difficulty of the new democratic regimes in opening up, widely and generously, their decision-making mechanisms to political and social sectors that, during the authoritarian period, had been kept outside the political process.

Grindle and Thomas (1991, 63) observed that in most developing countries large proportions of the population - peasants and urban shantytown residents, for instance - are not organised for sustained political activity. Societal interests are often likely to be represented through informal processes rather than through more public forms of lobbying. This was the case in Brazil, particularly during the sixties and seventies, when there was a combination of lack of political democracy with the exclusion of millions from the most basic services and goods made accessible to others through rapid industrialisation and modernisation. Can political democratisation stimulate the reversal of this perverse pattern of exclusion? Not necessarily but, as Moisés pointed out (1990, 33), the construction of channels for effective participation, which could articulate the political institutions and the social demands of those recurrently excluded before, is a central element for any strategy of democratic consolidation in Brazil.

Setting up these channels of effective participation would require, firstly, the existence of organisations that could consistently represent those systematically excluded (Marmor 1983, 92), such as urban shantytown residents. Secondly, it would help to have a "policy community" (Jordan and Richardson 1982, 83) interested in constructing these channels. In the case of the reform of the Brazilian health system, there were social movement activists eager to influence health policy formulation and implementation. There was also what Grindle and Thomas (1991, 20) defined, when referring to developing countries in general, as a policy community of reformers seeking to mobilise these interest groups, which social movement activists

represented, and trying to create alliances and coalitions to influence decision-making within the government.

Over the last decade, the reform of the Brazilian health system has made health services better integrated and decentralised. It is not yet clear whether the changes have improved the quality of health care, whether they have made it accessible to all Brazilians or whether they have helped to deepen the territorial and social inequalities that already existed (Collins 1989, 170). There is no doubt, however, that this reform has created, at the municipal level of government, a participatory forum that has contributed to democratising the decision-making process in the health sector. Between 1984 and 1993, participatory fora were created in nearly all cities in the country and most of them have worked regularly since their creation (IBAM and others 1993, 33). Although, during the eighties, there was an increase in the organisation of civil society in Brazil, there is still a huge variation in the quality of this organisation among different Brazilian cities and between urban and rural areas. The strength of the political institutions and civil society within a large city could make feasible the participation of interest groups, determining the type of involvement users would have in these fora. Although some studies have looked at the distribution of such fora in the country or in states (IBAM and others 1991, IBAM and others 1993, Carvalheiro and others 1992), very few have looked at the participatory process actually taking place there (L'Abbate 1990, Martes 1990).

As was mentioned before, the construction of channels for effective participation that could articulate political institutions and social demands from those traditionally kept outside the political process is essential for the consolidation of democracy in Brazil. It seemed to be relevant, thus, to analyse the participatory processes of these fora, especially in cities where there was a strong possibility of sustained and independent user participation. Moreover, the focus was placed on the participants representing users of public health services, who were mostly representatives of shantytown residents, usually placed outside the formal process of interest representation in Brazil.

The research, therefore, is concerned with the participatory process itself, aiming mainly at answering the following ***questions***: (1) *how users were involved in a municipal health forum of a Brazilian city, where they could be expected to participate*; (2) *what major factors could most affect their involvement.* To answer them the research analysed the involvement of users in the municipal health commission of Porto Alegre, the capital of the state of Rio Grande do Sul, the Southern most Brazilian state, between 1985 and 1991. The chronological limits

mark the year when the commission was created and the year before the research took place. The results of the analysis are presented in seven chapters.

Following chapter one (Introduction), the second and third chapters examine the concept of participation and its determinants. Chapter two analyses the concept of participation. Initially it stresses the idea of participation as a component of political change in liberal democracies and of development projects during recent decades. The analysis highlights the emergence and institutionalisation of participatory mechanisms in liberal democracies and the importance of the idea of participation in development projects. It goes on to discuss the different approaches to State theory and participation. This chapter also examines the social actors who are usually regarded as participants and what are the most used classifications of the modalities of participation. Taking into account these classifications and the nature of the case being studied, it defines the types of involvement of user representatives that were expected to be found by this research. Chapter three analyses the major influences that can reinforce or hinder user participation. Firstly it highlights the influence of the historical background of political organisations, considering their legal and institutional frameworks and their spatial organisation. The most influential actors were examined when discussing the concept of interest groups, of health authorities, of civil servants and of policy communities. Regarding users as an interest group, it discusses how different theories access the idea of interest groups. The chapter also discusses the other social actors inside and outside the State who could determine the quality of a given participatory process.

The following two chapters focus on the reform of the Brazilian health system, on the institutionalisation of the municipal health fora in Brazil, and on the main economic, social and health features of Porto Alegre. The first of these two chapters, the fourth of the dissertation, describes the evolution of the Brazilian health system, especially during the last decade. It allows us to understand how a system that was highly fragmented, centralised and offering socially unequal access to health care became better integrated and decentralised and, at least formally, universally accessible. Recent changes in the organisation of the health service also permitted the visualisation of the context within which municipal health fora became a widespread feature of the system. The fifth chapter examines, firstly, the distribution of participatory fora throughout the country, to verify whether the region and the size of Brazilian cities affects the participatory process. In this chapter, there is also a description of the demographic, social and health services of Porto Alegre.

The last three chapters analyse the case of the municipal health commission of Porto Alegre. In the first one, the sixth of the dissertation, the involvement of users in this commission is described. Firstly, the organisation and working rules of the municipal commission are described. Two indicators of user involvement are analysed: *the number and types of users attending plenary meetings*, which were the main decision-making division of the commission, and *the types of involvement of user representatives in the decision-making process of the commission.* Given the statutory nature of the commission, it was possible to discover the number and types of users attending plenary meetings, which offers a very precise but limited account of user involvement in the forum. Analysis of documents and interviews allows us to examine the way in which user representatives were involved in the commission. This second indicator is not as objective as the first, but it offers a substantive account of how user representatives were actually involved in the activities of the forum. The analysis of both indicators stressed the evolution in number and in types of users attending plenary meetings, the involvement of user representatives in the decision-making divisions of the commission, and the relationship between the user representatives and the municipal health authorities, who were the co-ordinators of the forum.

The seventh chapter examines the variation throughout the period in the major factors that could have influenced user involvement. On the one hand, the selection of these factors takes into account the literature on the subject, discussed in chapter three. On the other hand, it considers the reality of the Brazilian health system and Porto Alegre's political and social particularities, which are analysed in chapters four and five. As a result, the factors regarded as major influences on the involvement of users are: (1) *recent changes in the institutional framework of the Brazilian health system;* (2,3,4) *the position of federal, state and municipal health authorities on user participation*; (5) *the relationship between public health professionals, who worked at local health units, and urban social movement activists*; (6) *the organisation of urban social movements in the city*; (7) *the types of agenda of the commission.* Although examining each actor or factor separately, it highlights the interdependence and the importance of the policy community of the Brazilian health system reformers in mediating relationships among them.

Finally, the eighth chapter examines the possible existence of an association between the involvement of users and the institutional-political factors that could have influenced this involvement in the municipal health commission of Porto Alegre. Firstly, the chapter verifies whether the number of users attending plenary meetings indicates the intensity of the involvement of user representatives in the decision-making process of the commission.

Following this, variations in the behaviour of actors or factors that could influence user involvement are summarised to establish categories to be linked to the two main indicator-variables of user involvement. The chapter also discusses how the relationship between user representatives and Brazilian health system reformers has influenced the participatory process.

In Appendix I, the research methodology is described. Although many studies have proposed classifications for the types of user involvement in participatory processes (Arnstein 1969, 216-24; Ham 1980, 223-4; Lee and Mills 1985, 129; Paul 1987, 33-4), very few have proposed methods for appraising the nature of a participatory process. Bjaras, Haglund and Rifkin (1991, 199-206) did so. They were concerned, nonetheless, with "community" participation in non-institutionalised fora situations, very different from the municipal health commissions in Brazil. Probably because they could not count on documents, attendance lists or even on the regularity of meetings, they based their proposal for the assessment of participation on the opinions of participants, which could be regarded as a valid but limited type of evidence when not cross-checked against other data. Another example of a study of a participatory process was the research by Klein and Lewis (1976) on Community Health Councils in Britain. In this case they used various types of data, particularly the attendance lists at regular meetings of the council. These councils were similar to the Brazilian municipal ones, they met regularly at local levels of management and had a well defined institutional role. Nevertheless, the authors were mainly concerned with the social profile of "consumer" representatives in order to compare them with the profile of those they represented.

The present research focus on the participatory process taking place in the municipal commission of health of Porto Alegre. Using various sources of evidence to cross-check information about this process, the research tried to develop a new approach to the assessment of the participatory process in institutionalised fora. This approach takes into account: the physical presence of the users at the commission's plenary meetings and the type of involvement of the user representatives in the commission's decision-making process. Users are regarded as those attending plenary meetings through local urban or trade union organisations, representing non-health sector workers. User representatives were considered to be those who were legitimately elected or nominated by organisations, such as trade unions or residential associations, to represent them in the commission. There is always room for dispute when assessing the nature of a participatory process. Regarding these two indicators, it was possible to compare the relative intensity of user involvement in an institutionalised forum, in different periods, with a reasonable degree of precision.

Appendix II presents the transcription of the questionnaires from the interviews. Finally Appendix III displays the data upon which the Graphs, Tables and statistics presented throughout the dissertation are based.

Chapter 2

Participation and Other Related Concepts

2.1. Introduction

Since the seventies, popular, community, citizen, consumer and user direct participation has become a policy issue as governments and International Agencies have created participatory mechanisms in many State organisations, programmes, plans and projects. An overview of these experiences and of their academic appraisal can give support to building up a group of concepts suitable for analysing the particular case of user participation in the municipal health commission of Porto Alegre. This overview can contribute to distinguishing who, as a social actor, can participate through such mechanisms. Moreover, it can help to define a concept of participation. This concept can be qualified in order to establish the range of possible variations in intensity and in quality of a participatory process. The literature on participation and the case studied will provide the basis for constructing a classification that would make possible the analysis of the variable participation in this particular case.

The first section of this chapter shows the historical context in which the idea of participation arose, discussing, firstly, the institutionalisation of participatory mechanisms in some western liberal democracies and, secondly, the idea of participation in development projects. The second part defines the concepts usually associated with the idea of participation, as well as the distinct theories on the State role in this field. The third section discusses the social actors usually regarded as participants in participatory processes. The fourth discusses existing typologies of participation modalities and levels, building up a classification relevant to the analysis of the case of the municipal health commission of Porto Alegre.

2.2. Participation as a Component of Political Changes in Liberal Democracies and of Development Projects During Recent Decades

During the late seventies, the idea of participation emerged simultaneously as a new component of the political system in liberal democracies, and as an important aspect of development projects. Although there are some interfaces between these two processes, their paths were distinct.

2.2.1. The Emergence and Institutionalisation of Participatory Mechanisms in Western Liberal Democracies

During the late sixties and, in particular, throughout the seventies there was a tangible disillusionment with the political process in many western liberal democracies. Empirical studies carried out in the United States attested to declining voter participation in elections and political-party affiliation, and a growing mistrust of elected representatives. Moreover, they suggested decreasing confidence in the major American political institutions (Landsberger 1980, 229; Langton 1978, 1). Although the American political system was probably the most studied, the critique that resulted in a pessimistic view of the political system was extended to other liberal democracies (Landsberger 1980, 229).

The climate of dissatisfaction with traditional methods of representing interests was accompanied by the political scientists' critique of political institutions in those societies. Thinkers from diverse political and theoretical backgrounds converged, highlighting business corporation control over party competition, interest group processes and political coverage by the mass media. These corporatist arrangements and technocratic government have substituted representative politics in determining public policies. Business control of economic resources constrains the agenda for political debate (Dunleavy and O'Leary 1987, 323-5).

The political institutions of liberal democracies, such as State bureaucracies, elected representatives and centralised modalities of planning and decision-making, appeared not to be so democratic. The voters could only remotely and sporadically supervise the political process, and it rather legitimated the inequalities of a political system than increased public control over it. Senior officials and politicians were responsive mainly to more powerful social and economic groups. Alford's (1975) classical demonstration of how dominant structural interests created barriers to reform New York's health services, exemplify such a view. He associated those barriers with corporatist characteristics of American society and its political system, and was quite pessimistic about the ability of repressed interests to participate or influence the decision-making process in the health field (Alford 1975, 218-38).

A relationship can be identified between the debate about unequal opportunities for political involvement and lack of citizen control over State bureaucracies and elected representatives, and discussions about participation. Moreover, there should be a connection also between the former and the latter, and the growth of new social movements in the late sixties and throughout the seventies. As Langton (1978, 1) affirms:

> *"As confidence in and respect for government have declined, a 'passivity-participation' syndrome has emerged".*

It was a two way impulse. The demand for more citizens' participation came from government officials, as well as from citizens. This author affirms that, during the seventies in the United States, withdrawal and participation were the two predominant ways of expressing dissatisfaction with government and society (Langton, 1978, 1). The trend towards citizens' activism has increased not only in American society; European countries, such as Britain, Germany and France (Landsberger 1980; Olives 1976; Pickvance 1975), have also witnessed the growth of extra parliamentary citizens' initiatives during the sixties and seventies.

The end of the sixties and the seventies was also regarded as a period when strong social movements arose, especially in the larger urban centres of the most industrialised countries. These movements were rather distinctive in terms of their origins, the way people were enrolled and their objectives (Dunleavy 1988, 32-48; Hannigan 1985, 435-7). They range from the "May Revolution" in Paris (1968) to the growth of grassroots neighbourhood, consumer and environmentalist organisations in the United States and in other developed countries throughout the seventies (Hannigan 1985, 436; Langton 1978, 1-3).

Many studies have focused on these new social movements. Very influential in this stream of research were the frameworks built up by Touraine (1981) and Castells (1976). According to Hannigan (1985, 436), the genesis of Touraine's and Castells' perspectives was the 1968 "May Revolution" in Paris. They distinguished social movements on the basis of their anti-institutional orientation, and stressed their autonomy from organised institutions. For them, even alliances with political parties or trade unions, although regarded as important, should be circumstantial (Hannigan 1985, 444). Their mistrust of institutional menaces to the autonomy of social movement has been influenced by, and, at the same time, has influenced, the position of some social movement activists who perceived participation in State fora as a new way of co-optation by the establishment. Richardson (1979) has expressed very clearly this paradoxical attitude towards participation.

> *"In some circles, participation is urged as a vital mean of* ***increasing*** *the overall power of the participants, while in others it is seen as a devious method of* ***decreasing*** *their power"* (Richardson 1979, 228).

Participation could also be seen as a way of enhancing citizens' power over State institutions, or as a manner of legitimising and stabilising political regimes. Nonetheless, it is out of the question that the climate of disillusionment with liberal democracies' traditional participatory mechanisms, and the upsurge of new interest groups and their respective analysis, offered the justification and "created" the activists who would be involved in new participatory institutions.

Another element forcing the reshaping of political organisations was the economic crisis. During the second half of the seventies, it imposed limits upon government revenue. Welfare state agencies were placed under pressure to cut their financial expenditure. Behind the political and social unrest there were financial constraints which stimulated governments to promote reforms aimed at the rationalisation of State bureaucracy structures. These reforms, in many cases, implied the creation of participatory mechanisms.

Hirschman's work (1970) helps in the understanding of how governments with different political orientations developed diverse strategies of participation. According to him, there are two main ways for a consumer of a product, user of a service, or member of an organisation to manifest disapproval: (1) **exit**: giving up buying or using a given product or service or leaving the organisation; (2) **voice**: expressing opposition. The possibility of exercising the former or the latter alternative is directly related to a "market" situation that could ideally range from total monopoly to perfect competition. Although it is a very complex idea with many subtle implications, two important strategies which developed from the seventies onwards for changing liberal democracies' State organisations can be observed in these concepts.

Conservative policies had mainly stimulated exit as an important element for increasing the responsiveness of public or private services to consumer demands. New right thinkers maintained that there should be private provision for nearly all services and products supplied by governments (Dunleavy 1991, 36-8). Privatisation would ensure that monopolies would be replaced by market competition and by a variety of producers, providers and/or organisations. At the same time, conservative policies allowed and even promoted consumer participation, preferably treating consumers as individuals, given their scepticism about the legitimacy of interest groups' internal organisation and leadership.

Social Democratic policies tended to adopt a diverse perspective. Their emphasis was on reforming public organisation through non market based approaches. It focused on increasing consumers' or users' opportunities for expressing their opinions, increasing therefore their right to voice opposition in the sense defined by Hirschman. It aimed at preserving the notion of public provision and sought to reform the manner in which this provision was undertaken (Hogget and Hambleton 1987, 14).

These approaches were contrasting political alternatives for coping with such complex issues as: State financial difficulties, governmental bureaucracies' lack of responsiveness and accountability, public dissatisfaction with and mistrust of political institutions, and reshaping relationships between new social movements and the State. The strategies were different and the political projects were conflicting. The first aimed at the promotion of privatisation, the second at public sector reform. The former proposed the end of the dependence culture that would create "lazy" individuals, while the latter aimed at maintaining the egalitarian ideals of equity and social justice. The social sectors that backed these policies were also totally diverse. While business interest groups supported the first, trade unions endorsed the second (Hogget and Hambleton 1987, 14). Nevertheless, both sought the creation of participatory mechanisms, tightening controls over bureaucracies and rationalising the State apparatus.

There are several cases of the institutionalisation of participatory mechanisms throughout many western countries during the seventies. It was the case in the United States (Alford 1975; Bates 1983; Gormley 1986; Landsberger 1980; Langton 1978; Marmor 1983), in Great Britain (Bates 1983; Klein and Lewis 1976; Klein 1989; Landsberger 1980; Lee and Mills 1985; Levit 1980; McEwen, Martini and Wilkins 1983; Wainwright 1992), in Canada (Godbout 1981; O'Neill 1992), in Germany (Landsberger 1980) and in Japan (Broadbent 1988). In these countries several examples can be found that vary in terms of area or type of participation allowed or stimulated by State managers or bureaucrats. Participatory schemes were implemented in areas such as air traffic, food and drug licensing, coastal management, environmental, educational, housing, energy, social work and health regulation, administration and/or policy formulation. The nature of this participation could vary from mere advocacy of consumer or user interests and forms of user or consumer consultation to active citizen, user or consumer involvement in committees, commissions or councils.

Specifically in the health sector, the more consistent experiences can be found in the United States, Britain and Canada. In the United States, during the late sixties and the seventies, there was citizens' participation in the Boards of Neighbourhood Health Centres and

Community Mental Health Centres, and long-term ombudsman health care programmes were established in most states (Langton 1978; Landsberger 1980; Gormley 1986). The most innovative change took place in 1974, when the National Health Planning and Resource Development Act established that there would be a consumer majority on the governing boards of the 210 new Health System Agencies (Landsberger 1980, 231). In Britain, in 1974, there were the Non-Executive Members of the Health Authorities and the Community Health Councils (CHC). The latter were created, during that year, in the lower administrative tiers of the National Health Service (hereafter NHS): Area Health Authority and District Management Team. They would represent the independent consumer's view on the services provided by the NHS (Wainwright 1992; Klein and Lewis 1976). In the Canadian health sector there was the case of Quebec where, from 1970 to 1972, laws were passed reforming the health sector. They established that citizens would participate in the boards of hospitals and nursing homes and in social work agencies. They also created the Local Community Health Centre (Centre Local de Services Communautaires - CLHC) that would be the entry point for all health and social work services throughout Quebec province (O'Neill 1992, 292). By law, citizens were represented on the boards of CLSCs. Until 1982 they had the majority of the voting seats.

The importance and recurrence of the institutionalisation of participatory mechanisms in the health field can be associated with the pressures discussed above for changing public institutions, and also to the stimulus of International Agencies to community or popular participation during the seventies.

2.2.2. Development Projects and Participation

In many developing countries during the fifties and the sixties there were development policies aimed at increasing income per capita and changing

> *"national economies from predominantly rural-agricultural to urban-industrial. It required a continual incorporation of productivity-raising technological innovations, and an increasing ability to exploit natural resources and transform the environment"* (Wolfe 1982, 80).

Certain industrialised countries were identified as the model to be followed, while planning was seen as the main device for guiding and stimulating the development process. It was argued that, in the initial stages of this process, income had to be concentrated in the hands of entrepreneurs or of the State. In this phase, the participation of the population, as consumers or political actors struggling to participate in income sharing, was regarded as dangerous for dominant social sectors. People were seen mainly as producers who should improve their skills and internalise the work-ethic of industrial societies (Wolfe 1982, 80-1).

In many developing countries the distribution of income remained highly unequal. Industrialisation and agricultural modernisation proved to be very disruptive. There were recurrent balance of payments crises and rising debt burdens. The enormous urban agglomerations that were forming suffered from many environmental problems. At the same time, the developed countries had lost their plausibility as models and planning strategies appeared incapable of promoting development or a more equal distribution of the national income.

In this context, two opposed conceptions of development have emerged (Wolfe 1982, 83). One regarded State intervention through planning and regulation of social and economic affairs as a constraint on the development process. The role of the State should be limited to safeguarding the rules of the game, making markets function efficiently. The other was made up of distinct proposals based on the socially oriented criticisms of economic development. It consisted of projects that ranged from utopian blueprints for egalitarian new societies to relatively cautious projects looking at political and economic constraints, giving priority to the satisfaction of basic social needs. Despite their different political and ideological inspirations, the two conceptions had similarities. They conferred a large degree of relevance on the legitimacy of differing national styles of development, and on the values of equity, human solidarity and creativity. They considered popular participation as an element of the development process (Wolfe, 1982, p. 82-3). The idea was to create opportunities for political involvement and for

> *"the adoption of measures that would enable ordinary people to share fully in the development process"* (Midgley 1986, 19).

During the seventies, some important international organisations promoted projects that took into account at some level the notion of community participation. Such was the case at the World Bank (IBRD), at the Inter American Development Bank (IDB), at the Food and Agricultural Organisation (FAO), at the Milbank Foundation, at the Rockfeller Foundation and at the Kellogg Foundation, among others (Ugalde 1985, 41; Paul 1987, 11-4). Nonetheless, few of these organisations have regarded popular participation as a central strategy for achieving social development. Exceptions were the United Nations Research Institute for Social Development (UNRISD), the United Nations Children's Fund (hereafter **UNICEF**) and the World Health Organisation (hereafter **WHO**) (Stiefel and Pearse 1982, 146-55; Midgley 1986, 21-7; Wolfe 1982, 85).

Midgley observed (1986, 22) that the most significant contribution to consolidating policies concerned with popular or community participation came from the UNICEF/WHO

Declaration on Primary Health Care at the Alma Ata Conference in 1977. It recommended the implementation of primary health care policies, which would stimulate community self-reliance (Hollnsteiner 1982, 37-8). Midgley affirms that

> *"above all, it called for mobilisation of local communities to take responsibility for their own health"* (Midgley 1986, 22).

Although primary health care principles have also been very influential for the health policies of developed countries, in developing countries these principles became the major guideline for the formulation and implementation of health policies. It was seen by International Agencies and developing country policy makers as a powerful device for surmounting poverty. Some authors believed, however, that it could become a strategy for offering "poor" health services for the poorest groups in developing countries, while those not so poor would be able to buy better services in the market (Mendes 1987, 272-5; Navarro 1983, 150). Instead of helping to overcome poverty it would reinforce the social inequalities in developing countries.

The WHO and the Pan American Health Organisation (hereafter **PAHO**) promoted policies and advised Latin American governments to implement primary health care policies that could foster community participation. There were, nonetheless, different appraisals of Latin American experiences of community participation in the health field inspired by primary health care principles. According to Ugalde, the experience in Latin America, with the exception perhaps of Cuba and Nicaragua, showed that community participation failed to improve the quality of life of the majority of the population. He affirmed that:

> *"[o]n the contrary, the evidence suggests that community participation has produced additional exploitation of the poor by extracting free labour, it has contributed to the cultural deprivation of the poor, and has contributed to political violence by the outing and suppression of leaders and the destruction of grassroots organisations"* (Ugalde 1985, 43).

In a similar way, Midgley (1986, 149) affirmed that, with few exceptions, the ideals of community participation had been lost due to administrative inefficiencies in government administration. In contrast, Stiefel and Pearse's (1982, 156) general assumption was that, in Latin America, despite widespread authoritarianism,

> *"the present stage of development offers favourable conditions for the promotion of social movements as a form of expression of popular demands and participation"* (Stiefel and Pearse 1982, 156).

During the eighties, structural adjustment policies regarded popular or community participation as a secondary issue. The main international organisations took it into account only as a cost-reducing exercise for improving self-reliance, creating solutions without State help or direct intervention. The main interest of these agencies was in the adjustment of

developing countries' economies through liberal policies that were intended to reduce the State's size. At the same time, for Latin American governments, the central issue became how to cope with their economic and financial problems.

Although community participation was one of the basic assumptions of the primary health care approach, another, and probably the most central, was the rational use of scarce resources. The emphasis would be on applying simple technology throughout a comprehensive health system that would reach every community, although targeting the poorest ones. In this sense primary health care policies did not contradict the International Agencies' new tone. It could be a way of rationalising State resource utilisation selectively reaching the poor and extending the "market" for allopathic medicine. At the same time, the rest of the population could get health services from the private market, where the State would not be responsible for its organisation or regulation.

Behind the structural adjustment policy recommendations of the International Agencies there was a general climate in political debates which criticised the State's role and the conventional way in which liberal democracies had dealt with representation of interests. The previous creation of participatory mechanisms in many developed countries, during the seventies, and the International Agencies' concern with the role of popular or community participation in development projects during the late sixties and seventies, were thematically related but distinctive processes. The first process helped to reshape statutory political institutions, redefining the relationship between State and civil society. Its main directives were liberalisation through privatisation and deregulatory strategies or the reform of the public sector assuring the maintenance of the State's products and services provision. Usually it represents the institutionalisation of consumer or citizen involvement through the creation of participatory mechanisms or the opening of already existing statutory fora for their participation. The second process promoted projects or particular policies that, at low cost and maximum resources utilisation, would take advantage of cultural peculiarities and rely strongly on the community's own potentiality for self-help. The role of the community in primary health care projects, for example, could vary from temporary consultation, or help in terms of financing or labour, to taking part in the planning or implementation processes.

In the health field, primary health care strategy since the seventies has affected policy formulation in developed and developing countries. In the former it mostly meant establishing new directives to over-technological and hospital-centred policies. Community or popular participation was a contingent aspect of these projects or policies, although an important one.

They did not usually propose the institutionalisation of participatory mechanisms. These mechanisms could, however, become a helpful outside control over reluctant bureaucracies resisting the acceptance of expenditure cuts and other rationalising measures. Although this rationalisation was justified by primary health care arguments and epidemiological evidence that most health problems could be solved through a comprehensive network of services providing very simple health care, the changes that took place in the United States, Britain and Canada, during the late sixties and the seventies, were certainly part of a more extensive process of reshaping political institutions.

In developing countries, primary health care represented an effort towards rationalisation of the health sector and towards increasing popular or community involvement in the politics of this sector. The institutionalisation of participatory mechanisms in the Brazilian health sector during the eighties was related to the emphasis placed by International Agencies, especially WHO and PAHO, on primary health care principles and their stimulus to popular or community participation. It was associated also with the impact that the discussion of changing political practices in western liberal democracies had on the Brazilian political system then in the process of liberalisation after many years of military dictatorship. It was also a result of the huge Brazilian institutional, political, social and economic crisis during the eighties. Nevertheless, the political and administrative dynamic of the Brazilian health sector itself was the most powerful driving force for its reform and for the creation of participatory mechanisms inside the health system. Primary health care policies stimulating community or popular participation, and the polemic about liberal democratic political systems, shaped the arguments for the political agents acting within the context of the political discussions and conflicts surrounding the process of reform.

2.3. Different Approaches to State Theory and Participation

Hitherto, the concept of participation has been used in association with different agents or possible participants. The way it can be used varies according to the historical period or to the political-ideological conditioning factors. Although some advocates of community participation are anti-statist (Midgley 1986, 16), almost every political or sociological approach to State theory is concerned with the issue. Sometimes the creation or existence of participatory mechanisms is not a major concern, but State theories always have some sort of explanation for the relationship between State and civil society. These explanations do not usually place participatory mechanisms as a central issue, but they always discuss them, normally relating the concepts of community, popular, citizen, consumer or user to the idea of participation.

The analysis of popular participation in the public sector decision-making process implies focusing on the role and functions of the State in modern societies. According to Dunleavy and O'Leary (1987), approaches to this theme can be grouped into five clusters. There are enormous variations among the authors' ideas placed under each label, but some key issues allowed the classification they have made. Their general conceptions of the western liberal States and the way they posit the issues of decentralisation, of local government and of citizen, consumer or user participation are very briefly presented below.

(1) Pluralism

Pluralists consider

> *"that the State mediates between sectional interests compromising between the demands of various associations and classes"* (Midgley 1986, 6).

They conceive power in society as being dispersed among distinct interest groups that compete with each other in an open political system. Dunleavy and O'Leary (1987, 57-8) affirm that pluralists are advocates of decentralisation. Elected local governments, where specifically local decision-making processes can take place, in their understanding prevent the emergence of 'democratic' despotism

> *"and multiple points of access and sites for pressure groups activity enhance citizen participation and control over politicians"* (Dunleavy and O'Leary 1987, 57).

(2) New Right

The new right attacked the idea of State interventionism and welfarism. They are said to foster people's dependency on the State and to hinder economic growth (Midgley 1986, 8). They regard the democratic process as characterised by gross imperfections. According to Dunleavy and O'Leary (1987, 95-108), some authors point out the defects of the interest group's internal process - mainly criticising the restricted membership influence over leaders - and recommend improvements in democratic organisations. In general they assume that the leaders of civil society organisations, such as trade unions for instance, do not represent the interests of the majority of their members. Lobbies representing interest groups press for continuous enlargement of State control over society. The public choice approach assumes that citizens are rational actors concerned with maximising the ratio of benefits received from government, particularly from local authorities, which are assumed to be run by

> *"managers interested primarily in maximising the tax base of their localities"* (Dunleavy 1984, 61).

They usually advocate reducing the role of the State and restoring the role of individuals as consumers. They defend State administrative decentralisation where citizens or consumers can choose localities where services or goods are provided and can better meet their needs. The main way they conceive of citizen participation is as consumers. Public services or goods should be provided mostly by private organisations able to compete for potential consumers.

(3) Elite Theory

These theories suggest that the State will always exist and that oligarchies will always dominate political life.

> *"The overthrow of any elite merely results in its replacement by another elite"* (Midgley 1986, 7).

Some elite theory sociologists have studied communities analysing

> *"political process as one aspect of the social life of the locality, and concluded that only a handful of people were influential in setting major decisions"* (Dunleavy and O'Leary 1987, 144).

According to Dunleavy and O'Leary (1987, 145), radical elite theorists argue that existing political arrangements do not make feasible direct control by citizens over decisions affecting their lives. Decentralisation or local government, however, does not change the fundamental power structure, and does not allow any sort of authentic citizen participation. In a decentralised State organisation, instead of central elites, there will be local or regional elites,

> *"tied to national elites by networks of patronage, clientelism, and control over public expenditure"* (Dunleavy and O'Leary 1987, 179).

(4) Marxism

Marxists usually analyse the State as an instrument for managing the common affairs of the bourgeoisie. At the same time, its main function is to maintain the capitalist system. Only at very specific historical moments can it assume an arbiter's role (Dunleavy and O'Leary 1987, 208-11). Neo-marxists recognise that state-economy and state-society relationships are much more complicated than classical Marxism suggests (Midgley 1986, 6).

According to Dunleavy (1984, 63), there are basically two main Marxist perspectives on central-local government relationships. The first stresses the potential utility of local government as a defence of working-class interests against central government attempts to reintroduce 'market disciplines' into areas of social life previously dominated by 'welfarism'. In contrast, the second assumes that the continued decentralisation of functions to local authorities

serves mainly to break up working-class power over the central government to the benefit of dominant class interests (Dunleavy 1984, 64).

Many Marxists regard popular participation at local level as a means of organising the working-class for revolutionary change of the whole system. Nevertheless, neo-marxists, particularly eurocommunists, have accepted the liberal democratic way of achieving political power. In this sense, the idea of participation can become a political principle to be pursued and not only a means to prepare revolutionary change. Conventional Marxism, however, considers local government as an extension of the dominant class political network for working-class submission. User participation in any State organisation is seen mostly as a manipulative strategy to legitimise the capitalist system and to exert patronage over the working-class.

(5) Neo-Pluralists

Dunleavy and O'Leary (1987, 271-3) affirm that neo-pluralism is a derivation of the pluralist stream of thought. Neo-pluralists

> *"suggest a much more sophisticated liberal analysis, centring on the operations of large corporations and the modern extended State, sensitive to the problems and deficiencies of current social arrangements, but coldly realistic about the limited scope of reform"* (Dunleavy and O'Leary 1987, 272).

The traditional arrangements, emphasising direct control by representative political institutions over bureaucracy, have become less efficacious. Instead western States

> *"have shifted towards progressively more professionalised policy systems* [.] *(...) Governmental fragmentation remains important in such systems, however, as a means of building in controls and forcing different professional groups to balance out different aspects of public interest concerns"* (Dunleavy 1984, 59).

Pluralists posit that one of the fundamental causes of problems in western democracies is too little citizen control over the State decision-making process. Instead of centralised, statist strategies supported in different forms by western Communists and Social Democratic parties, most neo-pluralists

> *"advocate a mixture of market socialism, industrial democracy inside firms, a limited use of public enterprises and other forms of social ownership, and of course an extensive program of government decentralisation"* (Dunleavy and O'Leary 1987, 70).

Otherwise, other neo-pluralists clearly write off any possibility of reinforcing existing channels for public participation via representative institutions. The main issue for these writers is not how to increase power for the common people, but how to promote equal benefits. In this sense, popular rule means the fulfilment of popular needs (Sartori 1987, 150).

Although these five approaches treat the question of participation in very distinct ways, they are all concerned, some more than others, with the question of local participation in public sector decision-making processes. Nevertheless, the definition of who may participate can vary according to different authors and also according to the focus of each study. The concepts most often utilised are popular, community, citizen, consumer or user participation.

2.4. Who Participates

Popular participation has mostly been used by social scientists in a Marxist tradition to designate the participation of those who do not belong to the dominant class of a society. The expression "popular" is usually applied to people who take no part or little part in enjoying the wealth generated by society. It can be regarded as more accurate in sociological terms than the notion of "community", as it takes into account social class differences. Nevertheless, the concept of popular participation is very broad and diffuse. To use this concept, it is necessary to qualify the territory it encompasses and to establish who can be thought of as being able to participate under this label.

Many authors have criticised the concept of **community participation** (Glassberg 1981, 6-12; Hollnsteiner 1982, 39-40; Midgley 1986, 23-5; Tumwine 1989, 157-8; among others). "Community" is usually employed to refer to some local population as a whole. In this sense, the concept is precise in terms of spatial boundaries. Nevertheless, it does not express social cleavages. Thus, its utilisation becomes difficult, unless one employs qualifications that specify who is regarded as being able to participate, who is considered as belonging to the community or what the social differences within the community are.

The concept of **citizen participation** has its origins in classical pluralist theory (Dunleavy and O'Leary 1987, 293). Marshall (1963) developed the concept of citizens' rights, extending its range from political and civil rights to the notion of social rights. Mishra (1977, 34-8) criticises Marshall, arguing that the notion of political and civil rights differs from the notion of social rights. Even considering that critique, it is undeniable that Marshall's thought has been very influential in the diffusion of the idea that citizens' participation in the political process is as much a right as citizens' participation in the wealth produced in societies. Nevertheless, the concept of "citizen" designates every country's inhabitant. In this sense, one can call "citizens" individuals of any social origin. It also becomes difficult to utilise the concept to designate who participates in a particular process, which can take place in a specific territorial area and/or field of social policy.

The concept of **consumer participation** is currently related mainly to new right theory. Nevertheless, the notion is used largely by authors identified with other approaches. The notion of "consumer" comes from the economy. It refers to individuals buying, in the market, goods or services that are offered by different sellers or providers. The concept is closely associated with the notion of competition among sellers and providers for attracting consumers, and to individual choice in the consumption of some service or good. Hambleton (1988, 129) points out the difficulties of using these notions for some social services. Particularly in the health field in developing countries, it is rather unrealistic to suggest that the worse off have a free choice to opt for one type of service or another, or for choosing one region or another in which to live according to the public services they can find (Abel-Smith 1976, 155-7). They are actually 'compulsory' consumers of the cheapest and more accessible services.

Finally, the concept of **user participation** usually refers to a particular group of people that uses some specific service. It is the concept that this research mainly uses, associated with the idea of participation. It has some similarities to the concept of consumer participation, but the seller/buyer relationship is not its main characteristic. It combines notions of citizenship and citizens' rights that originated in the concept of citizen participation, but refers specifically to users of particular services provided in a single territorial area. In this sense, it retains the political dimension of the citizens' universal democratic right to participate, but refers to the participation of a given population segment that uses particular services.

2.4.1. User Representatives and the Concept of Representation

This research analyses the involvement of the users of health services in a statutory forum, highlighting the participation of their representatives. Whether it is possible to treat these representatives as legitimate, and what is the nature of their representation in this forum, is questionable.

According to Pitkin's classical study (1969) there are four main approaches or views on representation. The first presents a rather **formalistic** view, regarding the representative as a person

> *"who acts in the name of another, who has been given authority to act by that another, so whatever the representative does is considered the act of the represented"* (Pitkin 1969, 8).

Such a view portrays the representative as a free person who acts as s/he chooses. It does not matter whether s/he is a monarch, aristocrat or elected representative, s/he is the sovereign. In

that sense it does not matter whether people's wishes are considered or their interests protected (Pitkin 1969, 8).

The second view sees representation as **descriptive**. The representative stands in for someone who is absent, substituting the latter. They, representative and represented, should be sufficiently alike, resembling each other. The body of representatives must be an accurate map of the whole population,

> *"a portrait of the people, a faithful echo of their voice, a mirror which reflects accurately the various parts of the public "* (Pitkin 1969, 10).

In this case, the emphasis is on achieving the correct composition of representatives, as though they were a sample of the population represented. What the representatives should do, once they are chosen, is not discussed because they resemble the population and should act like it.

The **symbolic** view conceives of the representative as a symbol who, although standing in for someone, does not resemble that person. In this case, it does not matter how the representative is chosen or what he substantively does. The connection between representative and represented is not based on anything objective. It is mediated by irrational relations that make people believe in a symbol, a certain man. This usually means working on the minds of the represented. Irrational appeals that enhance belief in a charismatic leader became the focus instead of the representation itself. In this sense, representation becomes a power relation of the leader over those he supposedly represents (Pitkin 1969, 12-3).

The fourth approach perceives representation as a **substantive** political action. It relies on the idea of acting for another, not in the

> *"merely formal sense that one has been authorised or will be held to account, but the real substance behind that formality: the activity of representing"* (Pitkin 1969, 14).

Such a view allows us to distinguish between a person's formal, legal position and those s/he actually represents, in terms of actions. Thus, for instance, it is possible to say that some legislator or representative represents the interests of users of health services. More important than formal authorisation or accounting, or whether s/he symbolises or resembles the represented, is the substance of her/his activity which is identified with those interests (Pitkin 1969, 14).

In the health field these paradigms have influenced the way in which user representation was conceived when participatory fora were created. The discussion around the validity of the descriptive model of user representation that had been applied in the United

States to the Health System Agencies (hereafter **HSA**), can illustrate this model's pitfalls and points to alternative forms of dealing with the problem of user representation in the health sector. The user dominated HSAs were established in 1974. They were statutory and obliged to descriptively represent all the social and demographic groups in the community. There were some problems with this way of selecting representatives. Firstly, mirroring an entire population is impossible, as the potential range of interest groups is infinite (Wainwright 1992, 13). Secondly, rather than mirroring a given population's interests and opinions, it just reflects its demographic characteristics (Marmor 1983, 81). The third difficulty is that not all characteristics ought to be represented; racist or sexist discriminatory feelings, although present, should not be accepted (Marmor 1983, 82). The fourth problem is that it makes recourse to constituencies unnecessary, as it emphasises broad representation paying little attention to accountability (Marmor 1983, 82).

Moreover, representation would be more successful if the focus was displaced from demographic resemblance, which supposedly assures similar political views, to the pursuit of user interests. In this sense the

> *"effectiveness of representatives is crucial for substantive representation. An eloquent speaker or a skilful political operator can be said to provide better substantive representation than another with an equal understanding of constituent interests but without the same skills"* (Marmor 1983, 82).

Even if representatives have better social conditions than the average constituent, their representative capacity, or even leadership, will be legitimated through the idea of constituencies. Substantive representation introduces the idea of constituencies that should choose their representatives, who have to be accountable and easily substituted if not pursuing properly what users perceive as their interest.

Examining who can take part in participatory fora helps to define the participants involved in these fora. It does not clarify, however, the quality and intensity of their involvement. The next section discusses how this issue was tackled in the literature on participation.

2.5. Modalities and Levels of Participation

Many authors have elaborated different classifications for categorising (a) *types of "involvement"* in the decision-making process, (b) *distinct agency attitudes or proposals for* involving users in this process and (c) *diverse degrees* of user participation.

Lee and Mills' (1985) typology establishes four *types of "involvement"* of various bodies in the planning process. It is concerned especially with how different interests and organisations are articulated in the decision-making process. The authors define the following types:

(1) **Collaboration** when

> *"the organisation or groups in question have equal rights to be involved in the formulation of each other's goals and in their achievement where these are matters of mutual responsibility, concern and interests"* (Lee and Mills 1985, 129).

(2) **Participation** when

> *"representatives of interest groups actively take part in the decision-making process, and have equal power to affect the outcome"* (Lee and Mills 1985, 129).

(3) **Consultation** when advice, information or opinions are sought by a consulting body which has no commitment to follow views received and is alone responsible for the final decision.

(4) **Negotiation** when

> *"one body cannot get what it wants without seeking an accommodation with another party"* (Lee and Mills 1985, 129).

This classification establishes a conceptual distinction in the notion of participation itself. It considers as generic the term "involvement" rather than "participation". More than one of these types of involvement can be found in the same decision-making process according to its different moments or phases.

Two alternative classifications were formulated by Ham (1980, 223-4) and Paul (1987). Ham's typology is related mainly to different sorts of *public officers' attitudes* towards users. There is (1) **negotiation**, when public officers seek a group's view on a decision and it is contingent upon group approval. There is (2) **consultation**, when a group view is actively sought by decision makers but may or may not be taken into account. (3) **Public relations** exist when a group's views are sought but do not exert any influence over the decision-making process. Finally, there is (4) **articulation**, when a group's views are presented without having been sought by decision makers (Ham 1980, 223). Although this typology can be used for classifying government or public officers' intentions in promoting user participation, it is less useful than the first one for examining the actual relationships that can be established between users and different interest groups.

Another aspect discussed in the literature is *government or agency objectives* in supporting community participation. Paul (1987, 3-4) developed a classification for analysing

development projects. Nevertheless, it can be also applied to policy implementation analysis. Although the author's major concern was with the objectives of given projects, it can be used in the appraisal of participatory processes, promoted either by development institutions or by statutory agencies. According to the author, a project or policy can aim to achieve one or more of the following objectives.

(1) **Empowerment**

> *"should lead to an equitable sharing of power and to a higher level of people's, in particular the weaker groups', political awareness and strengths"* (Paul 1987, 3).

The empowerment of people through project or development activity is a means of making them able to initiate actions on their own and thus influence the process and outcomes of development. In this sense, political participation does not have value per se. It should also favour the sharing of the benefits of development by weaker groups.

(2) **Building Beneficiary Capacity** means promoting the beneficiaries' capacity for sharing in the management tasks of the project. They may take operational responsibility for a segment of the project or policy.

(3) Enhancing the **Effectiveness** of a project or policy may promote the beneficiaries' involvement in improving its design and implementation, and for improved matching of services with beneficiaries' needs.

(4) One objective also could be **Cost-sharing**, in terms of money, labour or maintenance of the project with the people it serves.

(5) User participation may improve **Efficiency,** promoting agreement, co-operation and interaction among beneficiaries, as well as between them and the implementing agency.

The classification elaborated by Arnstein (1969) established *different degrees* of citizens' participation through defining governments' or public officers' formal or hidden ways of and intentions in promoting it. However, this typology can be easily applied to the analysis of community, popular or user participation in the decision-making process. Working with the analogy of a ladder, she considers that at its bottom rungs lie (1) **Manipulation** and (2) **Therapy**, that is "non-participation".

> *"Their real objective is not to enable people to participate in planning or conducting programs, but to enable power holders to `educate' or `cure' the participants"* (Arnstein 1969, 217).

Rungs (3) **Informing** and (4) **Consultation** progress to levels of "tokenism" that allow the participants to have "hearing" and "voice". Rung (5) **Placation** is a higher level of "tokenism"

because, although the power holders allow the participants to advise, the right to decide remains in the hands of the former. The final three levels of participation signify real user involvement in the decision-making process. (6) **Partnership** enables them to negotiate and engage in trade-offs with power holders.

> *"At the topmost rungs,* (7) **Delegate Power** *and* (8) **Citizen Control**, *have-not citizens obtain the majority of decision-making seats, or full managerial power"* (Arnstein 1969, 217).

The Arnstein typology is concerned mainly with levels of user empowerment in the decision-making process. Her analysis highlights the actual level of sharing in decisions and the degree of power holders' utilisation of participatory strategies for keeping political power even if apparently they are sharing it.

The mere existence of participatory mechanisms does not ensure actual sharing of power. There can be citizen control over a given political forum but the issues decided there can be secondary or irrelevant. Behind the formal process of making decisions there is a previous selection of what should or should not be placed on the agenda to be decided by the actors who participate in this formal process. The real decision-making process is much broader than the formal or legal one. Decision-making can be analysed as a process where political actors have to decide some clear issues. It is established through political relationships in which social actors exchange empirically observable power relations.

Bachrach and Baratz (1962 and 1963) affirm that many studies looked only at formal decision-making situations. They alert investigators to the fact that there is an equal or even more important area to be researched which might be called "non decision-making". The decision-making process that is opened to citizens' participation is made up of only safe issues. The process of establishing the political agenda remains a very closed one (Bachrach and Baratz 1963, 632).

Lee and Mills (1985, 128), quoting Lukes, argue that the process of establishing open or hidden agendas is a very complex one. The exclusion may result from unconscious and non-individual choice. The socially structured behaviour pattern of groups and practices of institutions have a strong influence over the way power is exercised. Thus, decision-making processes are made up of a complex cluster of observable and non-observable conflicts and accommodations. In this context, power is exercised through coercion or consensus. The latter means a power relation where the powerful party might manipulate the other socio-political forces and/or exert authority or influence. It may also mean a situation where decisions are made with different socio-political forces participating often through negotiation.

Considering the objectives of this research, its focus on user participation, the empirical reality of a municipal forum in the Brazilian health sector and the literature discussion on the subject, it will mainly use the following typology for defining ***types of user representatives' involvement***:

(1) **Non-participation** - This means that, although users have the right to participate in the decision-making process, representatives of user organisations do not take part in it. The issues to be placed on the commission's agenda are selected and decided mainly by health authorities.

(2) **Manipulation** - This means that, although users have the right to take part in the decision-making process, they do not participate autonomously. Users can be involved in the commission's activities, but they only exert their legal discretionary power to reinforce health authorities' positions. In this situation, health authorities select most of the issues to be placed on the agenda and decisions are made almost only by these authorities.

(3) **Delegation** - As in the previous type, users have the right to participate in the decision-making process, but do not usually do so. Health authorities can allow and stimulate user participation, but users exercise very little of their discretionary power. Nevertheless, they are not relinquishing their political power but are just giving a sort of "confidence vote" to those authorities. In this situation, health authorities select most of the issues to be placed on the agenda with user representatives' agreement and the decisions are made mostly by these authorities with user representatives' acceptance.

(4) **Negotiation** - This means that "one body cannot get what it wants without seeking an accommodation with another party" (Lee and Mills 1985, 129). This situation can occur when health authorities try to hinder user participation but the users insist upon it. It creates a conflict situation that could be solved through "negotiation". The main issues are placed on the agenda by health authorities but some can be excluded and new ones can be added due to user representatives' political pressure. The decisions are the result of negotiations between health authorities and user representatives.

(5) **Participation** - There is participation when user representatives "actively take part in the decision-making process, and have equal power to affect the outcome" (Lee and Mills 1985, 121). In this situation, the agenda will be made up of issues selected by the health authority but also by user representatives. The decisions are made both by health authorities and user representatives.

2.6. Summing Up

During the last three decades the idea of participation has emerged in both developed and developing countries. This process took place in the context of a critique of traditional forms of political representation and discussions about their transformation. One innovative modality of political relationship between State and civil society arose in this context. It was the institutionalisation of participatory mechanisms, allowing or stimulating involvement of new social actors, such as the residential urban movement. Particularly in the health sectors of developing countries, since the late seventies and eighties, there has been a strong influence by International Agencies' primary health care policies which have stimulated popular or community participation in different phases of project planning and implementation. These two elements, liberal democracies' reshaping of their modalities of political representation and International Agencies' promotion of community or popular involvement in health actions, reached Brazil during a period of economic crisis and of political democratisation, thus influencing the nature of the health system reform in the country. One element of this reform was allowing and establishing that there should be popular participation in the health sector.

The literature about participation, in the health sector or in other areas, utilises normally the concepts of popular, community, consumer, citizen and user participation. The focus of this research is on user participation, users being defined as a particular group of people who use some specific services. Users normally participate on a regular basis through their representatives. Although the literature presents different approaches to this subject, substantive representation can be seen as a more effective way of representing users' interests.

The participation of users and their representatives can be more or less intense and its quality can vary. Studying different realities and highlighting distinct aspects, many authors have analysed participatory processes and built up typologies for classifying the degree and quality of its variation. They have focused on *types of "involvement"* in the decision-making process, *distinct agency attitudes or proposals for* involving users in this process and *diverse degrees* of user participation. Taking these models into account, considering that decision-making processes open to citizens' participation can be made up of only politically non-decisive issues, and regarding the empirical reality to be analysed, this research will mainly discuss the notions of non-participation, manipulation, negotiation, delegation and participation for defining different levels and types of involvement.

The quality and intensity of a participatory process are the result of a cluster of institutional rules, structures and practices which establish its possibilities and limits. Social

actors inside, around or behind this process also determine its shape and dynamic. This chapter has aimed to display the recent historical context in which the idea of direct participation has arisen, defining who can participate and how the level and quality of this social actor participation can vary. The next chapter will analyse the factors that can influence and explain why, even when the law allows and establishes that there should be user participation, it can or cannot occur and, when it occurs, its level can vary.

Chapter 3

Reinforcing or Hindering User Participation

3.1. Introduction

The last chapter analysed the various conceptual dimensions of participation, and this chapter will assess the major influences affecting participation. The political behaviour of interest groups and State bureaucracy can be seen as the main determinants of social policy formulation or implementation (Teixeira 1989, 45). It seems to be relevant to study both sets of behaviour, especially in the Brazilian context of transition from authoritarian rule to political democracy. Interest groups and State bureaucracy are, however, very complex concepts frequently used to designate distinct social actors. In the first place, the notion of interest groups is very broad, since these can come from totally distinct social classes representing opposite interests. In the second place, the concept of State bureaucracy is used to designate different sets of actors such as partisan administrators, senior officials and civil servants. The latter can also be referred to as professionals, as professional communities or as policy communities inside the State apparatus. Moreover, it is not only social actors who determine policy implementation or change, the institutional framework also can play a strong role in this process. This framework delimits the feasibility of implementing policies or transforming organisations. Nevertheless, only social actors can carry out such policies, can exert pressure for, or can resist, organisational changes.

This chapter presents a discussion of the main aspects associated with the increase or the decrease of user representatives' participation and with its qualitative change in a statutory forum. The initial section, which discusses the influence of institutional aspects on determining policy formulation and implementation, firstly assesses the role played by legal and organisational frameworks and, secondly, focuses on a key element in studying participatory mechanisms at local government level, the possible existence of a trend towards

decentralisation. The second section highlights the role of some social actors in influencing the level and quality of user participation in a municipal statutory forum in the health sector. Initially, it presents an overview of the different approaches of interest groups, stressing the role of user representatives in implementing policies, particularly when these policies implicate the possibility of their own empowerment. Secondly, it examines civil servants' possible influence in promoting user representatives' participation in statutory municipal health fora. Thirdly, it discusses the municipal health authorities' role in reinforcing or hindering user representatives' participation in these fora. The fourth part assesses policy communities in the health sector as decisive actors for policy change and implementation.

3.2. Historical Background and Institutional Framework

A State organisation's historical background and its legal and institutional framework are important elements both for understanding how, and explaining why, it has a given organisational structure and way of working. The transformation of its administrative or political structures and especially of its decision-making process - opening participatory channels for instance - will be bounded and shaped by a particular historical process. The analysis of its endogenous mechanisms, as well as its role as an active part of a more general social process, can help to elucidate why particular policy changes can or cannot take place. There are key institutional elements that can determine the successes or failures of statutory participatory mechanisms, and, moreover, delimit the shape these can take. They are, basically, the legal and institutional framework made up of laws, bills, policies, programmes, projects; the actual institutional practices; and the institution's spatial organisation, focusing on strategies leading to its centralisation or decentralisation. These crucial factors and the way social actors act, within institutional limits or forcing their modification, can strengthen or undermine proposed policy changes.

3.2.1. Legal and Institutional Framework

In democratic societies legal structure sets the major limits and establishes the main directives for political and social actions. Although the legal apparatus is not easily changed, especially in very stable democracies, social and political actors can modify or redefine it. Even if legislation is clearly worded, it can be modified during implementation. As Marmor (1983, 39) affirms, legislation is not the end of the policy-making process. General or sector policies can redefine priorities and targets, changing the quality and quantity of the provision of services and goods within a stable legal framework. Officials, administrators and professionals, when implementing laws and policies, are not just "executing" but making policy. Interest

groups, such as organisations representing users, can also affect policy formation and implementation when they refuse to use some services, express dissatisfaction with some services, demand new ones or actively propose modifications.

In societies with weak democratic political tradition, policy communities inside each policy sector would play a strong role, not only in proposing alternative solutions to problems, but also in placing issues on the political agenda. Authoritarian regimes in developing countries, such as the Brazilian regime between 1964 and 1985, actively discourage representation of societal interests through formally constituted interest groups (Grindle and Thomas 1991, 63). Grindle and Thomas argued that, as a consequence, societal interests were often represented through informal processes rather than through more public forms of lobbying. These informal processes took place inside policy networks that systematically excluded some social sectors, particularly peasants and urban shantytown residents. In this context, policy communities often would initiate reforms by placing issues on the agenda of government decision-making (Grindle and Thomas 1991, 32-3). The Brazilian political system, however, went through a deep process of democratisation during the eighties. Then, on the one hand, the role of policy communities was still central in policy formation and implementation. On the other hand, organised social groups, depending on their interests, effectively influenced decision-making processes either by supporting or by opposing proposed policies and their implementation. Moreover, the success or failure of policies would be often linked to the ability of policy makers to find societal allies and to identify opposition inside and outside the governmental political arena.

Planning strategies, that since the fifties have been seen as a means of reforming State organisations and policy implementation, paid little attention at first to political processes. Their failure in promoting the changes they planned was more intense in countries and sectors where there were private and public providers, and where consumers or users could choose among diverse provisions or products. Planning and policy implementation, in a sector of State apparatus, depends both on the particular political process there taking place and on the sectors' organisational characteristics. It is necessary to take into account how the sector organises its finances, who decides what matters, how decisions are made, what agencies execute what actions, whether actions are directly carried out by State or by private providers, and what is the spatial distribution of functions and political power. This last aspect is especially relevant in a country such as Brazil with large territorial dimensions, whose political organisation relies on municipal, state and federal tiers of government. Nevertheless, analysing the role of national and sub-national levels of government in diverse State sectors serves as an indicator both of

decentralisation or centralisation tendencies and of the distribution of political power along territorial and social lines.

3.2.2. Spatial Organisation: Trend towards Decentralisation

Decentralisation can be defined as the transfer of political authority to plan, to make decisions and to manage public functions from a central level to sub-national governmental or non-governmental levels (Mills 1990, 11; Rondinelli 1981, 137). Decentralisation involves, at the same time, the delegation of power in a territorial hierarchy (Smith 1986, 455-6). Most authors, when describing or analysing decentralisation processes, have used Rondinelli's classification (Cheema and Rondinelli, 1983; Rondinelli, 1983). According to this author, the first distinction can be made between **functional** and **aerial** decentralisation. The former means the transfer of authority to perform specific tasks or activities to specialised organisations. In this case, they operate nationally or at least across local jurisdictions. Aerial decentralisation aims at transferring responsibility for public functions to organisations within well-defined sub-national territorial boundaries (Rondinelli 1981, 137). In addition, he and Cheema (Rondinelli 1983; Cheema and Rondinelli 1983), affirm that a second distinction can be made among different degrees of decentralisation. These degrees are defined as follows:

(1) Deconcentration

This implies the distribution of responsibilities within the central government. Actually, it involves shifting attributions from the central level of government to regional or local tiers, within the same administrative structure. The staff of these tiers may or may not be given the authority to decide upon how these functions must be performed. Regional or local administration may be **integrated,** wherein the ministry field staff and the local officials work under the supervision of the local executive; or **unintegrated,** wherein the ministry officials

> *"and administrative staff of local jurisdiction work independently of each other and are supervised by different sets of executives"* (Rondinelli 1981, 137-8).

(2) Delegation

Delegation is the transfer of decision-making and management authority for specifically defined functions to organisations that are not directly controlled by the central government. It involves the creation or transfer of authority to plan and implement actions, relating to specific functions and duties, to semi-autonomous or parastatal organisations. These units have semi-independent authority to perform their responsibilities within well-defined spatial boundaries.

(3) **Devolution**

Devolution is the creation or strengthening of sub-national units of government. The central government relinquishes certain functions to regional or local levels or creates new units of government. Sub-national units are legally separated from central government, which exercises, at the most, supervisory control over such units.

(4) **Privatisation**

This means the transfer of some planning and implementing decisions, responsibilities, or public functions from government to voluntary, private or non-governmental institutions. The responsibility for licensing and regulating some actions or functions, and supervising government members, can be given to "parallel organisations" (Cheema and Rondinelli 1983, 24). The government may also shift the responsibility for producing goods or services that were hitherto offered by public or parastatal organisations to profit-making or non-profit-making enterprises.

This classification seems to be helpful for analysing important organisational aspects of different decentralisation processes, especially taking into account that, during the eighties, governments and International Agencies were promoting policies aiming to decentralise traditionally over-centralised bureaucratic organisations (Cheema and Rondinelli 1983, 9-10; Conyers 1983, 97-8; Oberst 1986, 163-4; Rondinelli 1981, 133). According to Rondinelli (1981, 133), development strategies at that time aimed at the promotion of equitable economic growth in order to reach the poorest groups. In this context, decentralisation was regarded as a means of stimulating the development process.

There were differences, however, between decentralisation processes that took place in distinct regional contexts. According to Mills (1990, 12), in some cases, mainly in Africa and Asia, there was an attempt to implement decentralisation policies in the new context of decolonization. Former initiatives during the fifties and sixties were implemented in a thoroughly different situation, as they aimed to reinforce colonial rule (Conyers 1983, 98-101; Mills 1990, 12). During the seventies and eighties, particularly in Africa, governments on the one hand felt secure enough to renounce part of their power to local organisations while on the other hand this became feasible because skilled administrators became available. In these cases, decentralisation was pushed by the central government rather than demanded by local or regional authorities and interest groups (Mills 1990, 12).

In West European and North American countries, the last two decades of debate on centralisation and decentralisation would have taken place in a distinct context. Many of these

countries had previous strong local governments, taking into account both their revenue and their functions. The identifiable trend was rather towards centralisation than the opposite. Nonetheless, decentralisation remained as a constant demand of local politicians from opposition parties and interest groups directly concerned with maintaining or increasing local autonomy (Mills 1990, 13). This trend did not seem to have been unique and uniform. A tendency toward less local government reliance on central grants can be identified in Denmark, the United Kingdom, the United States, Germany and France. It came together with increasing central government control of policy implementation, income-raising and spending in Denmark and in the United Kingdom (Pickvance and Preteceille 1991, 205-6). In France, there was a clear tendency towards decentralisation, with local governments increasing their autonomy over income-raising, spending and policy implementation. Nevertheless, unlike the first three countries mentioned above, the previous State organisation in France was very centralised (Pickvance and Preteceille 1991, 206).

Hence, among the decentralisation processes which took place in the seventies and eighties, there were inter-regional and inter-countries distinctions. Moreover, although the most apparent aim of these processes was to help development, behind the manifest objectives it is important

> *"to acknowledge that decentralisation policies are concerned with changing power relationships between levels of government"* (Mills 1990, 11-2).

Decentralisation often produced conflicting situations due to the transfer of political power they could provoke. As Collins observed (1989, 170), decentralisation may be viewed as both a product and determinant of political conflict. In the first place, decentralisation involves changes in administrative structures that induce conflicts, particularly among bureaucratic staff whose interests are affected (Oberst 1986, 164). Most of the time, these interests are connected with social class requirements to maintain privileges and political or economic power. In the second place, intra-governmental power shifts favour some bureaucratic and societal interest groups and undermine others (Collins 1989, 170). If it can formally bring decision-making arenas closer to citizens, it can also, in practice, reinforce the domination of local oligarchies over weakly organised social groups. This could be the case particularly in rural areas and in small cities in Brazil (Carvalheiro and others 1992, 118-9). In the third place, in the African, Asian and Latin American experiences of decentralisation, during the seventies, institutions for local control had been created, but significant powers were not often devolved to them (Smith 1985, 189).

In authoritarian regimes, there was a stronger probability that attempts at promoting devolution or deconcentration would not result in actual political and administrative decentralisation. Even if they did, it did not mean lesser oligarchic power at the local level. In democratic environments, however, organised societal interests can exert pressure to make formal decentralisation more effective. This can result in an uneven pattern of decentralisation, where more organised social groups and more powerful economic regions can enforce transfer of discretion to their political sphere or spatial area, while lesser powerful groups and regions obtain less benefit from the decentralisation process. This seems to have been the case in the process of decentralisation of the Brazilian health system during the eighties, analysed in the next chapter.

That chapter will also show that the Brazilian health sector process of decentralisation seems to be a particular aspect of an overall tendency towards the devolution of power from central to local government. Though erratically, political power, administrative functions and financial resources have been transferred from federal government to municipalities. Unlike in the African cases, although in some periods and sectors there was a central government deliberation to do so, state and municipal governments were the most influential actors and had exercised strong pressures since 1985 in order to enhance their political powers and revenue (Souza 1994, 588-609).

Hence, given the complexity of the matter, it is not an easy task to make extensive generalisations about the existence of a possible trend towards decentralisation. Nevertheless, as Hambleton (1988, 130) observed, decentralisation should not be regarded as a passing fad. New information technology has fostered the shaping of decentralised forms of organisation. This author suggests focusing on three variable aspects when analysing a particular case: (1) the degree to which power is being decentralised from the centre to the periphery of the organisation, (2) the amounts of different services that are being brought together at a local level, and (3) at what level it combines managerial with political change (Hambleton 1988, 130). As a result, one can find that there can be, for example, a huge devolution of power from central to local government, with integrated management of several services at this decentralised level, combined with empowerment of officials only or with the intense involvement of interest or user groups.

3.3. The Most Influential Actors

There are three sets of actors that can exert most influence upon a statutory participatory forum's workings: (1) interest groups, (2) officials or civil servants, and (3) policy

communities. The first set is made up of civil society organisations, which in the health field represent the interests of health professions or health workers, private providers of health care, trade unions excluding those representing health professionals, users of specific or territorially defined health services, and other non-governmental organisations whose activities have an impact on, or are affected by, the health sector. The second set of actors is made up of officials or civil servants responsible for policy formulation and, in the case of officials, for managing and executing health policies. The third set refers to very influential social actors, who are professionals working in the health sector in connection with interest groups. Policy communities act politically in a co-ordinated manner being guided by a common proposal for a given government sector.

The degree to and way in which users would participate in statutory municipal health fora will be determined by the behaviour of some key interest groups and by the type of support or opposition senior officials and health sector's policy communities will give to this participation. Firstly this section will present an overview of the different approaches of interest groups. Next it will analyse the role of civil servants, senior officials and policy communities in policy formation and implementation regarding the case being studied.

Interest Groups

Dunleavy (1991, 1-78) affirms that there are four major political science accounts of interest groups: pluralism, corporatism, the logic of collective action model and the new right view. As this author's appraisal of the subject is very complete and systematic, it was the main source for the classification presented below.

(1) Pluralists

Pluralists consider interest groups as one of the largest, longest-lasting and most active forms of political participation in liberal democracies. Interest groups have four distinctive features. They are multi-member organisations that bring together different types of actors, such as individuals, firms or other organisations. Membership is voluntary and joining or leaving cannot be enforced. They depend on member involvement. They have a narrow focus of concern, usually single issues or restricted areas of social life and public policy (Dunleavy 1991, 14-5).

Pluralists consider that most interest groups act internally in a basically democratic fashion. Internal democracy legitimates group representation and it

> *"is critical for achieving a successful public stance for a group, as well as demonstrating that group interests are in line with a broader public interest"* (Dunleavy 1991, 14-5).

They believe that imbalances in the influence of interest groups create systems of countervailing power. Any group that acquires privileged political power and economic benefits provokes rival groups to seek similar benefits or their reduction. The general pluralistic assumption is that any interest group has relatively equal political strength. According to pluralists, interest groups are related to government through a one-way flow and there is no significant tendency towards rising corporatist relations between government and dominant interest blocs (Dunleavy 1991, 24-9).

(2) **Corporatist**

Corporatists perceive strategic relationships between government and major interest organisations as different from the conventional pluralist process (Dunleavy 1991, 27-30). They regard much of the policy-making in liberal democracies as functioning in a pluralistic way. Nevertheless, trade unions, big business trade associations and professions play a privileged role in decision-making processes over key issues for economic and social development. Their special position in a political process can be explained by (1) their class basis, as they express the interest of larger social classes or class sections; (2) their control of resources, as they control resources that are vital for economic activity - labour, capital and investments, knowledge; (3) their ideological distinctiveness, as they generate and maintain widespread supported ideologies which condition how members interpret social issues; (4) their solidaristic group loyalties, as people's identities are partly constituted by their identification with these groups.

Leaders act to sustain organisational resources and to maintain a group's ideology. Group leaders do not respond to detailed control from their members, but both are tied by dependency power relations. Members have considerable resources, some groups depending heavily on mass participation, but they also rely on groups' leaders for information about national issues and feasible policy options. So, leaders try to limit or make members' exit options costly.

Decision-making for strategic political issues is set by

> *"conflicts and co-operation between functional interest groups themselves, and with government, relegating conventional representative politics to the side lines"* (Dunleavy 1991, 27-30).

Corporatists see arrangements between interest groups and government as a two way representation/control relationship. On the one hand, leaders control their members' behaviour on behalf of the government, on the other, the government makes concessions on issues that can benefit the former leadership.

(3) **Logic of collective action**

The logic of collective action model is mainly based on Olson's work (1978). It regards individuals and organisations as joining interest groups to achieve collective benefits which may be extended to everyone else in a particular social category (Dunleavy 1991, 30-6). The interest groups' main challenge is to persuade people to join, when they can get the benefits - non-excludable public goods - without incurring the participation costs. The larger the group the lesser will be the likelihood that an individual's contribution will be decisive or noticeable.

In such a context, group leaders are pictured as political entrepreneurs acting in a non-market environment of public goods production of which the central task is setting up strategies to reward those who join the group and to provide negative incentives against non-members. These selective incentives are vital in overcoming free-rider problems and they are also the main reason why interest groups are internally non-democratic, since leaders want centralised organisations capable of increasing their autonomy from members' control.

They contradict the pluralist view on the role of these groups in governmental decision-making using three arguments:

> *"First, patterns of interest group activity reveal very little about underlying preference intensities in society. (...) Second, groups acquire sharply unequal levels of influence over policy-making which once established persist for long periods. (...) Third, governments, legislators and public bureaucrats are all aware that the pattern of interest group activities gives little or no worthwhile or reliable information about the social distribution of preference intensities"* (Dunleavy 1991, 35-6).

Hence, as leaders represent non-democratic internal group political practices, governments tend to see them as illegitimate representatives of interest group members who are not able to represent public opinion. Governmental policy-makers can act freely, fostering or hindering distinct interest group pleas according to their political and ideological preferences.

(4) **New right**

According to Dunleavy (1991, 36-42), new right authors retain Olson's rational actor model. Nevertheless, they consider that most public goods sought by interest groups are divisible and excludable. These goods could be supplied through normal market mechanisms.

They stress, more strongly than Olson, the entrepreneurial character of leaders and their isolation and lack of control from the members of interest groups. Group leaders can affect the flow of benefits influencing the governmental agency

> *"by 'colonising' the agency providing the funding or regulation, winning over the agency's personnel by perks (such as lucrative post retirement jobs for senior agency officials) or political and legislative support for the agency"* (Dunleavy 1991, 37).

Closed and corporatist arrangements take place as groups' leaders are pushing at an open door since senior bureaucrats are seeking bigger budgets. Hence, leaders are not legitimate representatives of the members of interest groups and do not reflect public opinion. Bureaucrats are budget maximizers whose agencies are symbiotically linked to key interest groups. From this picture came their defence for private provision of nearly all products and services.

These four distinctive approaches evaluate differently the relationship between interest groups and governments. It can be seen as a one way flow from groups to governmental policy makers or as a two way flow with mutual influence. Governments can be perceived as having autonomy for deciding about which groups can get more benefits, or as bureaucrats seeking an agency's budget maximisation tied through corporatist arrangements to key interest groups.

However it is conceived, the relationship between interest groups and the State is doubtless one of the most decisive mechanisms of the governmental decision-making process. Participatory fora created during the last decades in most liberal democracies can be seen as a way of formalising this relationship. Nevertheless, it does not mean that the decision-making process has been transferred to these fora. The conventional pluralists' image of interest groups, with basically equal political opportunities for pressuring governmental bureaucracies, can only explain the apparent process that may take place. These fora can also have a hidden agenda, can hold covert political alliances and confrontations that occur inside and around them, and the main actors involved can be other than the leaders of interest groups and officials acting inside or around these fora. Moreover, even if a forum became central in the decision-making process of a government sector, the sector itself cannot be central in government political strategy, as the health sector is usually not (Walt 1994, 86-8). Underlying corporatist arrangements that would often guarantee openness to participatory mechanisms in governmental sectors regarded as non strategic, such as those dealing with social policies, can help to better explain how the decision-making processes take place. It can also help to understand how representatives of interest groups, such as users, can participate in such processes.

In the health sector, for instance, the absence of the medical profession and private providers of health services, or their lack of influence over participatory fora, does not mean that they exercise little power over this sector's decision-making process. It could mean, on the contrary, that they exercise their influence over policy formulation and implementation through concealed privileged channels. In this case, even if they do not directly affect the degree of user participation in these fora, they influence their agenda formation and contribute to setting the role of these fora in the health sector's decision-making process as a whole.

Another controversial point on these four approaches is the legitimacy of the leaders of interest groups. The first two, although to different degrees and with thoroughly diverse conceptions of the format and role of the groups, attribute a reasonable amount of membership control over interest group leaders. The last two mainly explain their lack of legitimacy by considering non-democratic internal group practices and members' weak control over these leaders. The view of the internal functioning of interest groups as quasi-commercial organisations, run in a very hierarchical manner by entrepreneurial leaders, is closer to an ideal image than to a real portrait. As Dunleavy (1991, 71) affirms, most interest groups are much less hierarchical than private firms.

> *"Indeed, their commonest formal structure is some type of imperfect democracy, a type of arrangement used in few other social organisations. Leaders are often directly elected (and re-elected) by grassroots members, who also vote on key policy decisions, often accompanied by decentralisation down to local level not just in organising activities but also in policy-making"* (Dunleavy 1991, 71).

So, leaders can be, and usually are, regarded as legitimate representatives of the membership of interest groups, once their organisations follow democratic, if imperfect, procedures. Although there are many interest groups influencing policy formulation and implementation in the health sector, users are often the most influential when the policy issue is whether or not to promote or not their own representatives' participation in a statutory municipal health forum.

Users

As has been seen when discussing representation, elected representatives of urban residents' associations or trade unions can be regarded as legitimate leaders of health services users' interest groups. Although the legitimacy of their representation can be contested sometimes, they are usually seen as rightful representatives, because they are normally elected, consult grassroots' members before taking the most important decisions, and the membership can organise their substitution. The last chapter treats users as an interest group of participants.

Here they are seen as organised into interest groups that can enhance or hinder the participation of their own representatives.

Some authors are sceptical about the possibility of users influencing policy formulation or implementation (Alford 1975, 218-38). Others discuss what can make it possible. Lee and Mills (1985, 131), for instance, present three major factors that will influence each interest group having more or less power. The first two are related to institutional aspects: the prevailing political, and the organisational, characteristics of the body inviting involvement. The third factor is the organisational characteristics of the groups themselves. These characteristics will involve: resources, such as money, skills and advice; prestige; legitimacy in terms of their status in law and statutory powers; organisational cohesiveness; and political skills.

Marmor (1983, 92) remarks on the importance of organisational features behind an interest group when specifically discussing the consumer influence on the health sector. For him, the potential for user participation lies in organisations that already exist within the consumer population. The previous existence of organised groups, according to him, demonstrates a commitment to enhancing the life circumstances of this population. As they are already organised, they can: (1) devote attention to issues in a relatively sustained manner; (2) often overcome low levels of expertise by re-deploying their staff.

> *"Representatives from these groups will have clearly defined constituencies, experience in organisational politics, and resources at their disposal"* (Marmor 1983, 92).

So, it is not the individual, selected or elected to represent a given population, who is the potential actor for influencing policy formulation or implementation, but pre-existing organised interest groups. These groups may commit themselves to pressure for their representatives to participate in a formal forum once they have the legal right to do so. They may opt for public protest if the established forms of representation of interest, including new participatory mechanisms, are regarded as inefficient. In the Brazilian case, they can choose, among the growing number of participatory fora open during the last decades, which are those to be considered as a priority. In any case, their interest will be decisive in whether or not to enlarge participatory channels.

Among user organisations trade unions have these characteristics. Urban social movements, although not as structured as the labour movement, have been building up, since the seventies, in many countries, an organisational pattern that can also support relatively constant interventions in statutory fora. Nevertheless, these groups' interests in pressuring for

increasing their representatives' influence in a given fora, will be related to the degree to which decisions made there will have an effect on the services provided for their membership. For example, in Brazil, many categories of regular urban workers, particularly those whose unions are the most active, have special arrangements - health-maintenance organisations, special services directly provided by firms, special private insurance schemes - for health care provision. Hence, their interest in promoting user participation in a forum that could decide upon services that their membership do not normally use will be only marginal. People living in shanty towns in Brazil, sometimes not formally employed, with no alternative but to use publicly financed health services, will be the same people who gather around residents' associations and would like their leaders or representatives to influence the decision-making process of these services, searching for some improvement.

In countries with a unified national health system, like in Britain, it is possible to define "users" as representing together "community" interests and "workers'" interests, since they have access to similar care (Lee and Mills 1985, 132-43). In countries where the health care provided for the formal economic sector's workers, particularly for qualified workers, is clearly distinct from the health care provided for the informal economic sector's workers, both types of workers may be also regarded as users but with distinct interests. As the difference in the quality and accessibility of care favours the formal economic sector's workers, it will often limit the interest of trade union members in pressuring for their representatives' participation in fora concerned with the provision of care by publicly financed health services. They will concentrate their demands on expanding the special insurance arrangements or in improving the exclusive health care they already have. On the contrary, as members of urban social movement organisations have no option but to use the standard health care provided by public financed health services, they will pressure their leaders to demand improvement in these services. Taking part in participatory fora may be seen as a means of so doing.

3.3.2. Civil Servants and Health Authorities

State officials and civil servants have direct influence over user involvement in participatory fora. Even when there are laws or policies establishing that there should be user participation in a given State forum, the way they implement this legal or policy provision can be very distinct.

Civil Servants

As Lee and Mills (1985, 67-8) observed, the picture of a faceless civil servant, executing but not making policy choices, appears to be unrealistic. They can be policy makers who hold the information and key means of policy implementation. Many authors have discussed their role in State bureaucratic organisations (Downs 1967; Niskanen 1978; Mills 1956; Lee and Mills 1985; Dunleavy 1991). The concept of bureaucracy is used sometimes as referring to senior officials, to civil servants, or to any organisation's administrative employees. Although the monolithic bureau does not exist (Downs 1967, 133), within broad limits,

> *"officials' influence on bureau policy is always extensively rank-structured, with those near the top being the most influential"* (Dunleavy 1991, 174).

Even considering the discretion that "street level" public workers or administrative low rank officials can have when executing their functions and choosing whether or not hold exclusive information, bureaucracies are fundamentally hierarchical organisations and the degree of political power tends to grow together with officials' rank. Hence, it is more precise to distinguish between (1) ordinary and low rank civil servants; (2) senior officials; (3) partisan directors. Their role in policy formulation and implementation and the way they are selected can vary from one country to another. For instance, in Britain, in the health sector, the first two groups are responsible for policy implementation and the Minister and a group of partisan aides for policy formulation. Although this division is not actually so clear, it is very distinct from the situation in the United States and in most Latin American countries, where

> *"top civil servants change with changes in government. Civil servants in these systems are not seen as 'neutral' but 'supportive' of one party or ideology"* (Walt 1994, 80).

In Brazil, in most governmental organisations, at federal, state and municipal levels of government, only the first type of civil servants were not chosen according to partisan lines. As in other countries, corporate networks link privileged economic groups, politicians and officials influencing both policy formulation and implementation. Nevertheless, in Brazil, State organisation is thought to have peculiar characteristics (Schwartzman 1982, 51-7). Public services posts sometimes would be viewed as property to be used in the holder's favour or to favour the political "godfather" that temporarily owns it. This generalisation, although valid, cannot be applied to many of Brazil's public or semi-public organisations. Public institutions vary according to regional, political and institutional traditions, according to the type of good or services they deliver, or according to their economic importance, along with other factors. During the eighties, political democratisation in Brazil has increased public controls on, and media exposure of, irregular civil servants' activities. Nevertheless, it has not affected the

institutional tradition in the Brazilian public services of changing nearly all managerial posts as soon as a new government takes office. Non partisan civil servants usually deal only with non politically sensitive and routine issues, having little influence over the decision-making process in the public sector. Delicate political matters, such as dealing with activists representing health service users, are not among their duties. Paradoxically, they can have very strong discretion over policy implementation functions, since formal supervisory mechanisms are very loose if they exist at all.

Health Authorities

Health services' directors in charge of participatory processes are acknowledged as powerful actors whose behaviour can influence the character of participation. As managers of public health services (Lee and Mills 1985, 130), they can be conceived of as supporters of particular interests - aiming at the maximisation of their agency budget in public choice and new right accounts for instance - or as arbiters of a planning or decision-making process, since they hold strong power over the health services under their management. Their role in the municipal participatory fora in Brazil is also multiple, because their position within the health services organisation attributes to them the "post" of municipal health authorities and their personal careers qualify them as professionals or as members of a policy community. They are "politicians" in the sense that they should belong to, or be strongly identified with, political parties or groups running the Ministry of Health, when they represent federal government; the state health secretariat, when they represent state government; the city hall government when they represent the municipal health secretariat.

Marmor discussing the American Health System Agencies (HSA) affirms

> *(...) the imbalanced political features of health planning will be tempered by two mechanisms - one internal to the HSA (staff assigned to the consumer representatives), the other external (selection of the representatives by groups)"* (Marmor 1983, 92).

The argument can be transferred to the Brazilian case. User representatives should be legitimate for representing users. The staff assigned to deal with user representation will be, in this case, municipal health authorities directly, who were the municipal secretary of health and the directors of the municipal health secretariat with partisan identification with the party or parties in office at the City Hall.

Federal and state health authorities may also have had an influence over municipal participatory fora in the health sector in Brazil, as they were responsible for transferring financial resources to municipal levels of management and for controlling directly most of the

publicly financed health services in the city, as will be seen in chapter five. Nonetheless, they were not exclusively responsible for the administration of health services in the area of Porto Alegre and they represent governments that are only partially concerned with the health care provided in a particular city.

Health authorities - municipal, state and federal - were partisan managers and also "professionals". They were normally medical doctors or health professionals, usually with a personal history of political activity in the health sector. Whether or not they identify with policy communities in the health sector, sometimes along partisan distinctions, can help us to understand their role in stimulating or not stimulating user participation.

3.3.3. Policy Community

It is central for thinking about how political decisions actually happen in the public sector, to ask about the implications of a professionalised State apparatus (Dunleavy 1981, 4) which formulates substantive sector policies. Quoting Larsons (1977), Dunleavy (1981, 7) used the concept of "ideological corporatism" for explaining the role of professional communities in modern complex State organisations. This community's central characteristic is

> *"the effective integration of different organisations or institutions at the level of substantive policy making, by the acceptance or dominance of an effectively unified view of the world across different sectors and institutions"* (Dunleavy 1981, 6).

This cohesion could mean a perverse integration of professional ideologies with capital interests or with party competition (Dunleavy 1981, 6). Following this stream of analysis, the profession becomes an important focus of study.

In the health field, for instance, the role of the medical profession is a major one. Nevertheless, the segmentation of the medical act, as well as the creation of complex health systems, has given rise to a new collective entity that could be defined as an administrative and technical team of health workers where the physician remains as the main element but not as the only one. In this context, its role has remained very influential, but other professionals in the health sector also became influential. Walt observed that by the eighties,

> *"there was a significant challenge to the medical profession's privileged status based on its technological knowledge and expertise, and to the 'medical model' which explained ill health and diseases largely in terms of biological factors. The primary health care approach was part of a revolution in health policy which put more emphasis on the value of lay care, and control of factors outside the medicine, to improve peoples' health"* (Walt 1994, 102).

During the early eighties, as costs for providing health care rose, many governments tried to find ways of decreasing the power of the medical profession in order to have control over the use of resources (Walt 1994, 81). The Brazilian government was not an exception to this pattern, as will be seen in the next chapter.

The multiplication of professional and political actors, however, is not particular to the health sector. The concept of **policy networks** (Heclo 1978, 87-124) attempts to categorise the increasing complexity and specificity of policy sectors, which demanded that specific policies should be dealt with by those possessing specialist expertise (Marshall 1988, 68). The policy networks are a means of defining the relationship between groups and the government/ government departments (Smith 1991, 235). They comprise

> *"a wide range of actors moving in and out of the policy arenas with different views of policy outcomes and a wide range of decision-making centres"* (Smith 1991, 235).

The concept of **policy community**, in contrast, refers to a limited number of relatively stable members who share the same values on policy outcomes. The decisions are taken within the communities and the process is commonly closed to other communities and to the general public (Rodes 1986, 23). Policy communities take part in the political process within policy networks. As policy-making becomes segmented, policies are made by a myriad of interconnecting, interpenetrating organisations (Jordan and Richardson 1979, 53-74). Policy communities are replacing the disintegrating centre - the Parliament or the Cabinet of Ministers - as the source for substantial decisions.

In the health sector policy networks and policy communities comprise individuals from various institutions, disciplines, or professions. They may be health practitioners, researchers or commentators. Policy networks would be made up of overlapping policy communities both within and outside government (Walt 1994, 110-1). The policy network in the health field at a given historical period will comprise the complex relationships between pharmaceutical companies, professionals, private providers of hospital care, any interest groups, and policy communities, which would have members within and outside government. The policy community would participate in this network trying to influence policy formulation and outcomes. There may be differences within the community, especially those related to more "administrative" issues (Dunleavy 1981, 9), which usually give rise to partisan cleavages, particularly in political systems, such as the Brazilian, where there were many parties competing without the clear predominance of any one. Nevertheless, the policy community has a common ground of consensus over basic political and ideological propositions.

In the health field in Brazil, during the last two decades, there could be identified two policy communities which had a strong influence over federal government policy-making (Paim 1989, 22-3; Teixeira 1989, 47-8). In the seventies, the most influential policy community was made up of senior officials in federal health organisations, who had strong connections with the pharmaceutical companies, as well as with organisations representing private providers of hospital care, representing health maintenance organisations and representing some health professionals, which were mostly unions of medical doctors from some Brazilian states. This articulation of policy makers had determined the consolidation and expansion of a model of health care provision whose central feature was the private provider - hospital, health maintenance organisation or the individual physician - placed in urban centres, financed by the social security system, and controlled by very weak regulatory mechanisms.

During the eighties, the dominance of that policy community was challenged by a new community proposing the reform of this model of health care. This new policy community was made up of academics, researchers and unions of health professionals and health workers. Its criticisms of the organisation of the health system and its new proposals were inspired by the primary health care approach. Its growing influence reflected the climate of democratisation in the country. It can be seen also as an expression of the complexity of Brazilian society which favoured the proliferation of interest groups pressuring the government to attend to their demands. The growing influence of this community over federal government was related also to the deep economic crisis the country was undergoing, which imposed constraints on government spending capacity, making welcome rationalisation policies, such as those the reformers defended. As will be seen in the next chapter, the Brazilian health system reformers proposed that users should be involved in the health sector. The idea of user participation in the health sector was inspired by primary health care defence of community involvement and by the ideal of democratising Brazilian political life. It can also be seen, however, as a way of obtaining more social support for the reform they were proposing, reinforcing their position against the resistance of the former policy community.

3.4. Summing Up

There are organisational factors that can determine the degree and quality of user participation in a statutory municipal health forum. These factors are mainly the legal and institutional framework of the health sector organisation and the actual policies and practices there implemented. As the focus of this research is on the municipal level, it is important to verify the nature of its relationship with the national, state and local administrative levels,

within the health sector. Power and functions can be distributed among these tiers of government, throughout the sector, in a centralised or decentralised fashion. Some policy aspects are easier to decentralise, such as the execution of functions and activities, and others are more difficult, such as decisions about the distribution of financial resources. Moreover, there would be a relation between the decentralisation of functions and political power and the level and quality of user participation in a statutory municipal health forum. This influence would be positive or negative depending on whether or not decentralised actions reached the local administrative level, near to where the users live and where their autonomous political organisations are placed.

The degree to, and the way in, which users will participate in statutory municipal health fora would also be determined by the political action of some key interest groups, such as health professionals, private providers of health care, labour movements, non-governmental organisations whose activities have an impact on, or are affected by, the health sector, and users themselves. Users, when organised as interest groups, are among the most important actors influencing the participatory processes open to them, as they can or cannot pressure for their own representatives' participation. The existence of a previous organisation can establish the conditions for the participation of user representatives on a relatively permanent basis. Trade unions and, to a lesser degree, urban social organisations can offer such a background. They can or cannot effectively support the demand for increasing user representative participation in these fora according to (1) what "sector" or arena the organisation regard as a priority at a given moment and (2) the degree to which decisions made there would have an effect over the services provided for their membership.

Other influential actors are those inside the State apparatus who co-ordinate these fora and are responsible for implementing decisions made there. Usually, in Brazil, low rank civil servants do not deal directly with politically sensitive issues such as running participatory mechanisms. More decisive are the attitudes of health authorities, which can be for or against participation. Health authorities can promote different types of participation depending on their political preferences. Municipal health authorities directly responsible for the co-ordination of the municipal health commissions created during the eighties in Brazil could have a strong influence over the way the forum would work. Health authorities from federal, state and municipal level exercise multiple roles, as their position within the health services organisation attributes to them the "post" of health authority, their personal careers qualify them as professionals and as members of policy communities trying to influence governmental decision-making processes.

Professionals in modern State organisations are central actors in explaining how political decisions actually happen. They can be seen as loose interest groups organised along corporate lines that can influence the formulation and implementation of substantive policies in specific areas of government. The traditional power of the medical profession over the health sector's decision-making processes has been weakened due to the segmentation of the medical act, and the creation of complex health systems that demanded a range of other professionals. The medical profession also lost prestige due to the difficulties for governments in maintaining the huge costs of models of health care which place on the medical professionals most of the discretion about treatments and the organisation of health systems. Although the physician remained the main element of the team of professionals working in the health sector, the decisions were more often made by policy communities. The members of these communities, who shared similar objectives for policy outcomes, are academics, professionals and interests groups which, in connection with governmental officials, influenced the policy-making in specific areas of government. An example of a policy community is the Brazilian health system reformers who defended, during the eighties, changes in this system in order to make it better integrated and decentralised. The next chapter will describe the evolution of this system during this century, aiming at explaining how in the last decade these reformers stimulated changes in the system that would promote also the involvement of users in municipal health commissions.

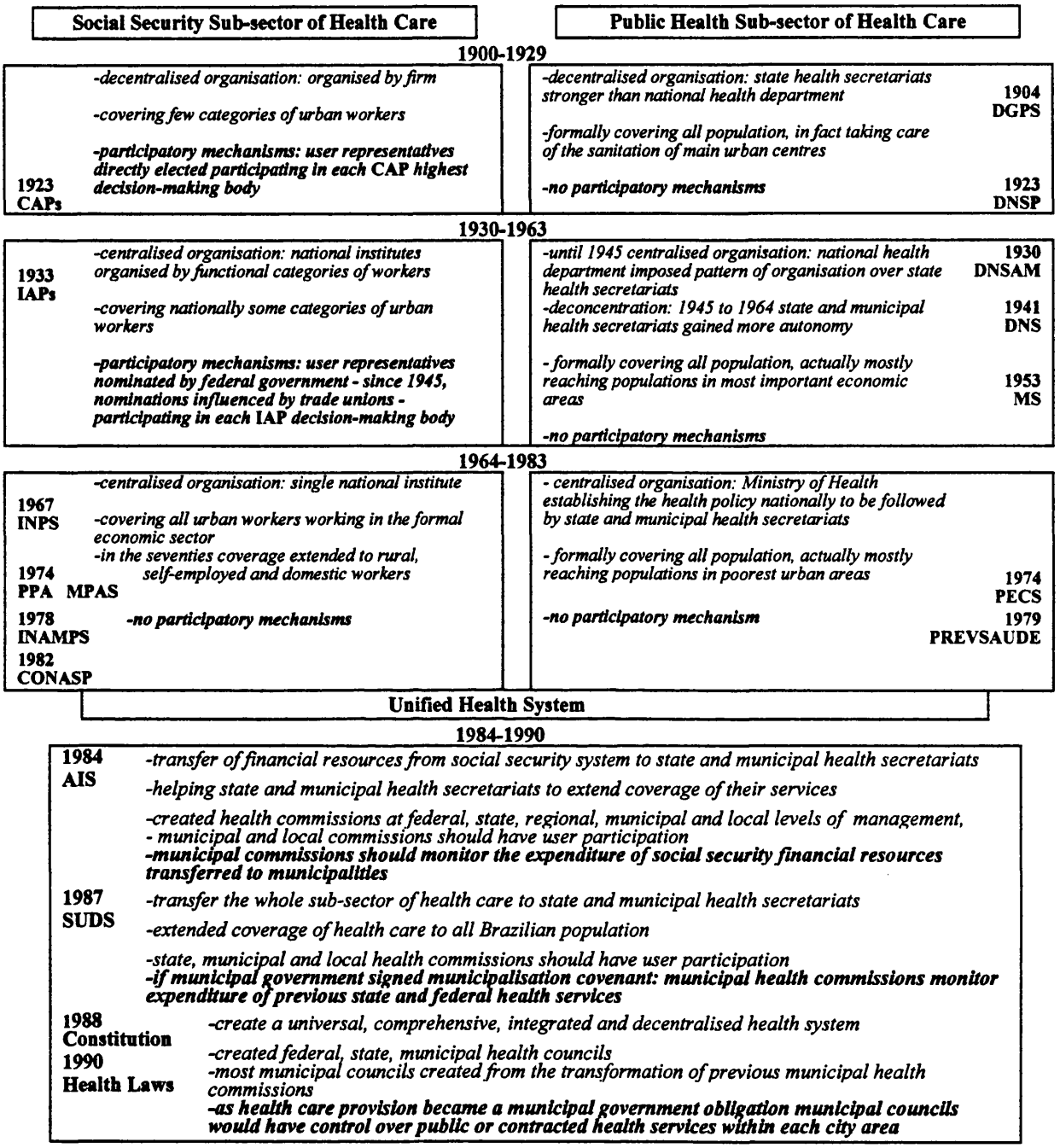
Chapter 4

The Brazilian Health System: Towards Decentralisation and Institutionalisation of User Participation

4.1. Introduction

This chapter aims at examining the evolution of the Brazilian health system in order to establish which was the system to be reformed during the eighties and how this reform created and consolidated municipal participatory fora. Firstly, this chapter shows the historical evolution of the Brazilian health system until the early eighties, taking into account the following aspects: (1) the type of actions and care offered, (2) the populations covered, (3) the way the system was financed, (4) the organisational characteristics and (5) the existence or not of user participation. During this period there were two sub-sectors of health care: the social security and the public health. The lack of co-ordination between the two sub-sectors, their ineffectiveness and high costs have attracted many criticisms particularly since the late seventies. Secondly, the chapter describes the recent reform of the Brazilian health system which attempted to tackle these problems at the same time that it created participatory fora at the municipal level of the system. The Figure 4.1 is intended to help the comprehension of the organisational evolution of this system, highlighting its main institutions, showing whether its organisation was mainly centralised or decentralised, the type of population it covered and whether there were participatory mechanisms.

Figure 4.1 - Evolution of the Brazilian Health System During this Century



CAPs - Caixas de Aposentadorias e Pensões
IAPs - Institutos de Aposentadorias e Pensões
INPS - Instituto Nacional de Previdência Social
PPA - Plano de Pronta Ação
MPAS - Ministério da Previdência e Assistência Social
INAMPS - Instituto Nacional de Assistência Médica da Previdência Social
CONASP - Plano de Reorganização da Assistência à Saúde no Âmbito da Previdência Social
DGPS - Diretoria Geral de Saúde Pública
DNSP - Departamento Nacional de Saúde Pública
DNSAM - Departamento Nacional de Saúde e Assistência Médico-Social
DNS - Departamento Nacional de Saúde
MS - Ministério da Saúde
PECS - Planos de Extenção de Cobertura
PREVSAUDE -Programa Nacional de Serviços Básicos de Saúde

AIS - Programa das Ações Integradas de Saúde
SUDS - Programa dos Sistemas Unificados e Descentralisados de Saúde

4.2. Brazilian Health Policies before 1930

Before 1930, the central government derived its political strength from very autonomous state and local oligarchies which supported a weak federal political power that promoted liberal policies, except when subsidising coffee production and exports. Political institutions were very decentralised, each state was autonomous in implementing its own policies in many areas, including health policies. Regarding the lack of central command (Braga and Paula 1981, 41-50), at the beginning of the twentieth century can be found the origins of the division in the Brazilian health system into two distinct, and often non-articulated, sub-sectors of health care that would characterise the country's health system organisation until the eighties. They were the social security and the public health sub-sectors of health care.

4.2.1. The Public Health Sub-Sector of Health Care before 1930

The public health sub-sector was mainly responsible for preventive public health measures and urban sanitation. It formally covered all the Brazilian population but, in fact, it reached only those living in economically important urban centres. It was created to deal with the crucial problem of the sanitation of ports and urban centres. Cities like São Paulo, Rio de Janeiro and Santos were strategic centres of commerce and finance for the export complex and nascent industries. Minimal sanitary conditions were required not only for maintaining trade relations but also for attracting migrants to build up a labour market (Braga and Paula 1981, 42).

The end of the last and beginning of the current century witnessed the setting up of departments of health in some Brazilian states, such as São Paulo, Rio de Janeiro, Pernambuco and Rio Grande do Sul. Aiming to control diseases like cholera, yellow fever, smallpox, malaria, tuberculosis, typhoid and leprosy, these state organisations promoted preventive measures such as vaccination, and the cleaning and reorganising of urban spaces, sometimes forcing poor populations to change habits or removing them to other areas. State departments of health also ran special hospitals network treating tuberculosis, leprosy and mental illness.

At the federal level, in 1904 the Diretoria Geral de Saúde Pública was created to co-ordinate public health actions in the country. Nevertheless, an important constraint on more effective central government action was the very decentralised political structure of the Brazilian State. Even the regulations of this Diretoria, issued in 1914, stated that any federal intervention should be exceptional and a response to public disaster.

Although state governments retained responsibility for public health policies, the Carlos Chagas reform in 1923 created the Departamento Nacional de Saúde Pública to be responsible for urban and rural sanitation health education child, industrial and professional hygiene. These responsibilities, however, never became actual policies and local solutions were the overwhelming reality (Braga and Paula 1981, 46).

The sub-sector was financed by federal and state budgets and had a decentralised organisation, in which each state had its own very autonomous secretariat of health. It had no participatory mechanism other than being accountable to the Congress or state Legislative Assemblies.

4.2.2. The Social Security Sub-Sector of Health Care before 1930

In 1923, the Eloi Chaves Law was passed by the Congress, providing the obligatory creation in each railway company of a fund for retirement and survivors' pensions that should offer insurance benefits and health care for employees. The fund was called **Caixa de Aposentadorias e Pensões** (hereafter **CAP**). In 1926, this system was extended to dock and ship workers. Through this insurance scheme the employee and his/her family - people living under the same roof and "economy" - were entitled to out-patient medical care, reduced priced medicine, retirement and invalidity pensions and, in the case of death, a pension for his/her heirs. From 1926, CAPs were allowed to have their own medical services and medical care included, as well the right to hospitalisation in case of surgery. By 1930, there were more than 40 CAPs covering more than 140,000 workers and their respective families (Oliveira and Teixeira 1986, 22), that is, only 0.4 per cent of the Brazilian population (140,000 people insured out of 37,625,436 inhabitants) (IBGE 1941, 3). People who were not covered by the services of CAPs had to pay for health care or rely on charity, since private insurance companies, then, did not cover health care.

While the public health sub-sector was financed directly by federal or state budgets, the social security system was maintained by deductions of three per cent of an employee's wages, one per cent of the firm's gross income and 1.5 per cent of the price of the services, such as railway tickets (Oliveira and Teixeira 1986, 32-3). By its very nature the system was decentralised, since the CAPs were organised by firms.

The system had participatory mechanisms, since the major administrative body of each CAP was made up of three employer's representatives and two directly elected employees' representatives.

4.3. Brazilian Health Policies from 1930 to 1964

The Revolution of 1930 provoked a strong shift in the country's political organisation. Placed in the world's economic and financial crisis, coffee imports fell, weakening the main economic basis of the power of regional oligarchies. The new government fostered industrialisation and shaped corporatist relations between employers and employees through State mediation. Federal government implemented social policies that, for the first time, sought to reach the entire population, but only actually benefited economically strategic categories of urban workers. The new economic and social policies were promoted through centralised institutions and mechanisms. Before 1930, federal government was weak, after this year it gradually became the political centre of a national State.

4.3.1. Public Health Sub-Sector of Health Care from 1930 to 1964

Between 1930 and 1945, when the Vargas dictatorship was in power, in the public health sub-sector there was a clear tendency towards centralisation. In 1930, the Ministry of Education and Health was created. It was made up of two national departments, one for education and another for health (Departamento Nacional de Saúde e Assistência Médico-Social - DNSAM). In 1941, the Ministry of Education and Health was reorganised, the former national department was renamed Departamento Nacional de Saúde. The department encompassed special services against diseases such as malaria and yellow fever and was responsible for health campaigns as well as for training public health specialists. The promotion of health campaigns and technical assistance were the two main devices used in imposing the Ministry's influence over state and municipal health secretariats. Health campaigns, during the thirties, were organised in a "military" way with centralised decision-making processes, aimed at reaching the Brazilian population as uniformly as possible (Garcia 1989, 205-6). According to Braga and Paula (1981, 54), they were an important element in political centralisation in the health field as well as in making health policies national in spatial terms. From 1930 to 1945, the national department of health's supervisors visited all states of the country, imposing uniform patterns of health care provision and similar institutional organisations on state departments or secretariats of health.

Between 1945 and 1964, when the political regime was democratic, the autonomy of state and municipal secretaries of health seemed to have increased, at the same time that the main policy goal was to promote economic growth (Braga and Paula 1981, 61). This period is known by Brazilian historians as the "developmentalist" years. It means that all policies were subordinated to a major aim: rapid industrialisation with transnational capital participation. In

1953, the Ministry of Health was created from the organisational structure of the previous Departamento Nacional de Saúde. The public health sub-sector's financial resources were channelled to health actions that would favour Brazilian economic development. For instance, the Departamento Nacional de Endemias Rurais was created in 1956 with the declared objective of acting in areas of clear social and economic importance for the nation's development (Ribeiro 1976, 5). According to Rivera (1982, 45), the main aim was to increase Brazil's economic productivity, preventing deaths without spending much. As the major policy concern was with economic growth, most federal government expenditure would go to policy areas directly related to economic production. In this context the Ministry of Health's participation in the federal budget declined between 1961 and 1964 from 4.6 to 3.6 per cent (Braga and Paula 1981, 62).

The sub-sector, which was financed through federal, state and municipal budgets, was made up of federal, state and municipal health units which promoted traditional public health measures, such as immunisations and health education, and also provided individual health care for those not covered by the social security scheme. This non integrated out-patient network of health care should implement campaigns and programmes against the most common infectious diseases that ought to reach all the country's population. In fact, it was made up of few complex units, usually called health centres, situated in urban areas targeting the poor or targeting special populations such as, since 1950, those living in strategic areas for economic development. These services remained isolated and only helped to improve health standards in small areas reaching insignificant populations. Moreover, they were not suitable for dealing with infectious diseases, which were then the most common illnesses in Brazil.

The sub-sector did not present, in this period, any type of participatory mechanism.

4.3.2. Social Security Sub-Sector of Health Care from 1930 to 1964

Similar to the other sub-sector, during this period, the social security sub-sector of health care underwent a process of centralisation. In the early thirties the social security system expanded its coverage through the creation of **Institutos de Aposentadorias e Pensões** (hereafter **IAP**). From 1933, rather than creating CAPs, new pension institutes were created which aimed at protecting national functional categories of workers such as dock and ship workers, bank workers or industrial workers (Malloy 1977, 46-7). By 1938, federal civil servants, commercial workers, dock and ship workers and industrial workers had been encompassed by the new IAPs' scheme or by the remaining CAPs, while rural workers and other categories of urban workers still were not encompassed by the system. In the whole period

workers whose categories did not have institutes or CAPs - those self-employed, domestic workers and rural workers - had to use public health sub-sector services, pay for care or rely on charity.

CAPs and IAPs had very different features. (1) The CAPs were organised by individual firms while the IAPs were organised by national functional categories of workers. (2) The first were civil societies totally independent of the State, and the second were quasi-governmental organisations under strict State control. (3) The CAPs encompassed bigger firms' workers while the IAPs were intended to reach all workers in the country of a given functional category. (4) The first were financed by workers, firms and consumers, while the second were financed by workers, firms and the State.

IAPs did not offer a uniform set of benefits and workers and firms did not pay similar contributions. Particular features of each occupational category, such as work conditions and strength of trade unions, could determine differences that had been accentuated throughout the years (Donnangelo 1975, 16). For instance, industrial workers, subjected to very bad work conditions that frequently caused invalidity or premature death, pressured for more illness, invalidity or death monetary benefits, while bank workers, whose work conditions were better, pressured for more health care.

The system as a whole restricted the supply of benefits and services if compared to those the CAPs had offered before 1930. The provision of health care, for example, became a secondary issue in all institutes, since their directors considered the provision of pensions and benefits as the primary, if not exclusive, obligation of their organisations. The bank workers' institute and the dock and ship workers' institute established that expenditure on health could not exceed limits of twelve per cent and eight per cent respectively of their annual revenue. Other IAPs would offer health care only to those who paid an extra premium (Donnangelo 1975, 25-30). According to Donnangelo (1975, 30), in 1945, the social security system insured nine million Brazilians, but offered health care to only 100 thousand people. That is, in 1945 circa nineteen per cent of the Brazilian population (nine millions out of 46,592,978 inhabitants) was covered by the social security system, while it offered health care to only 0.2 per cent of this population (IBGE 1951, 1).

Reducing benefits and regarding the provision of health services as optional and not as an obligation, were very adequate to the industrialisation project dominant in Brazil during the thirties. One third of the total revenue of institutes should be paid by employees, one third by the employers and one third by central government. As Oliveira and Teixeira (1986, 140)

observe, instead of paying its third federal government used the saving generated by employees' and employers' contributions for destinations other than guaranteeing benefits for urban workers and their dependants. Several decrees and laws demonstrated how the Brazilian central government, from 1930 to the early fifties, had been "allowing" - in fact forcing - IAPs to buy shares and bonuses in governmental or semi-governmental enterprises and to "invest" in programs for industrial development (Oliveira and Teixeira 1986, 141-8).

By 1950, political democratisation reinforced the trade union movement, and as a consequence its leaders could influence the choice of directors and, particularly, the nomination of employees' representatives to take part in the consultative bodies of the institutes. Moreover, during the fifties, the social security system became more amenable to interest group pressures for more assistance. Gradually IAPs had lifted restrictions on benefit concessions and limits on health care expenditure. Pressures for enlarging Institutes' provision of health care came from inside the social insurance system. Institute officials argued that, to reduce the concession of invalidity and illness benefits, more medical care should be provided to the insured population. Political democratisation and the growth of the urban-industrial sector made it easier for workers to express their demands for more and better health care (Donnangelo 1975, 28-30). An additional pressure was the increase in medical costs, due to the introduction of new medicines and technology. As a result, the late fifties and early sixties witnessed the growth of the expenditure of the social security system on medical care. In 1947, the social security system had spent 6.5 per cent of its revenue on medical assistance, while in 1964 it spent 17.3 per cent, surpassing therefore the limits established before (Possas 1981, 235).

At the same time, there were initiatives aimed at system unification. Although during the forties and fifties there had been much discussion on the theme, only in 1960 was the social security law passed by Congress. It equalised benefits, establishing that the social security system would encompass all urban workers in the formal sector, excluding therefore those who were self-employed, domestic workers and rural workers. However, this law was never applied, because there was strong resistance to the idea of unifying the system. The resistance came from social sectors interested in maintaining the old system: (1) private companies that used to insure accidents at work; (2) some work categories, such as bank and railway workers, whose institutes provided better benefits and who were afraid of losing them through unification; (3) workers from CAPs and IAPs afraid of losing their jobs; (4) political leaders reluctant to lose the political influence IAPs gave to them (Malloy 1977, 51-56). Another opposition group was formed by the senior officials of the Ministry of Labour, Industry and Commerce (Ministério do Trabalho, Indústria e Comércio), since they saw the possibility of creating a new giant rival

Ministry for Social Security as a threat. Trade union leaders, since the democratisation in 1945, had considerable influence over benefit distribution and over the choice of people to fill institute posts. Therefore, they also resisted losing this mighty source of political power.

4.4. The Late Sixties and the Seventies: Reshaping the Health System

The military regime that took office after the 1964 military coup promoted the centralisation of Brazilian political institutions and stimulated the growth of private provision of goods and services. The tax reform, the Institutional Acts, the 1967 Constitution written by the military government and the 1969 constitutional amendments, concentrated all discretionary power in the hands of central government. It became responsible for nearly all matters. Other levels of government could almost only execute the central directives. As a result of this concentration process, state participation in the total federal revenue distribution declined from 10.6 per cent, in 1968, to 8.8 per cent, in 1980, and the municipal participation from 7.3 per cent to 4.3 per cent (Médice 1987, 188). These general features of financial resources and power distribution throughout the levels of government also affected the health sector.

4.4.1. Public Health Sub-sector During the Late Sixties and the Seventies

The public health sub-sector did not change its organisational structure during the seventies and the early eighties. It still remained without participatory mechanisms, whose creation, in this period, would be very improbable due to the authoritarian political regime. The sub-sector, however, became less important in the Brazilian health system. In 1967, this sub-sector received 56 per cent, and the social security sub-sector 44 per cent, of the total federal expenditure on health and sanitation while in 1972, the public health sub-sector got 45 per cent, and the social security sub-sector 52 per cent of this total (Braga and Paula 1981, 93). The reduction in expenditure affected all the Ministry's programmes and services (Braga and Paula 1981, 91-9).

This did not happen because the health conditions of the Brazilian population had improved. On the contrary, the reduction of preventive and sanitary actions and of health care offered to those excluded from social security coverage could have had a bad impact on the poorest. This happened when the economy was growing very fast, during the so called Brazilian economic "miracle", and wealth concentration was worsening social inequalities. Between 1968 and 1974, the Brazilian GNP grew on average more than ten per cent a year. Industry alone, which was the economic sector leading the growth, grew sixteen per cent in 1973 (Luz 1979, 255-6). In this period, however, social inequalities increased. In 1960, the five per cent of the

population with the highest income earned 27 per cent of the national income, and the 50 per cent of the population with the lowest income earned seventeen per cent of the national income. In 1970, the richest five per cent earned 36 per cent and the poorest 50 per cent earned thirteen per cent of the national income (Cardoso 1975, 75). In 1973 and 1974, diseases seen before only among rural populations appeared in urban centres. Tuberculosis and meningitis returned as a cause for concern of public health professionals (Braga and Paula 1981, 93). In some regions of the country, infant mortality, a very sensitive indicator of poor social conditions, achieved its highest levels, after years of constant decline. It was the case in the state of São Paulo, where in 1966, in one thousand live births, 66 children had died at less than one year old, while in 1970, in one thousand live births, 89 children died (Luz 1979, 276).

In 1974 the economic growth slowed down and the military regime suffered its first big electoral defeat. The new military government took office, in 1974, proposing gradual political liberalisation. One important expression of this political shift was the development plan called II Plano Nacional de Desenvolvimento, which embodied the new military President "social discourse" (Paim 1989, 19). It established new strategies of social planning and proposed policies, aiming at health system rationalisation. From 1975, new health programmes were created. They were planned and executed vertically and subsequently imposed on states and municipalities. The most innovative programmes aimed to extend coverage to reach populations until then excluded from medical coverage. They reached mostly areas where there were almost no health services, such as the country's Northeast region, or destitute groups more easily affected by adverse conditions of life. Concomitantly, the Ministry of Health increased its participation in the federal budget from 0.9 per cent, in 1974, to 1.4 per cent, in 1979 (Médice 1987, 214). Although organisational rationalisation and better uses of financial resources were one of the II PND proposals, these programmes did not imply any attempt to integrate both sub-sectors.

Another set of initiatives which attempted to modify public health services came from some municipal health secretariats. Towards the end of the decade, in small or medium sized cities, most of them ruled by political parties in opposition to the military regime, municipal health secretariats implemented policies inspired by primary health care principles. Besides offering basic care to deprived populations, one of their goals was to involve health service users in some decisions over health service management. The degree of user participation was very different from one case to another, but for the first time the idea of user participation was introduced in public health services. Many health professionals were deeply involved in these experiences.

The Programa Nacional de Serviços Básicos de Saúde (hereafter **PREVSAUDE**) was the first attempt to integrate both sub-sectors through a unified health system encompassing the whole Brazilian population. In 1979, during the seventieth national health conference, Ministry of Health officials presented this programme whose main objectives were: (a) the extension of primary health care coverage to all Brazilians; (b) the reorganisation of the public health sector, linking institutions and reviewing the amount and type of services supplied, aiming at productivity increases; (c) the promotion of better environmental conditions, mostly through expanding drinking water provision and improving public health and sanitation. In order to achieve such goals: (1) the public sector would provide basic care and control the health system as a whole; (2) public institutions would integrate their management; (3) there would be decision-making and operational decentralisation; (4) there would be integration among the activities related to promotion, recuperation and rehabilitation of health; (5) simplified technology would be used; (6) there would be administrative efficacy; (7) community participation would be promoted (Paim, 1989, 20).

The discussion surrounding the possibility of the implementation of PREVSAUDE showed the different interests involved in the Brazilian health field (Paim 1989, 22-3). On the one hand, social security and Ministry of Health directors, private providers' associations representing hospitals and health maintenance organisations (Federação Brasileira de Hospitais - FBH, Associação Brasileira de Medicina de Grupo - ABRAMGE), and the Brazilian Medical Association (Associação Médica do Brasil - AMB) accused PREVSAUDE of being statist and of having communist inspiration. In contrast, many associations of health professionals and the trade unions' Institute of Studies on Health and Safety at Work (Departamento Intersindical de Estudos e Pesquisas de Saúde e dos Ambientes de Trabalho - DIESAT) supported the most important aspects of the programme. After one year of intense discussion, the programme was finally abandoned. Although it was never implemented, its ideas were the basis for the reform of the Brazilian health system that took place during eighties.

4.4.2. The Social Security Sub-Sector of Health Care During the Late Sixties and the Seventies

During this period, the social security system became the actual co-ordinator of national health policies as well as the main purchaser of health care provided by private suppliers throughout the country. The system offered health care free of direct charge to an increasing proportion of Brazilians: 22 per cent in 1964, 39 per cent in 1969 (Donnangelo 1975, 37). In 1979, it covered around 57 per cent of the total, and 90 per cent of the urban, population (Possas 1981, 249, FIBGE 1983a, 74). In the middle seventies, around 90 per cent of all

individual health care in Brazil was financed by the social security system (Donnangelo 1975, 34).

As has been seen, many interest groups were against the unification of IAPs. Nevertheless, after 1964, the repressive government neutralised that resistance. During this year, in all IAPs, central government substituted former institute managers with intervention boards. The new boards excluded any worker representation. The managers who controlled the system defended and imposed new policies "free of political pressures". This meant that trade unions would not have political influence on the decision-making process of the institutes. In fact, during the seventies, workers would only participate in the system by paying social security premiums.

In 1966, after studies carried out by an inter-ministerial commission, *social security communities* were created to unify routines and programmes among institutes at municipal and regional levels. In 1967, the **Instituto Nacional de Previdência Social** (hereafter **INPS**) was created, unifying the IAPs (Possas 1981, 218-27). The INPS lost some responsibilities, such as those related to food and housing assistance that were transferred to other institutions, but remained responsible for a complex range of financial benefits and for medical care. At the same time, it expanded its coverage which became nearly universal. In 1971 and 1972, some insurance benefits were extended respectively to rural workers and domestic workers. In 1973, autonomous workers were covered by the social security system. In 1974, a new plan (Plano de Pronta Ação - PPA) established that anyone needing emergency medical assistance could have it, on a non-contribution basis.

As was seen above, during the mid seventies, slower economic growth and electoral defeat induced central government to promote policies that could restore its legitimacy. Due to its national dimensions and revenue independence from the federal budget, INPS was seen as the most appropriate State institution for promoting policies of poverty alleviation. In fact, since the sixties, the social security budget had relied increasingly on employers' and employees' compulsory contributions. Between 1961 and 1981, the compulsory contributions paid by employees and employers rose from three per cent to 8.5 or ten per cent (lowest to highest salaries) of each employee's wage (Teixeira and others 1988, 51). According to Médice (1987, 188), from 1972 to 1982, compulsory contributions represented, on average, 89 per cent of the total revenue of the social security system. Hence, workers insured by the system financially supported the main governmental instrument of health policy implementation. They did it

directly when they paid premiums and indirectly when consuming goods and services whose prices included the costs of enterprises' compulsory contributions (Médice 1987, 188).

The importance of the social security system to the government's social policies was demonstrated by the creation, in 1974, of the Ministry of Social Security, the **Ministério da Previdência e Assistência Social** (MPAS). In 1975, the national health system (Sistema Nacional de Saúde - SNS) was created to co-ordinate all health activities inside what was intended to be a harmonious network of health services. The co-ordinator of this system would be the Conselho de Desenvolvimento Social, which had been created a year before. The creation of the national health system was an unsuccessful attempt at reorganising the health sector while avoiding political conflict. The military government was not strong enough at this moment to face the opposition that would come from a real organisational integration of the Ministry of Health, the Ministry of Social Security sector responsible for health care, and the state and municipal health secretariats. Senior officials in both Ministries were against such integration, if it implied expansion of public sector health care provision and increasing controls over private providers of health care. The proposal of creating a harmonious network of health services did not become a reality, but it placed the idea of health sector integration on the political agenda.

In 1978, the national system of social security (Sistema Nacional de Previdência e Assistência Social hereafter **SINPAS**) was created under the co-ordination of the Ministry of Social Security. One of the institutions this system comprised was the **Instituto Nacional de Assistência Médica da Previdência Social** (hereafter **INAMPS**) responsible for medical care. The creation of the INAMPS can be seen as a step towards the separation of health care from the social security system. It also expressed an institutional acknowledgement of the specificity of health care provision and the importance it had acquired within the social security complex, which can be illustrated by the dimensions of social security expenditure on health care. In 1978, when the INAMPS was created, its participation in total SINPAS expenditure was 30 per cent. Using Médice's (1987, 214) estimate for the years before 1978, it is possible to observe that this institute's participation in total SINPAS expenditure, from 1970 until 1982, was on average 27 per cent.

Between 1969 and 1976, the expenditure of the social security system on hospital care grew by 185 per cent and on out-patient care 400 per cent (Braga and Paula 1981, 115-6). Although, in 1976, most of the social security expenditure on health went to hospital services - 56 per cent of the total - the expenditure on out-patient care grew faster probably due to the

Plano de Pronta Ação (Braga and Paula 1981, 116). Concomitantly with the expansion of out-patient care, a private network of hospital services was built up to become the main provider of hospital care, during the late seventies and eighties. The Fundo de Apoio ao Desenvolvimento Social (hereafter **FAS**) was an important instrument in this process. The fund, which was created in 1984, received financial resources from the federal budget, federal lotteries and federal banks among other sources. It offered highly subsided loans to private entrepreneurs and governmental agencies for building social facilities. By August 1977, 80 per cent of FAS loans in the health area had gone to private hospitals (Braga and Paula 1981, 128).

During the seventies, the social security sub-sector of health care had two different types of services: its own and contracted services. Social security had its own network of out-patient units and hospitals, but both out-patient and hospital care were mostly provided through contracted services. In 1976, 32 per cent of the total social security expenditure on health care was on its own services and 68 per cent was on non-owned services (Braga e Paula 1981, 120). Nevertheless, the INAMPS' own hospitals provided highly specialised and complex care, leaving to contracted ones the provision of simpler and less expansive care (Possas, 1981, 254).

There were two main types of contracts: contract and covenant. Through the first type, private hospitals received fees-for-services (Unidade de Serviço - US) payments for hospital care or out-patient attendances in hospital based out-patient units. Covenants were usually established with industrial and commercial enterprises contracting health maintenance organisations. In this case, part of the social security compulsory contribution went directly to the health maintenance organisation. Other types of covenant were those established with state and municipal health secretariats, universities and trade unions. In these cases financial resources were transferred according to specific criteria depending on the type of institutions involved (Possas 1981, 247-70). Covenants with states and municipalities would increase in importance during the next decade when the idea of health system integration and rationalisation became politically relevant due to social security financial problems and "ideological crisis" (Oliveira and Teixeira 1986, 270-5). During the seventies, the authoritarian regime tried to increase its legitimacy offering more health care, mostly through private providers, to larger population sectors. The enduring economic crisis in the late seventies and early eighties, however, would force decision-makers to seek solutions not only for reducing the costs of contracted services, but also for making public health sub-sector out-patient units able to contain the demand for health care before it reached social security services. The social security crisis would make it feasible for Brazilian health system reformers to implement policies aimed at health sector integration and decentralisation, at increased control over private

providers and at the promotion of user involvement in the health sector decision-making process.

4.5. Changing the Brazilian Health System: The Eighties and the Shift towards Integration and Decentralisation

During the eighties, Brazilian society underwent a deep economic crisis and a process of political democratisation. Political life became freer although the "liberalisation" process was firmly controlled by military forces. New political parties were created. Many strikes occurred, although, at first, they were illegal. Press freedom was re-established. In 1982, state governors were directly elected. In 1985, all mayors were directly elected, but the President of the Republic was directly elected only in 1989.

In 1985, the first non-military President since 1964 was indirectly elected by an electoral college made up of members of Congress. It used to be a political mechanism used by the military regime for formalising their previously chosen candidates. This time, however, the climate of growing political liberty, the lack of military government legitimacy, the economic crisis and the unprecedented popular mobilisation that brought millions of Brazilians to public demonstrations asking for direct elections for the Presidency, had shaped the political basis for the complex political alliance supporting a civilian government. This political alliance was made up of very distinct political forces, such as ex-leaders of the military regime and left wing factions of the Party of the Brazilian Democratic Movement (PMDB), the biggest political party of this alliance. These left wing groups would have a strong influence over the reform of the Brazilian health system.

4.5.1. Towards Brazilian Health System Integration and Decentralisation: The CONASP Plan

As was mentioned before, PREVSAUDE launched the idea of a unified, universal and comprehensive health system. Although the Ministry of Health officials who proposed the programme had no political power to make it work (Paim 1989, 21), they were successful in starting what Oliveira and Teixeira (1986, 270-5) called the social security system's ideological crisis.

Behind the ideological crisis, however, there was the social security system's financial crisis (Oliveira and Teixeira 1986, 276-91). The latter was due, firstly, to the economic recession which, since 1973, reduced social security revenue from compulsory contributions from wages. Since then, there had been more unemployment and less increase in wage levels.

The recession also affected federal revenue, since less economic activity implied fewer taxes paid to the government. Central government decided to allocate its scarce financial resources to other areas lacking their own revenue or regarded as more important in economic terms. Between 1970 and 1973, the federal budget transfer to the social security system was on average ten per cent of the total social security system revenue, declining to 3.4 per cent in 1980 (Oliveira and Teixeira 1986, 277). The financial crisis was due, also, to the expansion of the population covered by social security without the enlargement of its revenue basis. During the seventies and early eighties, the system insured nearly all Brazilians but its main source of revenue still remained restricted to compulsory contributions from each regular worker's wage.

The mismanagement of financial resources helped as well exacerbated existing problems. The social security system had the biggest budget at federal level, only surpassed by the whole federal budget itself (Oliveira and Teixeira 1986, 279). Its financial operations involved huge amounts of money, so that losses from this amount of financial resources could be substantial. An example of mismanagement was the existence of two social security bank accounts in financial institutions, one receiving contributions and the other paying benefits or services, in the case of health care. The payment accounts always went "red" during part of the month, while the resources in the receiving accounts could not be transfered to the former. In an economic context of high inflation and high interest rates this mechanism resulted in large monthly transfers of financial resources from social security to the banking system. Although the social security's two accounts had been debated since the late seventies, the situation was only modified in 1986.

Trying to reduce social security expenditure on health care, the federal government adopted measures to rationalise this sub-sector at the same time that it laid the foundations of a broad health system reform. In 1982, federal government issued a plan for the reorganisation of social security's health care system (Plano de Reorganização da Assistência à Saúde no Âmbito da Previdência Social hereafter **CONASP**). The plan created new control mechanisms over private sector accounts, particularly over contracted hospitals. Social security had paid private hospitals until then through fees-for-services mechanisms but, after the plan, they were paid per average cost of disease treated (Autorização de Internação Hospitalar - AIH). This measure should have allowed more control, since hospitals could not add indiscriminate procedures to each patient's account. Although private hospitals had created new mechanisms to defraud social security controls (Respondent/15, 1992), the percentage of INAMPS expenditure on private services seems to have decreased. In 1985, for the first time in many years, private

sector services received less than 50 per cent of social security financial resources (Médice 1987, 192).

The CONASP plan recommended the creation of a comprehensive, integrated and decentralised health system, where primary health care could be stimulated and public out-patient and hospital networks should work according to their maximum capacity. It also proposed the creation in each Brazilian state of a trilateral covenant which would have the participation of the Ministries of Social Security, of Health and the state health secretariat. These ideas revived some PREVSAUDE propositions which aimed at creating a comprehensive and integrated health system. They would become actual policy when central government launched the **Programa das Ações Integradas de Saúde** (hereafter **AIS**).

4.5.2. Programa das Ações Integradas de Saúde: The First Step towards the Reform of the Brazilian Health System

This programme represented a significant step towards inter-institutional integration. It established that covenants would be signed between state governments and the Ministries of Social Security, of Health and of Education in each state of the country. After the state government had signed the **AIS** covenant, municipal governments could "adhere" to it. It would entitle state and municipal governments to receive social security financial resources to be used by their secretariats of health. These financial resources were paid through a fee-for-services scheme.

The programme also opened statutory mechanisms for user participation in the Brazilian health field. It created inter-institutional commissions, responsible for planning and co-ordinating health policy implementation, at federal, state and regional levels of government. These commissions were respectively the Comissão Interministerial de Planejamento e Coordenação (CIPLAN), the Comissão Interinstitucional de Saúde (CIS) and the Comissão Regional Interinstitucional de Saúde (CRIS). They had to have the participation of covenant institutions and other health care providers. At the municipal level - a city or a group of cities - and local level - city district - the **Comissão Interinstitucional Municipal de Saúde** (hereafter **CIMS**) and the **Comissão Local Interinstitucional de Saúde** (hereafter **CLIS**) should be created. Very few regional health commissions were created in the country, but municipal and local commissions became part of Brazilian health sector institutional life since that time. These last two fora had to have the participation of

> *"covenant institutions' representatives, municipal health secretariat or City Hall's representatives as well as community associations, trade unions, associations*

> *representing local population"* (Brasil. Ministério da Previdência e Assistência Social and others 1984, 8).

Ideally, planning and decision-making for the health sector at each level of government should take place in these fora. Nevertheless, it was still a frail health service integration, most decisions taken being related to the transfer of financial resources from social security to municipal health secretariats. Moreover, the programme established that municipal and local commissions had to have popular participation, but it did not define the nature of this participation or how to select popular representatives. Usually, municipal and state health secretariats established who had to be invited, but it could vary, depending on the political power and organisational capacity of the local popular or trade union movements. Even considering these limitations, for the first time, there was a decentralised network of participatory fora at the local level of government aiming at the integration of the management of health services. Some of them had only a formal existence, but others became the scenario of important political disputes within the health sector.

The **AIS** programme recommended that providers should integrate their plans and activities, but the only actual step taken towards that integration was the creation of inter-institutional commissions. The policy recommendation was that planning and decision-making for municipal health services should take place in the municipal fora. Nevertheless, the exclusive legal power of these commissions was over the expenditure and respective accounts related to the social security system financial resources transferred to municipalities. Health care provided directly or contracted by the social security system, health care provided by the Ministry of Health, state health secretariats and health care financed through municipal budgets, were excluded from any public scrutiny and could remain as disintegrated as ever. It made the creation of such municipal fora very attractive to municipal health authorities because they could obtain financial resources from federal government without sharing power or increasing their responsibilities. The enlargement of municipal commissions' decision-making powers on other issues would depend very much on health authorities' good will or on irresistible political pressure.

In 1985 the civilian federal government took office. Although right wing politicians, military and business interest dominated the so called New Republic (Nova República) government, there was also participation by some left wing politicians and professionals. In the health field, political co-ordination was given, in both INAMPS and the Ministry of Health, to Brazilian health system reformers who had links with left wing parties or left wing political factions. These reformers defended strategies aimed at health system decentralisation and at

strengthening public control over the system. They transformed **AIS** from just a programme into the central policy of the health sector. Although, in 1985, **AIS** represented only ten per cent of the social security's expenditure on health care, in 1986, the 2,500 Brazilian municipalities had "adhered" to **AIS**' covenants (Neto 1991, 61).

Defending the idea of decentralisation and more public control over health care provision, brought to them support from municipal secretaries of health (Neto 1991, 60) and opposition from both sides of the political spectrum. From the left, there were those, such as some health professional associations, some left wing political parties, parts of trade union and urban social movements, defending the claim that all health services should be immediately under State ownership. From the right, there were associations representing private providers of hospital care, health maintenance organisations, some trade unions of health professionals, especially medical doctors and dentists, afraid of increasing government controls over their practices. They argued that the market was the best health sector regulator, so governments should not intervene more than they already did. A third group against change was made up of health service civil servants at all levels of government, afraid of losing their jobs and privileges. INAMPS' employees were the most resistant group since they worked in the most powerful public organisation in the health sector.

In 1986, the eighth national health conference (VIII Conferência Nacional de Saúde) produced strong political mobilisation and its final report supported health system decentralisation and integration. There were approximately four thousand participants representing public and private health institutions, the main universities, student unions, the main trade union confederations, many health worker unions, urban and rural trade unions, urban residential associations, political parties, Catholic and Protestant churches and many other organisations. Its final report placed the very idea of health in a broad context, stating that

> *"health results from conditions of nutrition, housing, education, income, environment, work, transportation, leisure, freedom, access to land and health services"* (Relatório Final da VIII Conferência Nacional de Saúde 1987, 382).

This concept implied that only structural changes in society could actually improve the health situation of the Brazilian population. Nevertheless, some policy goals were proposed: (1) to improve the situation of the poorest, (2) to create a universal and comprehensive unified health system, (3) to decentralise health services, (4) to establish rules that could guarantee that public and private services would provide good quality health care.

Since this conference, although divergent positions have remained, those defending the Brazilian health system reform have agreed upon some basic objectives: creating a

comprehensive and universal health system, integrating and decentralising health services, defending State ownership of health services, or at least, strengthening public control over private providers and promoting user participation in the system.

4.5.3. Sistemas Unificados e Decentralisados de Saúde: The Second Step towards the Reform of the Brazilian Health System

In 1987, the central government created the programme of **Sistemas Unificados e Decentralisados de Saúde** (hereafter **SUDS**) aiming at the consolidation and qualitative development of **AIS**. The programme established that all citizens should have the right to use **SUDS** public or contracted services. Since then, any Brazilian citizen is, at least formally, entitled to receive health care, independently of paying social security contributions. Federal government would manage, co-ordinate, control and evaluate the national health system but it would only provide direct or indirect health services that reached the whole Brazilian population. It transferred nearly all INAMPS and Ministry of Health functions and services to state health secretariats. INAMPS would gradually reduce personnel and installations since it would gradually stop providing health services. State secretariats would become responsible for the direct or contracted health care provided within each state territory. The programme also stimulated the further transfer of functions and services from the state level to the municipal level of government. Municipalities would present a plan, sign a covenant and then receive financial resources from the state health secretariats which were becoming responsible for state and federal health units and hospitals within municipal territory. The transfer of financial resources would be made through new mechanisms of integrated budgets management.

SUDS reinforced the role of users in inter-institutional health commissions, since it recommended that state commissions would be open to civil society participation. Before then, only municipal and local commissions were open to user participation. Moreover, it also stimulated the enlargement of the role of the municipal commissions. If a municipality and the state government agreed on a municipalisation covenant, state, federal and municipal health units and hospitals, that were not referrals for state population, would be transferred to municipal responsibility. Municipal commissions would control the expenditure and the accounts related to health services transferred to the responsibility of municipal health secretariats. Municipalisation covenants were signed by many municipalities throughout the country. In 1989, in the state of São Paulo, 98 per cent of cities, 565 out of 572, had their health services municipalised (Carvalheiro and others 1992, 39-40). In 1990, in the state of Rio

Grande do Sul, 38 per cent of the cities, 125 out of 333, had their health services integrated (Respondent/32 1992).

SUDS's main strategy for speeding the pace of the Brazilian health system reform was implementing decentralisation through devolution. Nevertheless, the municipalisation process was not as easy as **AIS** implementation, because it was not just a way of receiving more financial resources. In the case of the largest cities, it also implied taking under municipal responsibility a large network of health services with immense financial and administrative problems. An example is the case of Porto Alegre. Since 1989, municipal health authorities had been asking for the municipalisation of state and federal health services, by then under the state health secretariat management due to the **SUDS** programme implementation. Municipal health authorities could not agree, however, with the state health secretariat proposal for transferring services without guaranteeing the concomitant transfer of financial resources to enable not only the services to function but to recuperate buildings and equipment, to qualify and contract personnel, among other improvements (Respondent/5 1992). The case of Porto Alegre does not seem to be an exception, since by 1991 no Brazilian state capital had its services integrated and decentralised, including the capital of the state of São Paulo, which by 1990 had more than 98 per cent of cities with health services municipalised.

Critics pointed out that the **SUDS** programme did not really change the relationship between the social security system and the private sector. In fact, it did not affect the way the public sector contracted and paid private providers. What the programme actually did was to transfer to states the former social security system's responsibility of dealing with contracted services, to transfer social security's own health units and hospitals to state and municipal administrations and to end the historical division between social security and public health sub-sectors of health care in Brazil. As a result the **SUDS** programme has pushed into the health sector political arena mayors and state governors pressing for the devolution process in the health field to be deeper and faster (Arouca 1988, 53).

The **SUDS** programme could be seen as a reaffirmation of the commitment of INAMPS and Ministry of Health directors to the reform of the Brazilian health system and as an attempt to push it further, before the alliance politically guaranteeing their posts was totally dissolved. In 1988, the tendency of central government to seek right-wing political party support, pressure from groups of health professionals, from private providers as well as from the INAMPS conservative bureaucracy, resulted in the replacement of the main INAMPS and Ministry of Health directors.

4.5.4. Constitution and Health Laws: The Third Step towards the Reform of the Brazilian Health System

Since 1987, pressure groups against or in support of the reform of the Brazilian health system have been mobilised and connected with members of Congress. On one side, opposing the increase in State control over the system and/or against devolution of functions to state and municipal governments, there were interest groups representing private providers, some medical professional associations and some factions of INAMPS and the Ministry of Health bureaucracy. On the other side, supporting the extension of state control over the health system, particularly over private providers, and the devolution of functions and financial resources to state and municipal governments, were some health professional associations, some trade unions, the main trade union confederations, urban residential associations and most state and municipal governments.

In 1988, the latter group created a national plenary that rapidly acquired political prestige, due to its capacity to formulate a clear and consistent project of constitutional text on health issues, to its constant pressure on the members of the constituent assembly and to its broad social representation (Teixeira 1989, 51). In the same year, municipal secretaries of health created the National Council of Municipal Secretaries of Health (Conselho Nacional de Secretários Municipais de Saúde hereafter **CONASEMS**) whose main priority at that moment was pressing the constituent assembly to approve items that would establish health system decentralisation and empower the municipal levels of government.

In 1988, in some way reconciling diverging political interests, not only in the health field but in all in areas of social life, the new Brazilian Constitution came into force. This Constitution buried for good the concept of social security as a system whose benefits and services would reach only those who paid premiums. It was substituted by the notion of social security as a universal social right. The new social security system was made up of a comprehensive health sub-system, a social insurance sub-system and a social assistance sub-system. In the health field the Constitution set up the legal basis for strengthening health system changes and created the **Sistema Único de Saúde** (hereafter **SUS**). The SUS had to be decentralised through the delegation and devolution of functions and discretionary powers to state and municipal governments. It had to integrate all the services in a territorial area under a unified command. The public sector would have overall control and would regulate the system.

After months of intense political dispute, in September of 1990 the health law (Brasil. Congresso 1990, Lei 8.080) was passed by the Brazilian Congress, to make operative

constitutional principles and to establish the legal parameters that could make the SUS feasible. Nevertheless, some articles that were present in the original Bill were vetoed by the President of the Republic. In fact, the Brazilian political situation had changed in 1990. Before then, as state and municipal governments had been directly elected, they had stronger political legitimacy than the federal government. In 1990, Fernando Collor, the first directly elected president since 1961, took office in Brasília. His political legitimacy reinforced the central government's role in the political scene. It was a right wing government supporting privatisation, but resistant both to devolution of political power from central to state and municipal levels of government, and to institutional democratisation. In the health field, it tried to regain power through slowing down the decentralisation process and restricting the influence of participatory channels. Therefore, the President of the Republic vetoed articles in the original Bill which: (1) established that there should be Health Councils and Conferences of Health with large civil society representation in the three governmental spheres (federal, state and municipal) as the main formulators of strategies and directives, controlling policy implementation; (2) established automatic and regular transfer of financial resources from the social security fund to states and municipalities; (3) established the proportion of financial resources to be automatically transferred to states and municipalities. In December 1990, the federal government lifted the vetoes after intense political mobilisation lead by the municipal secretaries of health, who were particularly concerned with the veto on the automatic transfer of financial resources.

The Law 8.080/90, together with the Constitution, created a health sub-system that was part of the social security system. The main functions of this sub-system (SUS) were: promotion of preventive and curative care; production of equipment, medicines and other substances of health interest; control of food and environmental quality; promotion of basic sanitation; human resources development; epidemiological and sanitary monitoring; control of health and safety at work. The SUS would be publicly financed, would have a unique direction in each governmental sphere (federal, state and municipal), guaranteeing the private sector freedom to realise its activities according to the law (Carvalho e Santos 1992, 36-7). The legal provisions regarded the municipalisation of health services as a priority for consolidating the new system (Carvalho and Santos 1992, 45). They placed on municipalities the obligation to plan, execute and control a variety of health related activities. Since that time, it has not been optional for municipal governments to establish covenants with the social security system, becoming responsible for the management of federal and state health units in exchange for financial resources. It has become obligatory, since their health secretariats were a decentralised sphere of the SUS.

Although financial and tax reforms are still to come in Brazil, the Constitution and the health law established the general parameters that would make it feasible for municipalities to bear their enlarged responsibilities in the health field. They stated that federal, state and municipal budgets, employers' and employees' compulsory contributions, as well as the federal and state lotteries, would provide financial resources for the social security budget. Organisations responsible for health, social insurance and assistance should prepare this budget in accordance with the directives of the annual budget law. Financial resources from the federal budget, the social security budget and other sources would be allocated to a national health fund managed by the Ministry of Health. Half the amount of the financial resources to be distributed to state and municipal health secretariats would be allocated taking into account the relation of the population size of the state or municipality to the country's total population. Municipalities should receive at least 70 per cent of this total. To receive such financial resources, municipal and state health secretariats had to have: (1) a health fund, (2) a health council, (3) a health plan, (4) a management report, (5) considerable participation of health in the municipal or state budgets, (6) plan of career for personnel. The other half would be distributed according to a combination of criteria which would take into account the epidemiological profile of the population and the efficiency of the health services. The SUS financial resources for each governmental sphere would be credited to special bank accounts whose transactions would be monitored by the health councils.

The reorganisation of the system after the implementation of the **SUDS** programme, therefore, resulted in transferring to states and municipalities functions, buildings, personnel, that is, the whole management of INAMPS' own and contracted services. As a consequence the social security system reduced its expenditure on health. Taking into account the resources allocated to INAMPS and to the Ministry of Health, in 1987, when the **SUDS** programme was introduced, the social security system spent on health 34.7 per cent of its total expenditure while, in 1991, it spent 23.6 per cent (Carvalho 1991, 12). Health laws have imposed the automatic transfer of, at least, part of the social security's financial resources to states and municipalities. Nevertheless, in 1991, while the private sector were paid integrally for the care they had provided, the state and municipal secretariats' own services had to share the "rest" (Respondent/5 1992). It seems that political affinities among governors, mayors and federal government, as well as the capacity of municipal health authorities for mobilising public support had more influence on the decision about whether each state or municipality would receive more financial resources than the technical criteria established by law (Respondent/5 1992; Respondent/15 1992). There are not yet any studies assessing whether the decentralisation and integration of the system resulted in better care or in the increased

effectiveness of health services, but there is no doubt that the federal government cut its costs on health since the reform came into effect, by transferring responsibilities to lower levels of government.

In terms of user participation, the Law 8.142/90 (Brasil. Congresso 1990, Lei 8.142) passed by Congress in December of 1990, went further than previous programmes in stating that the health councils in the three governmental spheres would be permanent and would have representatives of government, health service providers, health professionals and users of health services. Half of the council should be made up of user representatives and the other half of other representatives. These fora would participate in establishing strategies, deciding financial resource allocation and in monitoring policy implementation. Moreover, since health care provision had become a municipal government obligation, these councils would have control over all the services provided within each city area. Once these six prerequisites were fulfilled, the municipality would automatically become responsible for health services located there and, therefore, the councils would be entitled to make decisions concerning these services.

Nevertheless, the difficulties that were verified on the implementation of the **SUDS** programme in large cities, remained after the health laws had been issued. As was mentioned above, by 1991, no state capital had their health services municipalised. In the particular case of Porto Alegre, all the prerequisites had been fulfilled, but it was not possible to reach an agreement between state and municipal health authorities on what services would be transferred, at what pace each type of service would go under municipal management, and about the financial resources to be automatically transferred (Respondent/5 1992). As state and municipal governments were ruled by different political parties, the difficulties were made worse (Respondent/27 1992). While health services in a city did not go under municipal control it would be more difficult for a municipal health commission to monitor health care provision and to influence the decision-making process in the sector. This was so, firstly, because the commission would have to influence the state health secretariat, which legally was outside its jurisdiction. Secondly, because, as the health system was undergoing a process of reorganisation, it was often difficult to identify, particularly in large cities, which organisation could be held responsible for which type of activities. Even taking into account these problems, the perspective of municipalisation, which is 'an inevitable process', according to a user participant in the Porto Alegre's municipal health commission (Respondent/13 1992), and the institutionalisation of participatory fora through the law, seemed to have stimulated the

involvement of users in the municipal health commission of Porto Alegre, as will be seen in following chapters.

4.6. Summing Up

Until the early eighties, the Brazilian health system was divided into public health and social security sub-sectors of health care, both acting without co-ordination and with overlapping functions. The social security sub-sector had most of the financial resources, had the largest public out-patient and hospital network, and financed individual health care for the majority of the Brazilian population. By then, both hospital and out-patient health care were provided mostly by private services contracted by the social security sub-sector of health care. The economic crisis and the growing cost of health care provision for the social security system reinforced the idea among the policy makers, within and outside the health sector, that the health system needed to be reorganised for its better integration and decentralisation. The reorganisation implied the transfer of discretionary powers and financial resources from the social security to the public health sub-sector of health care, and from central government to state and municipal governments. Since the early eighties, following the country's general climate of democratisation and the recommendations of International Agencies, the policies and legal dispositions that aimed chiefly at integrating and decentralising the Brazilian public health system also stimulated user participation at the municipal level.

In order to liberalise the political regime, since the economic crisis had reduced the political legitimacy of the military government, the regime became less oppressive and took initiatives in building new channels of political representation. It sought to legitimise the authoritarian regime and broaden its social basis of support by implementing policies for poverty alleviation and expansion of social security coverage. Simultaneously, the former corporatist relationship between business interests and public sector technocracy (Cardoso, 1975, 181-6) were criticised even by some bourgeois sectors, which were dissatisfied with the slowing down of economic activities. Democratic forms of political representation were gradually restored or created, such as elections for executive posts, press freedom, freedom of association and of political parties to organise. New modalities of political representation inside the State apparatus were created. Government projects and programmes established boards and commissions that were supposed to have civil society interest group representation. One important element of the Brazilian health system reform, that took place during the eighties, was the establishment of participatory mechanisms.

During the eighties there were two federal government programmes and one set of legal provisions that could be regarded as the main landmarks of health sector reform. They were the programme of **Ações Integradas de Saúde (AIS)**, the programme for the development of **Sistemas Unificados e Decentralisados de Saúde (SUDS)** and the **1988 Brazilian Constitution** together with the **health laws.**

The **AIS** programme, created in 1984, was part of the military regime's strategy of reducing social security system costs, which had increased during the seventies. It established that the social security system would transfer its financial resources to the state governments and municipalities that opted to take part in the programme. The main goal was to improve the public health network of services spread through the three governmental levels, retaining the demand for specialised and hospital care financed or directly provided by the social security system. To facilitate the integration of public providers the programme created inter-institutional commissions at the federal, state, regional, municipal and local administrative levels. The first three types of commission did not have to have the involvement of civil society organisations but those at the municipal and local levels did. The municipal commissions would decide on the allocation of social security financial resources to be transferred to municipalities as well as monitoring their expenditure. The health care provided directly by federal, state and municipal spheres of government and the health care provided by private services did not have to be included on the agenda of these fora. Besides aiding inter-institutional integration, the municipal and local fora were also new channels of political representation inside the State organisation. They could become places where interest groups could present their demands to the government, taking part in the decision-making processes in the health sector.

From 1985, when the first civil government took office, the programme became a central element of the federal health policy. The municipal and local fora, placed in a rather centralised health system, could have little influence over the system, but they could absorb and alleviate interest group pressure on the government. Gradually, interest groups, such as user organisations, trade unions, health professionals and health workers' unions, organisations previously excluded from the sector's decision-making process, saw the empowerment of these fora as an opportunity to influence decisions. Particularly in large cities where social movements were better organised, these interest groups pressed for the enlargement of the fora's agenda in order to share power in the sector (Carvalheiro and others 1992, 116-27).

The **SUDS** programme was inaugurated in August of 1987 due to the initiative of the federal health authorities, who defended the health system reform. The main strategy of this

new programme was to universalise access to health care and, at the same time, to rationalise costs and resources, unifying the management of public health and social security health services. It would be done by taking advantage of the decentralised public health network of services. States and municipalities would sign covenants enabling the transfer of social security financial resources and of social security hospitals and out-patient units to state health secretariats. The programme also established that there should be a further transfer of services, as well as of states' own units, hospitals and public health services, to municipalities. The programme proposed real integration, virtually extinguishing the direct involvement of social security in the provision of health care and in the purchasing of private care. When there was municipalisation, municipal health secretariats would become the actual managers of the health services in their respective territorial areas, except for the services that acted as referrals for the state or country populations, that is those complex services that were used by the whole state and the whole Brazilian population.

The Brazilian health system reformers regarded it as a matter of principle that civil society should have control over the system, but they also needed to expand political support for their policies, which could be helped by interest groups being mobilised in participatory fora. The programme opened state commissions to civil society participation and reinforced the role of civil society representatives in municipal and local health commissions. The **SUDS** enabled municipal commissions to participate in decisions concerning all public or contracted health services in the city, since health services were municipalised.

The **Brazilian Constitution,** promulgated in 1988, and the **health laws** passed by the Brazilian Congress in 1990, were influenced by the lobby made up of reformers of the Brazilian health system in alliance with user interest groups. The general strategy was to create a universal unified health system (SUS) financed basically by social security funds and federal, state and municipal budgets, transferring most health care provision to the municipal level, leaving to the federal and state levels the monitoring and evaluation of the system. The legal provisions stated that the health system should have a unified and decentralised management. Municipal health authorities would be responsible for health care provided within the municipal territory, excluding the services which were referral centres for state or national populations. Although the responsibility for health services became by law a municipal duty, it was difficult to reach an agreement between municipal and state health authorities on how and when services would be devolved to municipal health secretariats in large cities, particularly in the state capitals.

Even considering the difficulties, and the resistance in turning policies and legal requirements into reality, a growing number of municipalities were taking control of health services in their territories. The growing number of municipalisations favoured the idea that there would be municipalisation even in the state capitals. User organisations and other interest groups, aware of the inevitability of the devolution process, tended to renew efforts to increase their influence on municipal councils. They acknowledged the centrality of the municipal sphere of government within the SUS and the possibility of opening these councils to playing an active part in the decision-making processes of the health sector.

The health laws also created health councils at federal, state and municipal levels of management of the system. Most municipal councils created since that time, were formed from previous municipal health commissions. In legal and institutional terms municipal commissions had been modifying their character inside a health system that had also been changing. Nevertheless, from 1985, when the federal health authorities gave priority to **AIS**, the municipal commissions, besides facilitating inter-institutional integration, could become places where providers, different levels of government, and organisations representing users, health workers and health professionals could channel their demands and expectations and could conciliate their differences.

Mediating interests in the sector, however, depended on the forum having discretionary powers over the system and on the capacity of the actors to participate autonomously and on a regular basis in a given forum (Marmor, 1983, 92). The first prerequisite was determined mainly by health policies, laws and institutional practices; nevertheless interest group pressures and the political views of health authorities could enlarge a forum's agenda. The second would depend on the strength of the organisations behind the representatives participating there. Trade unions, residential and community associations were the organisations that usually offered support for substantive user representation in Brazil. Without such pre-existing organised structures supporting user representatives, their involvement in State participatory channels may become manipulative, giving legitimacy to policies actually decided only by government officials and other powerful social actors, such as medical professionals or private providers. In small cities in Brazil clientelism and favouritism could hamper the political autonomy of user organisations (Carvalheiro and others 1992, 116-8, 135-43). In large cities, particularly in state capitals where there was a concentration of political organisations, it could be possible for user involvement in State participatory mechanisms to go beyond manipulation. On the one hand, these cities have a large network of out-patient units, hospitals and specialised complex services making the reconciliation of interests surrounding the municipalisation of health services more

difficult. On the other hand, in this situation there was more urgency in establishing channels for mediating conflicts.

Chapter 5

The Brazilian Municipal Health Fora and the Social and Political Scenario of Porto Alegre's Health Forum

5.1. Introduction

This chapter aims, firstly, at placing the municipal health commission of Porto Alegre in the broader country context and at justifying why users' involvement in this commission is an interesting case for analysis. The first section examines the existing information about the distribution of different types of municipal health commissions or councils by large territorial regions and by types of city, with regard to population size and city income. The types of fora were defined according to the regularity of their meetings and according to their internal regulations regarding the role of the fora in establishing municipal health policy and the role of users in the commission. Taking into account population and city income, when defining the size of the city, it has been possible to explore the relationship between city size and distinct patterns of political life, of urban social movement organisations, of public health professionals' role in the health sector, and of user involvement in municipal health fora activities.

The second section aims to show that this research focused on the case of the Porto Alegre municipal health commission because of the city's position in the Brazilian context and the city's own peculiarities. Firstly, Porto Alegre's demographic, social and epidemiological characteristics are described in the Brazilian context, verifying whether social inequalities could have favoured the emergence of the concern with health issues of the urban social movements. Secondly, Porto Alegre's health services are described, examining their capacity in principle to cover the needs of the population, but also highlighting the limited real access of poor sectors of the population to these services, which could also have produced demands for better care from urban social movement organisations. Nevertheless, the existence of social inequalities in

the distribution of goods and services alone neither creates political mobilisation nor defines who should be the social actors motivated to represent, and capable of representing, the interests of deprived social sectors. In Brazil, these actors have consisted mainly of urban social movements. Moreover, spatially-based organisations rather than class defined ones have been more interested in taking part in participatory health fora. As their members were the main participants in the municipal health commission of Porto Alegre, the origins of the urban social movements in the city are described, stressing the analytical difference between "traditional" and "new" organisations and highlighting the regions whose organisations, even before the creation of the municipal health commission in 1985, had included health issues on their political agendas.

5.2. Distribution of Municipal Health Fora in Brazilian Regions and by Type of City

The first municipal health commissions (Comissão Interinstitucional Municipal de Saúde) were created in 1984, when the Açõ̃es Integradas de Saúde (**AIS**) established the first covenants between federal and state governments. Although there are no systematic studies of the commissions created during the first years of **AIS** implementation, there is some information on particular periods and regions. By 1986, 2,500 Brazilian municipalities had "adhered" to **AIS** covenants (Neto 1991, 61), representing 59 per cent of the 4,212 cities in the country (FIBGE 1987, 45). All of them should have had a municipal health commission, but this does not mean that they were active, had civil society participation, or were even successful at integrating the activities of public and private providers of health care. In 1987 in the state of Rio Grande do Sul, whose capital is Porto Alegre, there were 192 municipal health commissions (Respondent/22 1992) representing 77 per cent of the 248 cities of this state (FIBGE 1989, 65).

After the creation of the Sistemas Unificados e Decentralisados de Saúde (**SUDS**), in 1987, municipalisation covenants were signed by many municipalities throughout the country. Any municipalised city was to have a municipal health commission, although those not yet municipalised could have one as well. In 1989, in the state of São Paulo, at least 98 per cent of cities had health commissions, since 565 out of 572 cities had had their health services municipalised by this year. In 1990, in the state of Rio Grande do Sul, at least 38 per cent of the cities had commissions, since 125 out of 333 had had their health services integrated (Respondent/32 1992; FIBGE 1991, 31).

From 1990, health laws dictated that the establishment of municipal health councils was a condition for municipalising the health services of a city. During 1991 and 1992, many municipal health commissions were transformed into municipal health councils, even if health services in the city had not yet been municipalised. The data available refer exclusively to municipal health councils, excluding the remaining commissions, and they also refer to only 68 per cent of Brazilian municipalities. The data, therefore, probably underestimate the actual figure of municipal health fora in Brazil in 1991 (IBAM and others 1993, 335). Even taking into account both limitations - dealing only with councils and the actual scope of cities reached - it is possible to draw some interesting conclusions concerning the distribution of the municipal health councils among Brazilian regions, attesting to the widespread institutionalisation of these fora throughout the country. Table 5.1 demonstrates that, by the end of 1991, just one year after the health laws had opened up the possibility of creating municipal health councils, at least 25 per cent of Brazilian municipalities had them. They were distributed over all Brazilian states. Rio Grande do Sul, the state whose capital is Porto Alegre, was the Southern state with the highest percentage of cities with a municipal health council. This state's percentage of 40 per cent of cities with councils was well above the national figure of 25 per cent.

Although beyond the temporal limits of the present study, it is interesting to observe that, between 1991 and 1993, there was an increase in the percentage of Southern state cities with municipal health councils. Between 1991 and 1993, the percentage of cities with municipal health councils in Southern states grew by 209 per cent - 188 to 582 - above the national average of 84 per cent - 1,143 to 2,108 - and the percentage growth of other regions. As a result, in 1993, this region had the highest proportion of cities with municipal health councils, 65 per cent - 582 for 1,058 cities - compared to the national average of 47 per cent - 2,108 for 4,973 cities (FIBGE 1991, 33; IBAM and others 1993, 35).

There are indications that, in the Southern region, not only has there been rapid proliferation of municipal health fora, but also the fora could have had more control over the formulation of municipal health policy and stronger user involvement. According to the Instituto Brasileiro de Administração Municipal and others (IBAM and others 1991, 1), who surveyed 11 per cent of the Brazilian municipalities in 1991, the internal regulations of most health councils stated that they should be places where decisions on municipal health policy were taken. As can be seen in Graph 5.1, the South had the highest percentage of councils' internal regulations (88 per cent) stating that decisions on health policy should be made there. Nevertheless, formal participation in the decision-making process does not imply actual

empowerment of the fora. Apparently, most of the researched councils were mainly fora where users made complaints and obtained further information about the health system (IBAM and others 1991, 4-5). Even with this consideration, the high proportion in the Southern region of councils' internal regulations stating that they should have discretionary powers over municipal health policy, coincides with the fast growth of the percentage of Southern cities with councils, between 1991 and 1993.

Table 5.1 - Cities with Municipal Health Council by Brazilian States - 1991

Brazilian States	Regions	Cities	Cities with Council *	Percentage of Cities with Council
Brazil		4,491	1,143	**25**
Mato Grosso do Sul - MS	Central-west	72	62	**86**
Mato Grosso - MT	Central-west	95	55	**58**
Ceará - CE	Northeast	178	89	**50**
Espírito Santo - ES	Southeast	67	32	**48**
Piauí - PI	Northeast	118	53	**45**
Rio Grande do Sul - RS	**South**	333	134	**40**
Rio de Janeiro - RJ	Southeast	70	26	**37**
Paraíba - PB	Northeast	171	61	**36**
Minas Gerais - MG	Southeast	723	216	**30**
Pernambuco - PE	Northeast	168	50	**30**
Rio Grande do Norte - RN	Northeast	152	45	**30**
Maranhão - MA	Northeast	136	36	**26**
Rondônia - RO	Northeast	23	6	**26**
Alagoas - AL	Northeast	97	24	**25**
Santa Catarina - SC	**South**	217	50	**23**
São Paulo - SP	Southeast	572	131	**23**
Acre -AC	North	12	2	**17**
Pará - PA	North	105	15	**14**
Tocantins - TO	North	79	10	**13**
Roraíma - RR	North	8	1	**13**
Amapá - AP	North	9	1	**11**
Sergipe - SE	Northeast	74	6	**8**
Bahia - BA	Northeast	415	32	**8**
Amazonas - AM	North	62	1	**2**
Paraná - PR	**South**	323	4	**1**
Goiás - GO	Central-west	211	1	**0**
Distrito Federal - DF	Central-west	1	0	**0**

* Sample of 68 per cent of Brazilian cities reached by the research "Avaliação do Funcionamento dos Conselhos Estaduais e Municipais de Saúde - Relatório Nacional/Versão Final" (Instituto Brasileiro de Administração Municipal and others 1993, 335).

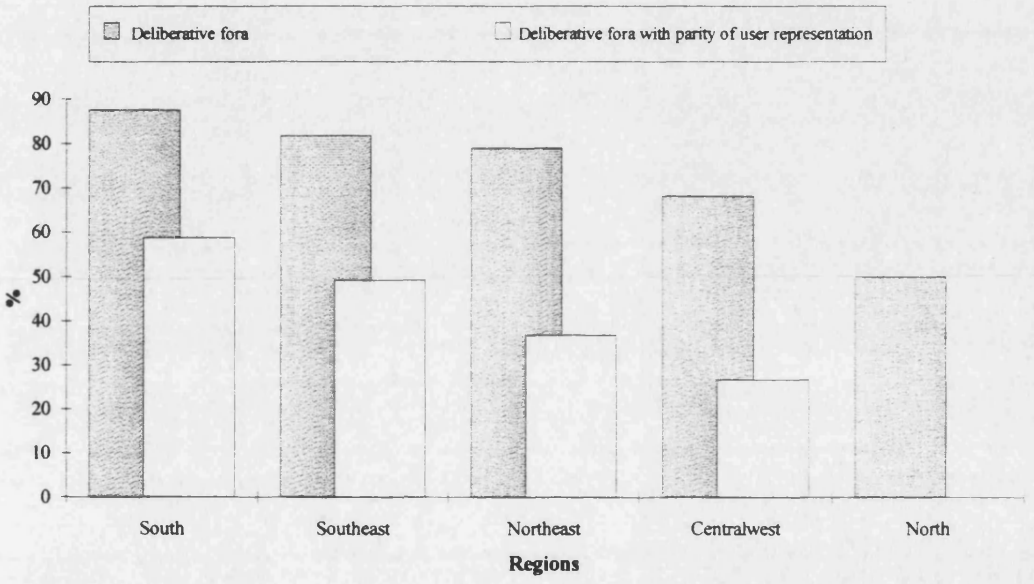
SOURCES: Fundação Instituto Brasileiro de Geografia e Estatística, *Anuário Estatístico do Brasil* (Rio de Janeiro: IBGE, 1991), 33.

Instituto Brasileiro de Administração Municipal and others, "Avaliação do Funcionamento dos Conselhos Estaduais e Municipais de Saúde - Relatório Executivo" (Ministério da Saúde, Conselho Nacional de Saúde, 1993), 35, photocopied.

As can be seen in Graph 5.1, it also coincides with the fact that, in 1991, the Southern region had the highest percentage - 59 per cent - of surveyed councils with regulations establishing that they should have discretionary powers over health policy, and also establishing

that there should be parity between user representatives and all other groups of representatives together. Although Law 8.142/90 stated that half of council participants should be user representatives, internal regulations indicated that councils were not fulfilling this legal requirement (Brasil. Congresso 1990, Lei 8.142). As will be seen in the next chapter, when Porto Alegre's Municipal Law 277/92 transformed the municipal health commission into a council, it also did not follow this legal provision (Porto Alegre. Câmara Municipal 1992, Lei Complementar 277).

Graph 5.1 - Percentage of Deliberative Municipal Health Councils with Parity of User Representation, by Brazilian Region - 1991 *



* Research surveyed 11 per cent of the Brazilian cities (Instituto Brasileiro de Administração Municipal and others 1991, 1).

SOURCE: Instituto Brasileiro de Administração Municipal and others, "Perfil dos Municípios na Área de Saúde - Síntese" (Ministério da Saúde, Fundação Nacional de Saúde, IBAM, 1991), 25, photocopied.

Hence, Brazilian literature indicates that, in the Southern region, municipal health fora, given their characteristics, could have strong user involvement in their activities, although it neither guarantees that these fora had actual power over municipal health policies nor that users necessary participated in their decision-making processes. Nevertheless, it points to a possibility that there is the potential for this to occur, particularly in large cities where civil society organisations could support the consistent involvement of user representatives in these fora.

In 1991, more than 56 per cent of cities with over five hundred thousand inhabitants - fourteen out of 25 - had municipal health councils, well above the average of 25 per cent for all cities (IBAM and others 1993, 33; FIBGE, 1991, 36). By 1993, the highest proportion of councils working regularly - their last meetings were in the three months before the survey took place - were those situated in cities with more than five hundred thousand inhabitants. Among 21 cities with more than five hundred thousand inhabitants, 57 per cent (twelve) had councils working on a regular basis, also above the national average of 46 per cent (IBAM and others 1993, 38).

The population size of cities is often related to the level of complexity of their political life. Carvalheiro and others (1992, 39-62) used combined indicators of population size and of city income to analyse differences in political organisations, health services and health indicators among cities in the state of São Paulo. The authors defined "city size" according to a range of population size combined with a range of income size. A city with a small population but a large income could be regarded as "medium-sized", while a city with a large population and a small income could be considered "small". Using this type of classification, when population size or income size was considered alone there could be overlaps. For example, a city with 80 thousand inhabitants could be regarded as a "small", a "medium-sized" or as a "large" city. Only the combination of the two criteria will define what they regarded as the actual "city size".

Using this methodology, they (Carvalheiro and others 1992, 41-52, 95-133) demonstrated that, in the state of São Paulo, the larger the city, by population size and city income, the more complex was its civil society organisation and its political life, and the more active was its municipal health commission. In small cities - with a population of between five and one hundred thousand inhabitants, and a municipal income of up to one hundred million cruzados (1987 prices) - personal relationships were stronger than political ones. Political parties were seen as an inessential part of the political arrangements, being personally identified with some local elite individuals. There was no clear distinction between public and private spheres, or room for autonomous civil society organisation. In these cities, not surprisingly, the municipal health commission's existence was only formal. The commissions did not have internal regulations and the meetings were very irregular. Neither user representatives nor other interest group representatives were involved in these forum activities.

In medium-sized cities - with a population of between fifteen and two hundred thousand inhabitants, and a municipal income of between ten and one hundred and fifty

thousand million cruzados (1987 prices) - political relations were reasonably institutionalised. Traditional clientelistic relations coexisted with the actions of emerging political parties, such as the left wing Workers Party (PT) and the centre-left Party of the Brazilian Democratic Movement (PMDB). There were organised interest groups such as residential associations, trade unions, popular health councils and professional associations. Most of the political actions of these organisations, however, did not involve even their membership, usually being promoted by individual leaders alone. In these cities, municipal health commissions were reasonably active and institutionalised. They had formalised internal regulations and meetings were held regularly. Among the representatives of the civil society organisations participating in their activities, there were some users. Nevertheless, some of them were mere individuals assigned by municipal authorities, who were confused about their role and were unable to distinguish whether they should represent the interest of municipal authorities or that of users.

Unlike the others, large cities - more than forty thousand inhabitants and more than fifty million cruzados of municipal income (1987 prices) - had highly institutionalised political relations. Not only did political parties have distinct policy agendas, but some politicians, who belonged to the mayor's party, even had independent positions and used to criticise aspects of municipal policy. Although clientelistic relations endured, political parties were the main vehicle for expressing political relations. Several civil society organisations could be found, such as trade unions, residential or professional associations. In large cities, the activities of municipal health commissions were very institutionalised. The fora worked according to formalised internal regulations and the time and place of meetings were announced publicly in advance. Civil society representatives were chosen and indicated by their organisations as clear representatives of these organisations' interests.

In these cities, public health professionals co-ordinated the implementation of health policy. Their multifaceted political positions mirrored the complex political life and society of these cities. In small cities, there were hardly any public health professionals and they were strictly under the mayor's influence. In medium sized cities, there were more than one, and sometimes public health professionals opposed the mayors' policies. In large cities, there were several public health professionals and they were identified with partisan cleavages or with some civil society interest groups. They were political actors, who could basically be divided between those identified with some factions of the popular or trade union movements or with more traditional social sectors.

The size of Brazilian cities seems to influence whether there is a municipal health council working regularly. Large cities tended to have an institutionalised political life, and urban social movements were able to propose alternative policies articulating broad inter-sector projects. In these cities, public health professionals could have different types of relationship with social movements, depending on whether the organisation represented the trade union or the urban social movements. Brazilian trade unions were highly State-regulated organisations, whose enduring corporatist structures had been created during the thirties and forties (Rodrigues 1990, 61-70). Urban social movement organisations had their main period of emergence during the seventies. Members of the strongest trade unions usually had agreements with employers that guaranteed access to special health care. In contrast, most urban social movement members had precarious access only to publicly financed health care. Representatives of residential associations had more incentive, thus, to participate in municipal health fora than trade unions, even if trade unions had a better institutional structure to sustain their representatives' participation.

Health issues were not a priority for most trade unions, but they were for trade unions of health professionals or health workers. The latter have often shaped the discussions on health issues within trade union confederations, and have often represented the views of confederations in institutional health fora. In Porto Alegre, as will be seen in the next chapter, since issues related to publicly financed health care did not mobilise members and leaders of the most powerful trade unions, health professionals or health workers could represent the views of their particular trade unions or professional community rather than those of the trade union confederations they were supposed to represent (Respondent/23 1992). There are indications that, in Campinas, which is the second most populous city in the state of São Paulo, health professionals played a similar role within the United Confederation of Workers (Central Única dos Trabalhadores hereafter **CUT**) (L'Abbate 1990, 435-6).

Residential associations, even in big cities, did not have a large staff that would enable them to have representatives with some degree of expertise in different areas. Nevertheless, they could build up connections with professionals identified with the claims of residential associations for better public services and for the empowerment of health service users. During the eighties, especially in large cities in the state of São Paulo, public health professionals working in poor neighbourhoods, together with urban social movements, defended improvements in public health care provision and in sanitation (Carvalheiro and others 1992, 106-8). In Campinas the popular health movement started in poor regions of the city during the late seventies. It was promoted by urban social movement activists concerned with health

problems in association with public health professionals working in health units in these regions (L'Abbate 1990, 448). During the eighties, in the city of São Paulo, the popular health movement, especially in the East Zone, has in its origins two main social actors besides urban social movements themselves: Catholic church grassroots organisations called "Comunidades Eclesiais de Base" (Grassroots Ecclesiastic Communities - CEBS), and public health professionals committed to the reform of the Brazilian health system (Fantin 1989, 37-78; Martes 1990, 99-109).

Large cities, with their complex political life, active civil society organisations and policy communities of public health professionals, could apparently provide better conditions for user involvement in municipal health commissions. Although recent research has mostly focused on the municipal health fora in the large cities of São Paulo state, the Southern region's health fora in large cities seem to be interesting subjects for study, given the strong role their internal regulations confer to user representatives. In 1991, Porto Alegre was the second largest city in the Southern region and had an active civil society and political life, which could help to explain the vitality of its municipal health commission and, in particular, the enduring involvement of user representatives in its activities after 1986, as will be seen in the following chapters.

5.3. Porto Alegre: The Scenario of the Municipal Health Commission

Porto Alegre is the capital of the state of Rio Grande do Sul, in the extreme south of Brazil. This research focuses on the involvement of user representatives in the municipal health commission of this particular city of the Southern region for four main reasons. First, because the commission has functioned regularly since its creation in 1985. There have been weekly plenary meetings and, from 1987, they were held each fortnight, allowing the dynamic of the forum to be followed during a period when the Brazilian health system had undergone remarkable changes and when the fora had been institutionalised throughout the country. Second, Porto Alegre is not only Rio Grande do Sul's largest city and its capital, but it has also developed a strong tradition of political mobilisation, where many political organisations representing many different interest groups are concentrated. These organisations supported the regular involvement of user representatives in the commission. User representatives, as political actors, have enough political autonomy to choose whether to participate in the commission or to participate with variable intensity at different periods of time. Third, the political parties that have been ruling Porto Alegre, Rio Grande do Sul and Brazil have varied. So, during the period being studied - 1985 to 1991 - there have been distinct health authorities with different

positions on user participation, ranging from total opposition to enthusiastic support. It makes it possible to verify the influence which health authorities can have in hindering or stimulating user participation in the commission. Fourth, in Porto Alegre there were very active members of both the medical profession and the Brazilian health system reformers, facilitating analysis of the relationship between them and user representatives.

Before analysing the case of Porto Alegre's municipal health commission, the city itself will be examined. The aspects highlighted are those that would help to explain the reasons for users becoming involved in the commission. They are the demographic, social and epidemiological characteristics of Porto Alegre's resident population, the city's health services and urban social movements.

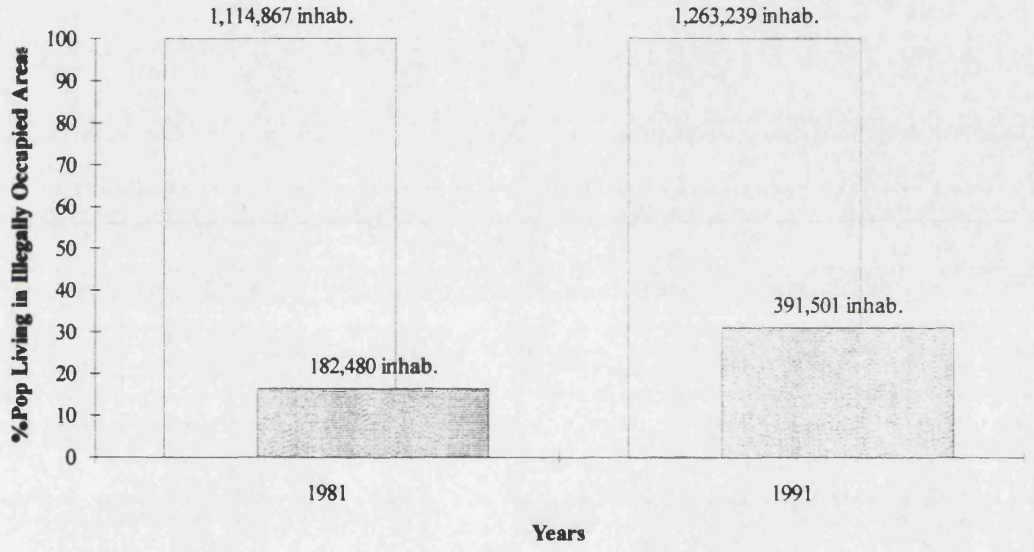
5.3.1. Demographic, Social and Epidemiological Characteristics of Porto Alegre's Population

Porto Alegre is the economic and political centre of the Greater Porto Alegre region, which is made up of 22 municipalities. In economic terms, Porto Alegre is the capital of the state of Rio Grande do Sul, whose GNP in 1992 was US $ 38.6 billions, representing around eight per cent of total Brazilian GNP (Contri and others 1994, 9). In 1992, the GNP per capita of the state of Rio Grande do Sul was US $ 3,890 while the Brazilian average was US $ 2,995 (Contri and others 1994, 9). In 1980, in Porto Alegre, 60 per cent of the economically active population were occupied in service activities, eighteen per cent being employed by commercial firms and 21 per cent by industries (Giacomoni 1993, 104). According to Alonso and Bandeira (1988, 3-28), during the last decades, Porto Alegre's industrial production decreased in relative importance, while there was a growth of tertiary economic functions such as commercial, financial and governmental activities.

According to Giacomoni (1993, 104-5), due to the state's model of agrarian production and to the insufficient generation of urban jobs in the medium-sized cities of Rio Grande do Sul's hinterland, there has been a strong migration towards Greater Porto Alegre. During the seventies the growth of Greater Porto Alegre's population was 46 per cent, while in the eighties the population growth was only 36 per cent. Nevertheless, these percentages of growth were much higher than the rest of the state of Rio Grande do Sul, which were respectively eight and ten per cent (Giacomoni 1993, 106). Porto Alegre itself had a smaller population growth than other cities of Greater Porto Alegre. During the seventies and the eighties, Porto Alegre's population grew respectively by 27 and twelve per cent, and the other 21 cities of Greater Porto Alegre, without Porto Alegre, grew by 71 and 59 per cent (Giacomoni 1993, 106). This

demonstrates that migrants went mostly to other Greater Porto Alegre cities and not to Porto Alegre itself. Although the best job opportunities, in the formal or informal sector, were in Porto Alegre, high residential costs induced people to settle in other cities of the region. Additionally, during the last two decades, at the same time as the economic importance of services and commerce in Porto Alegre increased, Greater Porto Alegre's cities became important industrial centres, attracting enterprises and labour force. Those who stayed in Porto Alegre increasingly dwelled in houses they built themselves in suburban or slum areas less valued in the urban housing market (Giacomoni 1993, 106; Carrion 1989, 233-47).

Graph 5.2 - Percentage of Porto Alegre's Population Living in Illegally Occupied Areas - 1981/1991



SOURCES: Giacomoni, James, *A Comunidade como Instância Executora do Planejamento: o Caso do "Orçamento Participativo" de Porto Alegre* (PPGA - Departamento de Ciências Administrativas da Faculdade de Ciências Econômicas - UFRGS, Porto Alegre, 1993), 107, photocopied.

Fundação Instituto Brasileiro de Geografia e Estatística, *Anuário Estatístico do Brasil* (Rio de Janeiro, IBGE, 1993), 208.

In 1991, the population of Porto Alegre was 1,263,239 (FIBGE 1993, 208). In 1980, it was the fifth biggest state capital in Brazil; in 1991, it became the ninth. Hence, during the last decade, the rate of growth of Porto Alegre's population was inferior not only to other cities of Greater Porto Alegre but also to other state capitals. Nevertheless, if during the period 1981 to 1991 Porto Alegre's urban population as a whole grew by eleven per cent, the population living in illegally occupied areas grew by 114 per cent. In these areas, residents do not have legal

ownership of the land or domicile and normally, but not necessarily, have a very precarious urban infrastructure (Giacomoni 1993, 106-7). They are usually located in slum areas. Each slum area is called a *vila* in Porto Alegre, in the same sense as other Brazilian regions employ the word *favela*. In 1981, as can be seen in Graph 5.2, there were 182,480 inhabitants living in illegally occupied areas, representing sixteen per cent of Porto Alegre's total population. In 1991, there were 391,501 inhabitants living in these areas, representing 31 per cent of Porto Alegre's total population. At the same time, in 1981, there were 163 *vilas* in Porto Alegre, increasing to 263 in 1991 (Giacomoni 1993, 106).

Data on urban infrastructure, and social and health indicators often refer to averages and it was difficult to obtain information about the population living in illegally occupied areas in Porto Alegre. Even so, it was possible to gather some information. For example, 95 per cent of the population had access to drinking water, above the Brazilian average of 81 per cent (Secretaria Municipal de Saúde e Serviço Social 1991, 2; Comissão Interministerial para a Preparação da Conferência das Nações Unidas sobre Meio Ambiente e Desenvolvimento 1991, 21). Nevertheless, in some slum areas of the city this access was restricted to public water taps or even to mobile tanks distributing water some days a week. In 1990, sewage facilities reached around 45 per cent of the population, slightly above the national average of 36 per cent (Secretaria Municipal de Saúde e Serviço Social 1991, 2; Comissão Interministerial para a Preparação da Conferência das Nações Unidas sobre Meio Ambiente e Desenvolvimento 1991, 21). It is reasonable to suppose that, among the regions without sewage facilities, were the illegally occupied areas. There was daily refuse collection in central areas, but in other areas it was on alternate days only. In some slum areas, nevertheless, very narrow and irregular streets did not allow access to lorries. In these cases, the litter was collected by small tractors and placed in containers for disposal later (Secretaria Municipal de Saúde e Serviço Social 1991, 2).

Social indicators also point to strong social inequalities. *Life expectancy at birth* - the average number of years a new-born baby can be expected to live if current trends of mortality continue (Last 1988, 45) - is usually regarded as an accurate indicator of a given population's quality of life. In 1980, *life expectancy at birth* in Brazil was 60 years while in Porto Alegre, considering the triennium 1979-1981, it was 70 years, men being expected to live, on average, 64 years and women 74 years (FIBGE 1993, 228, Secretaria Municipal de Saúde e Serviço Social 1991, 3). In the same year, in Greater Porto Alegre, people living with or without adequate access to drinking water and sanitation, showed no significant difference in their *life expectancy at birth*, since the indicator reduced from 71 to 67 years. Nevertheless, those born in Porto Alegre, in 1980, in families without access to these facilities, and whose mothers had no

formal education, could expect to live only 63 years (Leite and others n.d., 9-20). So, if the education of poor mothers is added to living without access to drinking water and sanitation, as was often the case for families living in illegally occupied areas, the *life expectancy at birth* would decrease significantly in comparison with the rest of the population.

The rate of *infant mortality* - number of deaths among children less than one year old per 1,000 live births (Last 1988, 65) - is a very sensitive indicator of social conditions and of the quality of health services. Both types of *infant mortality*, neonatal mortality - deaths during the first 28 days of life - and late infant mortality - deaths during the first year of life except the first 28 days - are associated with the socio-economic conditions of life and the quality of health care available to mother and child. Nevertheless, the former is more strongly associated with the quality of health care during pregnancy and birth and the latter with socio-economic living conditions. In 1980, the Brazilian rate of *infant mortality* was 87 deaths per 1,000 live births, while Porto Alegre's was 37 deaths per 1,000 live births. In this city, 70 per cent of deaths occurred in families living in illegally occupied areas, and 30 per cent in families living in regular housing areas (Barcelos and others 1986, 56-61). So, although the *infant mortality rate* was low in Porto Alegre if compared to other Brazilian areas, social inequalities affected the distribution of infant deaths in the city.

During the eighties, Porto Alegre's *infant mortality* rates underwent a significant reduction. In 1989, the rate was 14 deaths per 1,000 live births (Ceccim and others 1990, 48). The reduction in Porto Alegre's rate of *infant mortality* occurred in both neonatal and late infant mortality. This was due possibly to the immunisation and re-hydration campaigns promoted by public health services. It is also probably associated with the extension of refuse collection and drinking water services to slum areas (Secretaria Municipal de Saúde e Serviço Social 1991, 3). There could also have been improvements in women's education in the region. Future studies can explore these possibilities, since these data have not yet been systematically analysed. Nevertheless, it is certain that, in the first six months of 1990, the majority of deaths (55 per cent) occurred during the first 28 days of life and the main group of causes of *infant mortality* were perinatal conditions (Secretaria Municipal de Saúde e Serviço Social 1991, 3). It indicates that lack of adequate care for mother and child during pregnancy and birth could be associated with these deaths.

In general terms, Porto Alegre has better social indicators than the national average. However, social inequalities seem to have reduced life expectancy for the one-third of the population living in illegally occupied areas and to have brought about limited access to health

care. The population living in these areas usually had their interests represented by urban social movements, and from these movements came most of the user representatives taking part in the municipal health commission between 1985 and 1991. It is thus reasonable to suppose that these inequalities motivated the involvement of their representatives in the commission.

5.3.2. Porto Alegre's Health Services

The municipal health commissions could in theory exercise power over Porto Alegre's health services, whose general features and evolution were presented in the last chapter. As in the rest of the country, by 1990, there were in Porto Alegre municipal, state and federal networks of out-patient and hospital services that, according to legal provisions, should be unified and comprehensive. These services were much more integrated than before 1985, when the **AIS** covenant was signed, but complete integration through a genuine municipalisation process was, until late 1993, only a proposal. As seen before, until 1993, no health services in Brazilian state capitals were municipalised. Nevertheless, since 1988, after the **SUDS** programme was issued, nearly all federal services went under the direct management of the state health secretariat. By 1990, there were also private services in Porto Alegre, encompassing autonomous physicians and dentists, hospitals, clinics, health maintenance organisations and services for the support of diagnoses and health recuperation. The lack of governmental control or regulation of private and liberal practices makes it difficult to paint a complete picture of the health services in Porto Alegre during the late eighties and early nineties. Even so, it is possible to identify the main private organisations providing health care in the city, as well as to have an idea about these organisations' relations with the public sector.

As can be observed in Table 5.2, the biggest **out-patient network** in the city was made up of government-owned units. In 1990, there were in the city 30 small and 43 medium-sized out-patient health units, offering primary health care and general clinics. Some medium-sized units also provided specialised care in paediatrics and gynaecology-obstetrics as well as promoting public health actions. Nearly all of them were located in impoverished areas of the city, mainly near illegally occupied areas. The small ones were all under the management of the state health secretariat, while the medium ones were under federal, state or municipal management. They would be open between eight and ten hours a day from Monday to Friday. It is well known, however, that physicians and dentists worked fewer hours than their job contracts established, allowing them to have alternative jobs or activities. Poorly qualified

nurses kept the units open the rest of the time, offering a reduced range of health services, such as immunisations and information about the unit or other health services (Rosa 1989, 76-93).

Table 5.2 - Types of Government-Owned Out-Patient Health Units in Porto Alegre - 1990

Type and Number of Units	Statistical Function	Area in m²	Physicians	Dentists	Nurses	Other Profess.	Assistant Nurses	Daily Open Hours
30 **Small PHC**	average	49	2	0	0	0	2	9
Primary h. care, general	median	40	1	0	0	0	1	8
clinics	mode	40	1	0	0	0	1	8
43 **Medium PHC**	average	192	6	1	1	1	7	10
Primary h. care, general clinics,	median	150	6	1	1	1	6	10
Some: specialities and pub.	mode	140	7	0	1	1	7	10
8 **Medium Specialised**	average	1151	16	3	2	3	21	10
Specialities, Some: primary h.	median	890	14	3	2	3	16	10
care and public health	mode	-	15	4	1	0	14	12
3 **Large Specialised**	average	1159	118	16	8	16	73	12
Specialities, Some: primary h.	median	1215	107	15	7	17	83	12
care and public health	mode	-	-	-	-	-	-	12
3 **1 or 2 Specialisms**	average	1250	27	0	3	8	17	12
Specialities	median	1419	21	0	3	7	16	12
	mode	-	-	0	-	7	-	12
1 **Emergency**	-		43	10	6	1	48	24

SOURCE: Secretaria Municipal de Saúde e Serviço Social, *Plano Municipal de Saúde de Porto Alegre* (Porto Alegre, Prefeitura Municipal de Porto Alegre, 1991), 19-46, photocopied.

In Porto Alegre there were also eight medium-sized and three large specialised out-patient health units and there were three out-patient health units offering one or two specialisms (Secretaria Municipal de Saúde e Serviço Social 1991, 19-46). Most of them also offered primary health care, but they mainly, and in some cases exclusively, provided specialised care. Although some of these units were located in poor areas of the city, most of them were not. Considering the total of fourteen units, seven were located in the central area of the city and most of the others were located at a distance from illegally occupied housing areas. Most of them, nine out of fourteen, were previously social security system units, which by 1990, were already under the management of the state secretariat of heath. Out of the five remaining, four were under the administration of the state health secretariat and one under the command of the municipal health secretariat. Most of them were open from ten to twelve hours a day from Monday to Friday. Similarly, as in non specialised units, physicians and dentists in specialised units did not work the hours their contracts stipulated. The number of professionals in specialised units thus did not represent actual availability for users.

There was in the city one municipal out-patient unit providing emergency care. It was located in district four, inside a slum area, called Vila Cruzeiro, in the same building as the second biggest specialised out-patient unit in the city. The service was open 24 hours a day. The

installation of this unit in 1988 was due to the strong pressure of the users in the region, whose urban social movements were the most mobilised by health issues in Porto Alegre.

Apart from these federal, state and municipal services, there were in the city out-patient units, most of them providing emergency care, located in federal or state hospitals and in the main non-profit making and profit making hospitals. The latter hospital units had been previously contracted to the social security system and, in 1990, were contracted by the state health secretariat on behalf of the United Health System (SUS). In the same year, the SUS contracted around 600 private services in Porto Alegre, which provided health care in clinics, dental care and diagnosis and therapeutic services (Secretaria Municipal de Saúde e Serviço Social 1991, 5-6).

Although there was no information on the total number of out-patient attendances provided in Porto Alegre, it is possible to use the Brazilian Ministry of Health ideal parameter to appraise the relative importance of the provision of governmental units. This parameter established that there should be two attendances-per inhabitant-per year, these being 65 per cent of the total number of attendances at the basic specialities, which are general clinics, obstetrics, gynaecology, paediatrics and surgery (Secretaria Municipal de Saúde e Serviço Social 1991, 5). Considering the population of Porto Alegre in 1990 - 1,263,239 inhabitants - there was a theoretical demand for 2,526,478 attendances, with 1,642,209 in basic specialisms. There was no reliable information on the type of the attendances, whether in clinics or specialities. The information available referred to government-owned out-patient units without specification on the type of attendance. These units, in 1989, catered for 933,667 attendances, representing 36 per cent of the total of those theoretically needed by Porto Alegre's population in the basic specialist services. Although the area and personnel of non hospital out-patient units were considerable, they seemed to be offering much less care than they should (Secretaria Municipal de Saúde e Serviço Social 1991, 5). The capacity of these units to effectively solve health problems were hindered by lack of equipment, medicine and by recurrent problems related to the absence of physicians and dentists. This has generated a demand for health care from the emergency units of the main Porto Alegre hospitals, jeopardising the capacity of these services to attend urgent cases. In 1989, two important hospitals, the Hospital de Clínicas, the most complex Porto Alegre hospital, and the Santa Casa de Misericórdia, an important non-profit making group of six hospitals, affirmed that respectively 75 and 62 per cent of the cases their emergency services attended were ordinary health problems (Secretaria Municipal de Saúde e Serviço Social 1991, 5).

By 1990, there were eleven **government hospitals** in the city (Secretaria Municipal de Saúde e Serviço Social 1991, 4-5). There was one federal hospital, the Hospital de Clínicas de Porto Alegre, which was administratively linked to the main federal university in the state and was a referral point for complex health care for the Southern region population. There was one municipal highly specialised hospital, treating trauma cases in Porto Alegre, Rio Grande do Sul and other Southern region states. It is regarded as "the" city's hospital for emergency cases, caused by accidents or violence. There were also nine hospitals under state government management, five of them previous social security system hospitals (Secretaria Municipal de Saúde e Serviço Social 1991, 4-5). Among the hospitals managed by the state health secretariat, seven were specialised hospitals, one general and one a large hospital attending complex cases from Porto Alegre and from the rest of the state.

There were also 53 **private hospitals** in the city. A non-profit making Catholic organisation, the Santa Casa de Misericórdia group owned six general and specialised hospitals. This organisation was closely linked to the federal university and to the state health secretariat. Among the other 47 private hospitals, there were sixteen contracted by the SUS, and the others were purely private. Most of them were small clinics attending the elderly (Secretaria Municipal de Saúde e Serviço Social 1991, 5-6).

In 1990, taking into account all government owned and privately contracted hospitals, there were in the city 7,455 hospital beds, 68 per cent (5,088) for clinics, paediatrics, obstetrics and surgery (Secretaria Municipal de Saúde e Serviço Social 1991, 6). Therefore, excluding the "pure" private hospital beds, Porto Alegre had, in 1990, six hospital beds per 1,000 inhabitants, exceeding by 50 per cent the ideal parameter of four beds per 1,000 inhabitants recommended by the World Health Organisation (Secretaria Municipal de Saúde e Serviço Social 1990, 13). Nevertheless, there were constant complaints about difficulties of access to hospital beds in the city.

There are three main reasons for this apparent paradox. Firstly, many of Porto Alegre's hospitals, the complex or specialised ones, were referral points for the state or even for the entire Southern region population. The way the process of the municipalisation of health services has been carried out in many of Rio Grande do Sul's cities enabled many city halls to invest in ambulances and not in improving the quality of their services. This "transport-therapy" (Respondent/5 1992) seems to have increased the overload on Porto Alegre's hospitals. In fact, in 1990, around 48 per cent of Porto Alegre's public beds were occupied by residents of other Rio Grande do Sul's cities, reducing the actual availability of beds to three per 1,000 inhabitants

(Secretaria Municipal de Saúde e Serviço Social 1991, 6). Secondly, patients paying privately or through private insurance contracts had priority. Hospitals or professionals would ask patients to pay additional charges to obtain beds and treatment. In this sense, the lack of beds could mean financial barriers for having access to services that by law should have been universal and free of charge. Thirdly, although for basic specialities there seemed to be enough beds, there was a lack of beds for some specialisms such as heart disease, malign neoplasm, respectively the first and second causes of death in the city, and AIDS (Secretaria Municipal de Saúde e Serviço Social 1991, 6).

As was seen in the last chapter, the new constitution and health laws transferred to municipalities the responsibility for all **public health** functions, retaining at the national level the functions of overall planning, regulation and control. Even considering that by 1990 Porto Alegre's health services had not yet been municipalised, some public health activities, which had been the responsibility of the state health secretariat, had been transferred to the municipal health secretariat. This was so, for example, in the case of the service for prevention and control of zoonoses. Nevertheless, the majority of epidemiological and sanitary activities related to regulation, notification, prevention and control of diseases have remained in the hands of the state health secretariat (Secretaria Municipal de Saúde e Serviço Social 1991, 4-5).

Hence, to inequalities in housing, sanitation and household income were added differences in access to health care. On the one hand, enduring deficiencies in the public out-patient network made people seek care in the emergency services of hospitals, undermining the capacity of these services for dealing with very urgent and complex cases. On the other hand, there was the process of health service municipalisation. The recurrent delay in Porto Alegre's health services municipalisation has hindered attempts at their reorganisation because, since 1987, it has been said to be on the verge of happening. The municipalisation of other cities' health services in the state, without consistent guidelines and supervision of the process, has resulted in an additional burden on already overloaded Porto Alegre hospitals, since cases that could have been treated locally were sent to the capital. The process of universalising access to publicly financed health services, during the last two decades, has created, in fact, a disguised two tier system: one offering easy access and better care for middle class and qualified workers who were able to finance it directly through private insurance companies, entitled to use health maintenance organisations' services or other special services; and another, providing precarious and sometimes inaccessible health care for those unable to pay for it. Most people who rely only on the second type of health care live in low income families, in illegally occupied urban areas, lacking urban infrastructure, with the worst social indicators in the city.

As in other large Brazilian urban centres, during the last two decades, people living in Porto Alegre's deprived areas have created associations to organise and represent their interests when facing other interest groups and governmental agencies. Improvement of health care has been on their agenda together with other issues. When, in 1985, participatory channels were opened in the health sector, these organisations supported their representatives' involvement. Since most of the people they represented only used public health services, they were very interested in making real the formal right to have access to universal, comprehensive and decentralised health services.

5.3.3. Porto Alegre's Urban Social Movements

As has been seen, an important pre-condition for effective user representatives' involvement in an institutional participatory process is the existence of user organisations which can: (1) discuss previously polemical issues, preparing representatives to face decisions to be taken in the forum; (2) help to overcome lack of expertise, re-deploying the organisation's staff or developing connections with non governmental organisations specialised in supporting social or trade union movements; (3) give legitimacy to these representatives since they supposedly represent the membership of their organisations. Porto Alegre was home to professional associations, the biggest trades unions in the state, the state's federations of trade unions and trade unions national confederations, such as the CUT and Central Geral dos Trabalhadores (hereafter **CGT**). Moreover, there were urban social organisations that would support the most prominent and enduring user representatives in Porto Alegre's municipal health commission.

Since the thirties there had been residential associations (associações de moradores) and neighbourhood associations (sociedades de amigos de bairros) in Porto Alegre (Baierle 1992, 97). Nevertheless, most of them were created during the fifties, not only in Porto Alegre but throughout the biggest cities of the country. These associations adopted clientelistic practices; they did not mobilise or try to extend their membership, neither did they confront governmental policies. Rather, they sought informal ways of influencing public officials or governmental agencies, trying to obtain advantages especially for dwellers supporting their policies (Baierle 1992, 97-105). They were created during the populist Vargas government, when the pension institutes had built many working class housing complexes. Associations were created to represent residents' interests, but mainly to mediate in the relationship between the Brazilian Labour Party (PTB) and residents, helping the party to select those who would have preference in the allocation of the low price, long-term financed houses of the complexes. The central criterion for selection was the degree of loyalty to or good connections with party

leaders or activists (Baierle 1992, 97-105). During the seventies and eighties, due to the high standard of urban facilities in these complexes, such as sanitation, transport and electricity, most working class residents had gradually sold their homes and left the region, going to illegally occupied areas or to regions outside Porto Alegre's territorial limits. During the eighties, residential associations, created in these circumstances, could still be found in middle class and in poor residential areas. They remained connected to populist politicians, especially those of the Democratic Labour Party (PDT), the party that inherited the Brazilian Labour Party (PTB) populist tradition.

In the late seventies new urban social organisations could be found in Porto Alegre. Their line of action prioritised confrontation with government. They distinguished themselves from clientelistic associations that used to agree with government policies (Baierle 1992, 118). The mobilisation of residents to obtain land, better urban infrastructure and services was seen by their leaders and influential advisors as a tool for transforming the capitalist structure of society (Baierle 1992, 120). In the late sixties, the authoritarian regime had separated housing policy from the social security system, creating a national bank responsible for housing policies, the National Housing Bank (Banco Nacional da Habitação). Housing policies promoted by this bank, during the seventies, mostly benefited middle class social sectors. Municipal and state agencies involved in housing issues had to promote policies determined by the federal government. The main actions of Porto Alegre's department of housing aimed at removing the poor population from central areas, relocating them in the periphery of the city. Initial perplexity in the face of compulsory relocation was replaced by defensive action resisting removal, organising the occupation of new areas, searching for political solutions and denouncing violence to the press. These actions gave birth to new residential associations, community associations, mothers' clubs and other similar organisations that have proliferated in the slum areas of Porto Alegre since the late seventies (Baierle 1992, 113). During the early eighties, the liberalisation of the Brazilian political system allowed them to represent the interest of those living in these areas, also opening up opportunities to defy the military regime, together with the trade union movement and other social forces seeking to extend the process of political democratisation in Brazil.

In the early eighties, organisations such as mothers' clubs, youth groups and community nurseries, which became central for the new urban social movement in Porto Alegre, were usually created with the help of government agencies. Often officials, promoting policies in areas such as health or housing, were personally critical of the dictatorship and stimulated activities which challenged the regime. As in other large cities in Brazil, in Porto Alegre, there

were groups of professionals, religious and political activists, which had links with and influence over urban social organisations. There were also Catholic activists, priests and nuns, as well as left wing militants of opposition political parties. There were Democratic Labour Party (PDT) militants, whose left wing sectors extended the party's influence beyond the traditional clientelistic forms of interest group organisation, there were activists from communist parties, from left wing factions of the Party of the Brazilian Democratic Movement (PMDB), from the recently created Workers Party (PT), and there were representatives of non-governmental organisations such as FASE, CAMP and CIDADE (Baierle 1992, 123-4). The actions of these "external" actors, together with the growing dissatisfaction with governmental policies, created what Baierle called a *culture of rights* (1992, 125). During the eighties, a growing number of leaders, representing those living in the slum areas of Porto Alegre, demanded from politicians and governments what they gradually started to regard as their legitimate right.

In the early eighties, leaders and activists of these new types of association contested the control of organisations that unified the urban social movements of Porto Alegre and of the state. They disputed and obtained representation in the directorate of the Rio Grande do Sul Federation of Community and Neighbourhood Associations (Federação Riograndense de Associações Comunitárias e Amigos de Bairro hereafter **FRACAB**). In 1983, they led the creation and the first directorate of the Porto Alegre Union of Residential Associations (União das Associações de Moradores de Porto Alegre hereafter **UAMPA**), an organisation which brought together residential, community and neighbourhood associations as well as other associations of Porto Alegre's urban social movements (Baierle 1992, 118, 157-97).

Considering the social indicators of those living in illegally occupied areas and their difficulties of access to health services, it is not surprising that the urban social movement leaders representing them were the most active user representatives in the municipal health commission of Porto Alegre. Nevertheless, until 1985, apart from isolated campaigns among the ten health districts in the city, only in health district four had the urban social organisations placed health issues as priorities on their political agenda. There were mobilisations for better health services in district four before and after 1985. In 1980, residential movement leaders, together with Catholic activists, health professionals supporting the Brazilian health system reform and militants of left wing political parties, created a health commission in the area (Rosa 1989, 94; Respondent/7 1992; Respondent/8 1992; Respondent/23 1992). The commission created in 1980 in district four area at first had no institutional links. It promoted protests and pressured for better and new services in the region (Rosa 1989, 94-7; Respondent/7 1992). In

1981 and 1982, the state secretary of health, who was running for governor of the state of Rio Grande do Sul, opened 26 new small or medium primary health care units in Porto Alegre, nearly doubling the number of state government units. Not surprisingly, 30 per cent of these were opened inside the most populated slum area of district four (Cattani and others 1988, 71-81). After 1985, the commission was transformed into a local health commission institutionally linked to the municipal health commission, which was created in the same year. User representatives of this district were the most active and regular participants in the municipal health commission, as will be seen in the following chapters. During the late eighties, some health professionals, who had participated in the commission since its creation, integrated the department of health of the trade union confederation CUT and declared their support for the Workers Party (PT). They would become CUT representatives in the municipal commission in 1987 and 1988 and, from 1989, when the Workers Party (PT) took office in the municipal government, some of them became directors of the municipal health secretariat.

During the second half of the eighties, other local health commissions would became active, as will be seen in the following chapters. The municipal health commission created in 1985 gradually became the central locus of political articulation and interest representation for popular organisations aiming at improvements in the quality of the health service or at mobilising people for broader social changes, through the politicisation of health issues. Other interest groups in the health sector also regarded the municipal commission as the main arena for establishing political alliances, opposing or supporting policies and exercising influence over health policies. Nevertheless, the possibility of constructing a forum where users could influence policy in the health sector was the real novelty. During the second part of the decade, user representatives of nearly all regions of Porto Alegre participated in the commission, mainly through a network of local commissions active to varying degrees depending on the regions and period.

5.4. Summing Up

In the early nineties, Southern region cities had the highest percentage of municipal health councils in comparison with other regions of the country. They also had the highest proportion of councils with internal regulations establishing that they should have deliberative power over municipal health policies, and that these formally deliberative councils should have parity of representation between user representatives and all other groups of representatives together. Although it does not guarantee that there was authentic user participation in these fora, it does indicate the potential for such power being experienced.

The data also indicate that cities with over five hundred thousand inhabitants had more municipal health fora than smaller towns. There was also a tendency for the percentage of municipal health fora working regularly to increase when the urban population was larger. When the concept of "size" of city takes into account population and city income, it appears that large cities tended to have an institutionalised political life; public health professionals used to be articulated both with political parties and social movements; and urban social movements were organised enough to propose alternative policies to governments. The complexity of the social and political life of large cities offered the potential to make user representative participation feasible in municipal health commissions.

When user organisations already exist within a user population, as in the case of large Brazilian cities, user representatives can take part in statutory participatory fora in a relatively sustained manner. User organisations were mainly residential associations and trade unions, which were not created to deal exclusively or even centrally with health issues. Nevertheless, residential associations tended to participate more than trade unions in municipal health fora.

Trade union representatives, when taking part in municipal health fora, were mostly concerned with issues related to health and safety at work. Members of the most powerful trade unions usually have access to health services through special insurance arrangements. Since issues related to publicly financed health care did not mobilise the members and leaders of powerful trade unions, health professionals could exercise strong influence on the views about health policy of trade union confederations. Residential associations, even in big cities, did not have staff large enough to enable them to have representatives with some degree of expertise in many subjects. Nevertheless, they could build up connections with professionals identified with residential associations' claims for better public services and for the empowerment of health service users.

In the late eighties, the municipal health commissions gradually became the centre of political articulation between the popular health movement and other political and social actors. During the same period, especially in large cities, political parties became more influential in Brazilian political life, creating cleavages within trade union and residential movements and among professionals aiming at the reform of the Brazilian health system. It affected the way user representatives - coming from urban social movements - participated in municipal health fora as well as the way professionals - as health professional representatives, or health authorities - positioned themselves for or against the participation of user representatives in these fora.

Although in the Southern region there were more municipal health councils per city than in other regions of the country, and most of these fora had internal regulations favouring user participation, there have been no studies focusing on these regional fora or user representatives' participation in them. The case of the municipal health commission of Porto Alegre was selected because it is a large city, having social and political characteristics that can make user representatives' participation feasible, and because: (1) The commission has worked regularly for seven years, making it possible to follow the dynamic of the commission's activities during a period when the Brazilian health system underwent remarkable changes. (2) The concentration of civil society organisation in cities can enable user representatives to obtain sustained support from their organisations and can facilitate follow-up alliances or confrontations between these representatives and other social actors. (3) The variety of political parties that has taken office in municipal, state and federal governments, during the period 1985 to 1991, makes it possible to distinguish health authorities with different positions on user participation, ranging from opposition to support. It makes it possible to verify the influence health authorities can have in hindering or stimulating user participation in the forum. (4) The concentration of very active members of both the medical profession and the Brazilian health system reformers, could facilitate the analysis of the relationship between them and user representatives.

During the seventies and the eighties, housing standards and sanitation in Porto Alegre were above the Brazilian average. Social indicators, such as life expectancy at birth, infant mortality and access to formal education for men and women, were better than the Brazilian average. Nevertheless, social inequalities increased the risk of premature death among those low income families living in areas with the worst urban infrastructure in the city. Between 1981 and 1991, the population of these areas grew by 114 per cent, compared with the city average of eleven per cent. These growing populations not only were affected by poor standards of housing, sanitation and low household income, but had limited access to deficient public health services.

Reform has created a two-tier health system: one offering easy access to, and better care for, middle class and qualified workers who were able to pay for care directly or through private insurance companies, or had the right to use special services; and another providing precarious, and sometimes inaccessible, health care for those unable to pay for it. People living in illegally occupied areas, with the worst social indicators in the city, were those able to rely only on the second type of health care.

During the last two decades, people living in Porto Alegre's most deprived areas have created new types of associations to organise and represent their interests. These organisations, instead of adopting traditional clientelistic practices, have promoted membership mobilisation and confronted governmental agencies and politicians not identified with their movement. Improvements in the quality of health care were on their political agenda together with other issues, but were promoted to varying degrees depending on the regions of the city or the period. During the late eighties, when participatory channels opened in the health sector, many of these organisations supported the involvement of their representatives.

Chapter 6

User Involvement in the Municipal Health Commission of Porto Alegre - 1985/1991

6.1. Introduction

This chapter will describe the dependent variable of this research, that is, user involvement in the municipal health commission of Porto Alegre. Two main indicators of users' involvement were considered in this description. One is *the number and types of users attending meetings of the plenary*, which is the deliberative forum of the commission. The physical presence of users at these meetings did not explain how they were really involved in the activities of the commission. The ways in which they take part can be appraised by analysing the second indicator of their involvement: *the types of involvement of user representatives in the decision-making process of the commission.* Before looking at these two indicators, it was necessary to understand the environment in which they could develop. Hence, the set of rules that regulated the work of the commission and its fora were examined.

Following this is an analysis of the first of the two indicators of the modes of participation and the intensity of the involvement of users within the commission: *the number and types of users attending plenary meetings.* Everyone attending plenary meetings had to sign an attendance list as well as stating the name of the institution or organisation s/he came from. This latter piece of information made it possible to classify the vast majority (95 per cent) of those present at these meetings into four major categories: (1) **providers**: were those coming from health institutions, independently of being health professionals, health workers or senior managers; (2) **health professionals or health workers**: were those coming from associations

or trade unions of health professionals or of health workers; (3) **users**: were those coming from organisations such as residential, community or neighbourhood associations, trade unions representing non-health sector workers, confederations of trade unions or confederations of organisations of urban social movements; (4) **others**: were those who could not be classified within the previous three categories.

To identify whether user participants came from centralised or decentralised organisations they were further classified into four major categories according to the type of organisation: (1) *large* organisations, such as confederations of trade unions or of urban social movement organisations; (2) *local* urban organisations, such as residential, community and neighbourhood associations; (3) *trade unions*, excluding those representing health sector professionals and workers; (4) *others*, such as associations of sufferers of particular diseases - AIDS, diabetics or haemophiliacs - or associations concerned with environmental issues.

Local organisations were situated in particular areas of the city. By 1991, Porto Alegre was divided into eleven health districts, each one corresponding to one local health commission. Users attending plenary meetings were usually participants in the local health commission or in some urban organisation in the area. Since the location of grassroots organisations was identified, it was possible to distribute users of these organisations according to each health district. This further classification helped to verify whether users from different regions of the city were uniformly involved with the activities of the municipal health commission.

Following this, the second indicator of the involvement of users was analysed: *types of involvement of user representatives in the decision-making process of the commission.* This analysis stresses the participation of users in the processes of agenda formation and of decision-making. Strong indications of their participation in both processes can be drawn from an examination of the commission's regulations, as well as from the verification of whether users participated in, or had control over, the executive and technical divisions of the commission. The results of such analyses were used to distinguish the types of involvement which user representatives enjoyed in the decision-making process. The types of involvement that were mainly taken into account were those presented in chapter two: (1) **non-participation**, (2) **manipulation**, (3) **delegation**, (4) **negotiation**, (5) **participation**. Each sub-period was defined by the existence of particular patterns of user representative involvement in the decision-making process of the commission. Table 6.1 summarises the main elements of the description,

given in this chapter, of the two indicator-variables of the involvement of users within the municipal health commission of Porto Alegre by each sub-period.

Table 6.1 - Attendance of Users at Plenary Meetings and Involvement of User Representatives in the Decision-Making Process by Sub-Periods - Porto Alegre - CIMS - 1985/1991

Periods	Attendance of Users at Plenary Meetings	Involvement of User Representatives in the Decision-Making Process
Sep 1985 to 11 May 1987	**.mostly weak** 82 meetings: 69 (56) per cent 0-2 users 18 (15) per cent 3-7 users 14 (11) per cent 8 or more users	**.Non-participation** .no formal internal regulations .no co-ordinating committee .decisions/agenda formation: health institutions, mostly municipal health authorities
12 May 1987 to Dec 1988	**.mostly strong** 46 meetings: 61 (28) per cent 8 or more users 35 (16) per cent 3-7 users 4 (2) per cent 0-2 users	**.Negotiation** .internal regulations .co-ordinating committee: -with participation of user representatives .decisions/agenda formation: -mostly negotiated among municipal health authorities, other health institutions, representatives of users and representatives of health professionals or health workers
Jan 1989 to Nov 1990	**.mostly moderate** 49 meetings: 55 (27) per cent 3-7 users 35 (17) per cent 8 or more users 10 (5) per cent 0-2 users	**.Participation and Delegation** .internal regulations .co-ordinating committee: -1989: working with participation of user representatives -1990: inactive .decisions/agenda formation: -during 1989 mostly agreement among municipal health authorities, other health institutions and representatives of users and representatives of non medical health professionals or health workers -during 1990 mostly municipal health authorities and other health institutions, some user representatives withdrew from the commission delegating to municipal health authorities power over decisions -during both years representatives of private providers and of the medical profession were almost excluded from the process of agenda formation and had minimal participation in decisions
Dec 1990 to Dec 1991	**.mostly strong** 29 meetings: 93 (27) per cent 8 or more users 7 (2) per cent 3-7 users	**.Participation** .internal regulations .co-ordinating committee: -with participation of user representatives .decisions/agenda formation: -mostly agreement among municipal health authorities, other health institutions and representatives of users and representatives of non medical health professionals or health workers -private providers and members of the medical profession were almost excluded from the process of agenda formation and had minimal participation in decisions

6.2. Organisation and Rules of Work

The municipal health commission of Porto Alegre was created in September of 1985, when the municipal government signed an agreement with the state AIS covenant (CIMS 1985,

2/9). The agreement allowed the transfer of financial resources from the social security system to the municipal health secretariat. Following **AIS** guidelines, participants in the first plenary meeting of the commission had established that the plenary should have representatives of the Ministry of Health, Ministry of Education, of the INAMPS, and representatives of the state and municipal health secretariats. They also agreed that the co-ordinator of the commission should be the municipal secretary of health (CIMS 1985, 2/9). It was established that the forum could invite other organisations to participate, depending on the agenda of the commission (CIMS 1985, 9/9).

The **AIS** covenant stimulated the creation of local health commissions (**CLIS**). In 1980, a covenant between INAMPS and the state health secretariat had proposed the division of the territorial area of Porto Alegre into ten health districts. Since then, in each district, health institutions with services there had been meetings, aiming at the integration of planning and management. By 1986, districts two, three, ten, and four were the most integrated (Respondent/CLIS2 1993; Respondent/CLIS3 1993; Respondent/CLIS4 1993; Respondent/CLIS10 1993; Respondent/15 1992). Nevertheless, users were only occasionally involved in the meetings of the first three districts. The exception was district four. In 1980, in this area, an initial working party for institutional integration ended up joining the independent health commission created by the union of residential and community associations of the region: the União de Vilas Zona Sul. Since then, in this region, there has been a close relationship between urban social movement activists and public health professionals working there in out-patient units of the state health secretariat.

Between September 1985 and August 1987, there were no internal regulations guiding the work of the commission. The commission followed vague guidelines proposed by the federal health authorities and occasional rules established by the representatives of health institutions taking part in plenary meetings. The **plenary** had to discuss municipal health policies, but its main role was to decide about spending the financial resources transferred from the social security system to the municipal health secretariat. It also had to supervise the accounts relating to the expenditure of these financial resources. The other divisions of the commission were the **technical secretariat** (Secretaria Técnica) and the **inspection commission** (Comissão de Fiscalização). The **technical secretariat** was responsible for technical issues, especially for the preparation of proposals for spending the transferred financial resources. It would also analyse the accounts of the expenditure of these resources. Both the proposals and the analysis of expenditure should subsequently be appraised by the plenary. The secretariat was made up of representatives of the health institutions participating

in the plenary meetings (Secretaria Técnica/CIMS 1985). A provisional **inspection commission** was created in September 1986 (CIMS 1986, 9/9) but there is no register indicating that it had met during this year. In March 1987 it was reactivated, having its internal regulations approved by the plenary in April 1987. The commission was made up of representatives of the Rio Grande do Sul Medical Association (Associação Médica do Rio Grande do Sul), of Rio Grande do Sul Private Hospital Association (Associação de Hospitais do Rio Grande do Sul hereafter **AHRGS**), of the Porto Alegre Union of Residential Associations (União das Associações de Moradores de Porto Alegre hereafter **UAMPA**), of the INAMPS and of the municipal health secretariat (CIMS 1987, 24/3). Its main objective was to verify whether the providers of health care contracted by the INAMPS were following their contract provisions (CIMS 1987, 24/3). The commission would act in response to complaints. The restriction on inspecting only "contractual" matters seems to have created difficulties for the commission, since there were recurrent complaints about the quality of care. The minutes of the commission's meetings demonstrated that it worked more like a bureaucratic formality than as an inspecting commission. Its main task seems to have been to send, when asked, enquires or files to hospital directors or senior government officials (Comissão de Fiscalização/CIMS 1987).

On 12 May 1987, user representatives, especially those from large organisations, led the initiative for the constitution of a working party to draft a proposal of internal regulations (CIMS 1987, 12/5). The party had a majority of four user representatives from large organisations over three institutional representatives. There were two users representing the confederations of urban organisations, UAMPA and FRACAB; two users representing the trade union confederations, CUT and CGT; one representative of the INAMPS, one representative of the state health secretariat and one of the municipal health secretariat (CIMS 1987, 12/5). In July, the plenary established that, during the process of decision-making about internal regulations, fifteen representatives of institutions and organisations should vote. User representatives had eight votes while representatives of health authorities, providers and health professionals had only seven (CIMS 1987, 14/7). On 4 August 1987, after months of intense discussions, the internal regulations were approved (CIMS 1987, 4/8).

The internal regulations (CIMS 1987, 4/8) stated that the municipal health commission would plan, decide and supervise health actions taking place in urban and rural areas of the city. The commission would promote inter-institutional integration as well as the decentralisation of management of health services. It would guarantee universal access to health care aiming at the institution of a comprehensive network of health services. It would have three divisions:

(1) The **plenary**, which would have ultimate power to take decisions. It would evaluate plans for expenditure and accounts related to the financial resources transferred from social security to municipality. The plenary would appraise applications for plenary membership and reports of the inspection commission. It would elect the co-ordinating committee and nominate members for the technical secretariat and for the inspection commission. It had four groups of voting participants. (1) The first should be made up of representatives of the Ministries of Social Security, Education, Health and Labour, as well as representatives of the state and municipal health secretariats. (2) The second group should have two user representatives and one health professional nominated by each local health commission. (3) The third should have representatives of organisations of health sector professionals and workers. (4) The fourth group should have representatives of the trade union confederations, CUT and CGT, and of the confederation of urban social organisations of Porto Alegre, UAMPA. It should also have representatives of the state association of private providers of hospital care, AHRGS, of the state association of non-profit making hospitals, of the municipal legislative chamber's health commission and of the union of rural workers of Porto Alegre (Sindicato dos Trabalhadores Rurais de Porto Alegre).

(2) The **co-ordinating committee** would be responsible for the organisation and co-ordination of the overall work of the municipal commission, establishing the agenda of plenary meetings and representing the forum. It should have seven members, elected by voting members of the plenary. Although it was not required by the internal regulations, the municipal secretary of health was always the co-ordinator of the committee.

(3) The **technical secretariat** would prepare appraisals, plans, projects, proposals, inquiries and reports to help the plenary to make decisions. The members of the **technical secretariat** should be representatives of the Ministry of Health, Ministry of Education, INAMPS, municipal and state health secretariats, whose nomination was approved by the plenary. The plenary should also indicate one to five other members to take part in the secretariat.

The regulations also established that **local health commissions** would participate in the decision-making process, would help to supervise the health care provided and to define health priorities in their respective territorial areas.

During 1987 and 1988, municipal health authorities had reinforced the organisation of local health commissions (Respondent/4 1992). Commissions *six*, *seven*, *eight* and *nine* were created then. During these years, however, only commissions *six* and *nine* worked regularly and had some user involvement (Respondent/15 1992; Respondent/27 1992; Respondent/CLIS9 1993). Others, created before, had weak involvement of users in their activities. This was the

case, for instance, in commissions *one* and *three* (Respondent/CLIS3 1993; Respondent/27 1992). Only commissions *two*, *five*, *four* and *ten*, out of the ten local health commissions formally constituted in the city, met regularly and had constant user involvement in their activities. All of them had their activities supported by public health professionals working in the region, and by urban social movement activists. In health district two, public health professionals, mainly those from the out-patient units linked to the programme of family medicine of the hospital Nossa Senhora da Conceição, stimulated leaders of local urban associations to participate in the commission as a means of improving the provision of health care (Respondent/CLIS2 1993). Local commission *five*, created in 1987, came under the influence of the same group of public health professionals. From the beginning, urban social movement activists from the region were involved in its activities (Respondent/27 1992; Respondent/13 1992). Local commission *four* had enjoyed the constant mobilisation of public health professionals and of activists of urban social movements since the beginning of the decade. During 1987 and 1988, local issues, such as the opening of a 24 hour emergency service in the region, motivated users to participate in the local commission as well as stimulating them to participate in the municipal health commission (Respondent/CLIS4 1993, Respondent/28 1992). Local commission *ten*, created in 1986, would have strong user involvement, especially in 1988. Again, this came about due to the combined initiative of public health professionals, particularly those working in out-patient units, and activists of local urban social movements (Respondent/CLIS10 1993).

In 1989, there were two changes in the organisation of the municipal health commission. One was the withdrawal from the commission of the direct representation of INAMPS (CIMS 1989, 19/10). As a result of the implementation of the **SUDS** programme, during 1988 and 1989 the management of this institute in Rio Grande do Sul was transferred to the state health secretariat, deepening the process of integration and decentralisation of the health system in the state. There were also changes in the **inspection commission**. In June 1988, a new commission made up only of users was nominated by the plenary. Nevertheless, there were always health professionals present when the inspections took place (Respondent/15 1992; Respondent/27 1992). The internal regulations of the commission were modified during 1989 (Comissão de Fiscalização/CIMS 1989). New regulations extended the "jurisdiction" of the commission to all health care provided by any health service in Porto Alegre. The irregularities to be verified could be of any type. It also established that the commission should regularly visit hospitals or out-patient health services. Later it should write a report to be discussed by the plenary, which should seek solutions to irregularities detected by the inspection commission. The new type of commission ended the policy of "hospitals inspecting

themselves", according to a user representative (Respondent/7 1992). During 1988, 1989 and 1990 the commission was very active. Many hospitals contracted by INAMPS as well as other health services had inspection visits (CIMS 1988, 7/1, 6/6, 7/7, 18/8, 27/10, 1/12; CIMS 1989, 5/1, 16/2, 2/3, 4/5, 3/8, 5/10, 19/10, 30/11; CIMS 1990, 18/1, 17/5, 5/7, 19/7, 8/11, 22/11). The INAMPS accepted negative reports of the inspection commission as evidence for cancelling contracts or, at least, for exerting pressure on hospitals to improve their services. The reports of the commission resulted in the suspension of some contracts, which were only revalidated when the reforms had been carried out (Respondent/7 1992; Respondent/11 1992; Respondent/13 1992; Respondent/15 1992).

During 1989 and 1990, **local health commissions** did not work uniformly. Commissions *one*, *seven* and *eight*, which had had problems with their consolidation in previous years, still had difficulties. They had occasional meetings and did not sustain the permanent involvement of users or professionals (Respondent/15 1992; Respondent/27 1992). In local commission *six* there was a deterioration in the relationship between public health professionals working in the area and urban social movement leaders. The main problem was the difficult relationship between these leaders and the director of the main group of out-patient units in the region, the São José do Murialdo complex of the state health secretariat. The director, who took office at the end of 1989, was also the co-ordinator of the local health commission. The works of the local commission relied very much on the facilities and resources provided by these units. The commission relied as well as on the constant support offered by the health professionals of these units and, most of all, by their director (Respondent/10 1992). In commission *five*, during 1990, the public health professionals of out-patient units, linked to the programme of family medicine of the hospital Nossa Senhora da Conceição, reduced their involvement in the commission (Respondent/15 1992). Additionally, the leader of the urban social organisation most involved in the local commission became ill and was forced to withdraw from local and municipal health commissions (Respondent/13 1992).

Two local health commissions worked regularly during 1989 and 1990. One was local commission *four*, which had strong involvement of leaders from the major urban organisations in the region and of many public health professionals working in the area. Some of these professionals, especially those who worked in units of the state health secretariat, became directors of the municipal health secretariat when, in 1989, the Workers' Party (PT) took office in the municipal government. Commission *two* maintained regular meetings, but it developed a "pragmatic" pattern of work. This local commission seemed to be more interested in solving

practical problems in the region than in taking part in broader discussions about the organisation of the health services in the city or about the reform of the system (Respondent/15 1992). Local commissions *three*, *nine* and *ten* consolidated their organisation during 1990. This consolidation was apparently due to the establishment of a solid relationship between the public health professionals working in these regions and the main local leaders of urban social movements (Respondent/15 1992; Respondent/CLIS3 1993).

During 1991, there was no important change in the way the municipal health commission worked. The novelty was the discussion surrounding the bill that, once passed by the legislative chamber of Porto Alegre, would transform the commission into an institutionalised municipal health council. There were many discussions in plenary meetings related to amendments or modifications to the bill proposed by the co-ordinating committee (CIMS 1991, 2/5, 16/5, 21/11). There were also pressures from different interest groups that would have liked to be officially included in the future council. These groups were residential and community associations, trade unions of health professionals and health workers, trade unions confederations, associations of specific disease sufferers, and environmental groups, among others.

During this year nearly all the **local health commissions** were working regularly with user involvement. The exceptions were commission *one*, which has never consolidated its organisation, and *eleven*, which was new and did not have time to firm up its organisation (Respondent/15 1992). Commissions *seven* and *eight*, which had traditionally been weakly organised, worked regularly in this period. Local commission *seven* had intense mobilisation during the period immediately before the first municipal health conference, due to the intense participation of activists of the Workers' Party (PT) (Respondent/15 1992). The involvement of users in commission *eight* was due to the action of public health professionals and urban social movement leaders of the region Menino Deus (Respondent/15 1992). Local health commission *two* maintained its pragmatic method of working. It did not establish a strong relationship with the regional popular council, but its meetings were regular and had intense user involvement (Respondent/15 1992). In local health commissions *four*, *three*, *nine* and *ten* there was intense user involvement. Regular user participants in these local health commissions helped to consolidate the popular councils in their respective regions (Respondent/28 1992, Respondent/CLIS3 1993, Respondent/CLIS9 1993, Respondent/CLIS10 1993). At the same time, urban social movement activists in these regions participated in or supported the activities of these local health commissions. Both organisations, together with others, would also articulate the demands and propositions to be presented during the assemblies of the

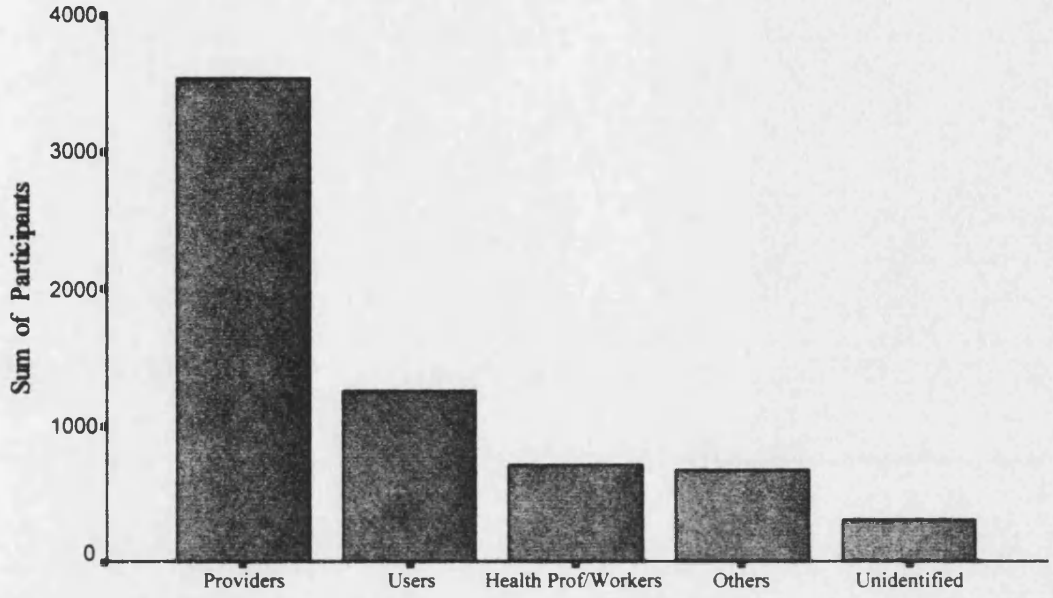
Participatory Budget, which had been created by the Workers' Party (PT) municipal administration, as will be seen later in this chapter (Respondent/15 1992).

Two local health commissions experienced a revival during 1991. One was local commission *five*, whose main leader, who had been ill, resumed participation at the same time that new participants became involved. One example of these new participants were representatives of the strong trade union of metal workers of Porto Alegre. Another was health professionals and workers from the biggest specialised health unit of the region, the PAM four (Respondent/15 1992). Local commission *six* was also revived during this period. By the end of 1990, some health professionals and activists of urban social movements in the region proposed that a user should be the co-ordinator of the local health commission. It aimed at undermining the influence of the director of the health unit São José do Murialdo within the health commission. As the proposal was accepted, the election of a user representative to co-ordinate the forum made it easier to establish connections between the commission and the regional popular council of the area, especially because urban social movements in this region had traditionally been very concerned with health issues (Respondent/8 1992; Respondent/10 1992; Respondent/27 1992).

6.3. User Attendance at Plenary Meetings

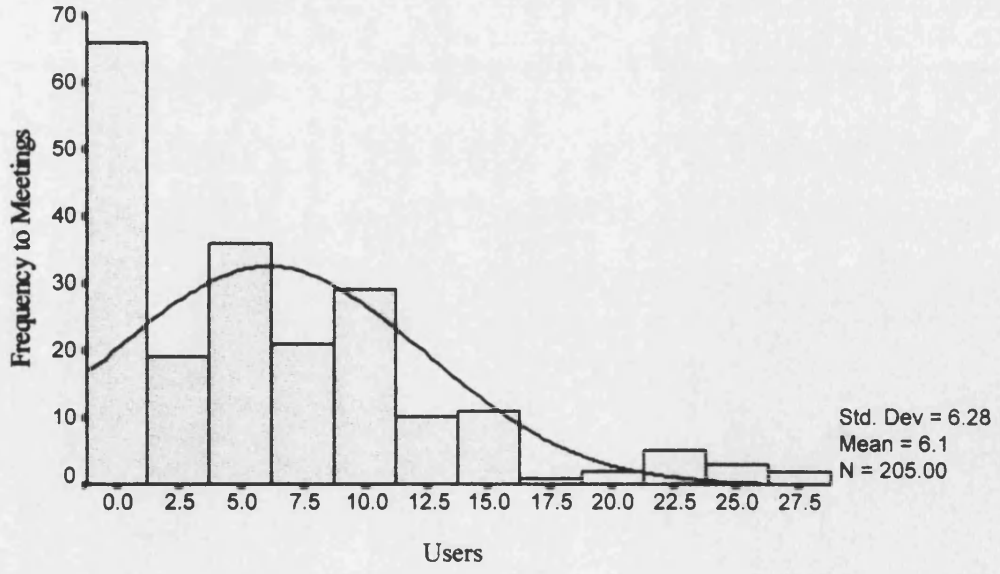
The number and types of users attending plenary meetings does not indicate, on its own, whether *users* had any political influence over the forum. Nevertheless, it is a very objective means of indicating whether *users* were involved at all in the activities of the forum, since it is used in combination with other types of evidence. Graph 6.1 demonstrates that the most frequent types of participant in plenary meetings were *providers*. *Users* came in second place. Graph 6.2 shows that in most meetings there was no *user* present. This graph, however, does not show the evolution of *user* attendance throughout the whole period. Table 6.2 demonstrates that most meetings without the presence of *users* were held in the first years of the commission. During the later years, the number of *users* attending plenary meetings increased. In fact, while in the whole period, that is between 1985 and 1991, there were 61 meetings without the presence of *users*, between September 1985 and 11 May 1987, there were 60 plenary meetings in which *users* were not present. In contrast, between December of 1990 and December of 1991, the minimum number of *users* present at a meeting was five.

Graph 6.1 - Attendance at Plenary Meetings: Mean by Type of Participant - Porto Alegre - CIMS - September 1985 to December 1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, Sep/1985 to Dec/1991), typewritten.

Graph 6.2 - Users' Attendance at Plenary Meetings: Histogram and Normal Curve - Porto Alegre - CIMS - September 1985 to December 1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, Sep/1985 to May/1987), typewritten.

Table 6.2 - Attendance at Plenary Meetings and Evolution of User Attendance by Sub-Period - Porto Alegre - CIMS - September 1985 to December 1991

Period	Number of Meetings	Participants			Evolution of User Attendance *
		Total	Providers	Users	
Sep 1985 to 11 May 1987	82	1198	929 (78 %)	80 (7 %) Mean = 1.00 Most Meetings (Mode) = .00 **60 meetings = .00** Range 0 to 10	Linear Regression b = .035 Rsq = .165 Sigf = .000
12 May 1987 to Dec 1988	46	1859	816 (44 %)	442 (24 %) Mean = 9.609 Most Meetings (Mode) = 5.00 **1 meeting = .00** Range 0 to 24	Linear Regression b = .172 Rsq = .180 Sigf = .003
Jan 1989 to Nov 1990	49	1763	941 (53 %)	330 (18 %) Mean = 6.735 Most Meetings (Mode) = 5.00 **2 meetings = .00** Range 0 to 24	Linear Regression b = .017 Rsq = .003 Sigf = .705
Dec 1990 to Dec 1991	29	1663	856 (51%)	399 (24 %) Mean = 13.759 Most Meetings (Mode) = 9.00 Range 5 to 27	Linear Regression b = .329 Rsq = .214 Sigf = .011

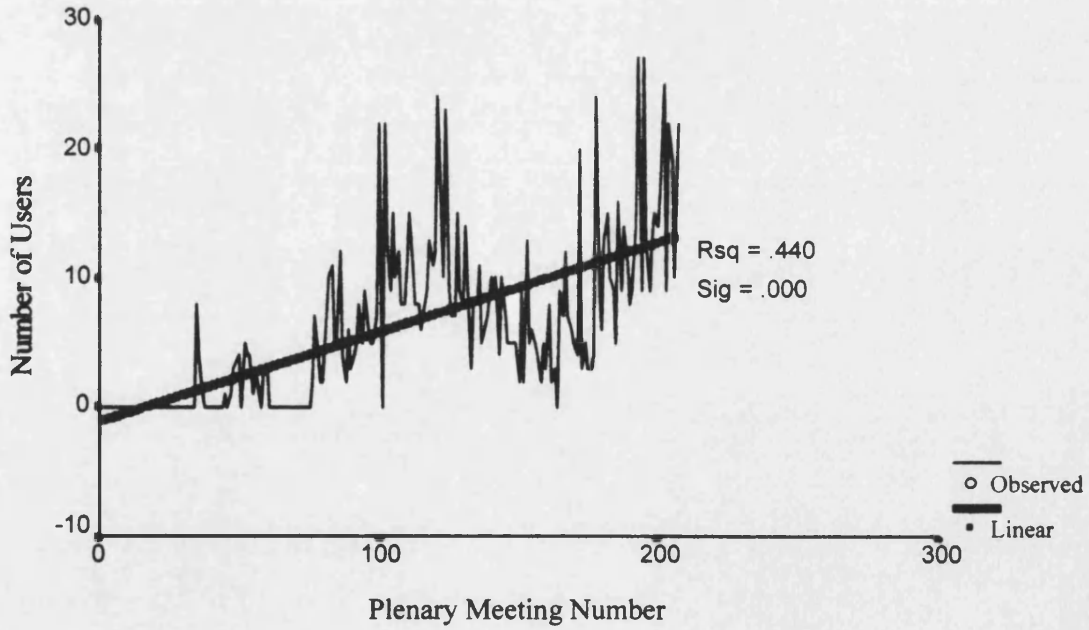
* The scarce number of cases and the irregularity of values remove the predictive power of the regression, but it does give an idea of past tendency.

SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, Sep/1985 to Dec/1991), typewritten.

As can be seen in Table 6.2, during the **first sub-period** *users* were present at only 22 meetings out of 82. Towards the end of this sub-period, however, the number of *users* coming to plenary meetings increased. During 1985, they did not come to one single meeting. On 13 May 1986, *users* attended plenary meetings for the first time (CIMS 1986, 13/5). During the rest of 1986 they came erratically to meetings. Nevertheless, from the beginning of 1987, the number of *user* participants increased. In the **second sub-period** there was a significant (Sig. = .00) although gradual increase in the number of *users* attending plenary meetings ($r^2 = 18$). The small number of cases and the high variation in values weakened the predictive power of the regression. Nevertheless, it indicates that there was a tendency towards growth in the number of *users* at meetings. In the **third sub-period**, *users* regularly attended plenary meetings, but in

slightly lower numbers than in the period immediately before. As these numbers refer to a total and not to a sample, even this small difference could be taken into account. In the **fourth sub-period**, *users* had regularly attended plenary meetings, and they had the highest attendance average of the four sub-periods. In this sub-period, there was a significant but weak tendency (Sig. = .01, r^2 = .21) towards the increase of *users* attendance at plenary meetings. In this case also, the regression only indicates a past trend. Graph 6.3 demonstrates that the attendance of *users* at the 207 plenary meetings, taking into account the whole period between September 1985 and December 1991, saw a significant growth (Sigf = .00, r^2 = .44). Nevertheless, this growth was not very regular. Even considering that again the regression did not have predictive power, it is possible to observe the long term tendency in the increase in *user* attendance at plenary meetings. The line in Graph 6.3 indicating the values actually observed also shows that, between January 1989 and December 1990 (meetings 129 to 178), *user* presence at plenary meetings did not increase.

Graph 6.3 - Evolution of Users' Attendance at Plenary Meetings - Porto Alegre - CIMS - September 1985 to December 1991



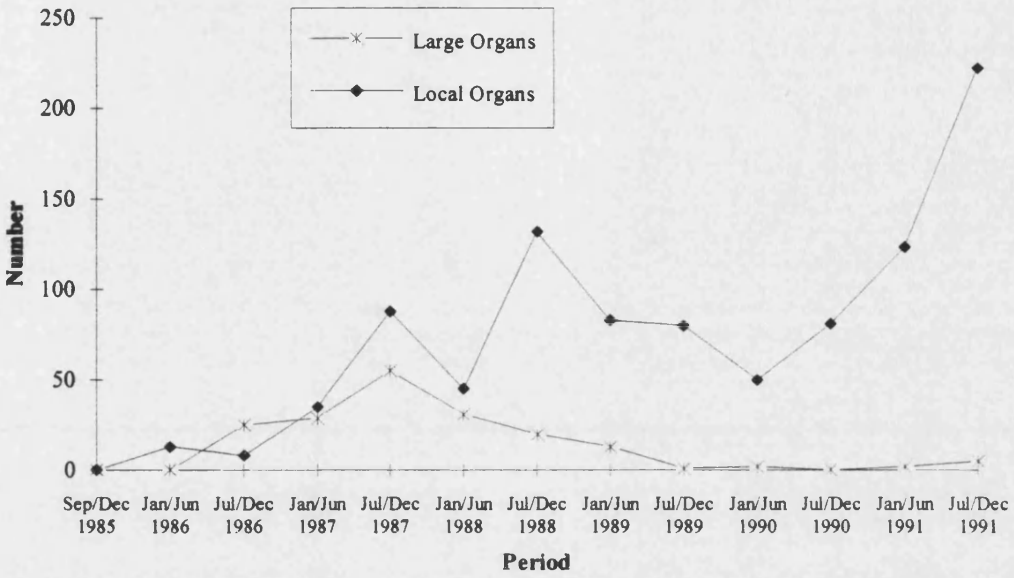
SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

User participants in plenary meetings could be classified into three major groups: (1) those from associations concerned with environmental issues or specific diseases, (2) those from the trade union movement, and (3) those from urban social movement organisations. The first group had no significant presence either as user representatives involved in the decision-making of the commission or as participants in plenary meetings. During 1987 and 1988, trade union representatives had been involved in the decision-making process of the commission, particularly those representing the Federation of Rural Workers (Federação dos Trabalhadores da Agricultura hereafter **FETAG**), the CUT and the CGT and the union of rural workers of Porto Alegre. Nevertheless, they were never a large group. Proportionally, only ten per cent (122 out of 1,251) of the users attending plenary meetings came from trade unions. On the contrary, user representatives from urban social movement organisations had been constantly involved in the decision-making process of the commission and 86 per cent (1,077 out of 1,251) of the users attending plenary meetings came from this type of organisation.

Until 1988, there was a tendency towards centralisation of the organisation of these movements. An expression of this tendency was the creation, in 1983, of the confederation of urban associations of Porto Alegre, UAMPA (Baierle 1992, 54). In July 1988, after successive political crises related to partisan disputes, a divisive electoral battle took place for the directorate of the organisation. After this election, the UAMPA lost influence among urban social movements. The weakened UAMPA illustrates, and possibly influenced, the reversal of the trend reflected in the type of users attending plenary meetings.

Regarding the size of the organisation they came from, there were two types of user participants: (1) those coming from large organisations, whose members were themselves organisations, such as confederations of trade unions (FETAG, CUT, CGT) or confederations of associations of urban social movements (UAMPA, FRACAB); (2) those coming from local organisations, whose members were individuals usually living in the same neighbourhood, such as residential associations or local health commissions. As can be observed in Graph 6.4, during 1988, the absolute and the proportional number of users from "large" organisations attending plenary meetings decreased.

Graph 6.4 - Attendance of Users at Plenary Meetings by Type of Member Organisation: Porto Alegre - CIMS - 1985/1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

During the first half of the eighties, the authoritarian features that still dominated the political system helped to make large organisations partial substitutes for political parties. During the last years of the eighties, due to the growing liberalisation of the regime, political parties increased in importance. In the new context, these large organisations gradually lost political weight, becoming, at the same time, more "specialised" in their particular area of concern and more subject to constant and divisive partisan disputes for their control (Baierle 1992, 156-98). The tendency towards the relative increase in *users* from local organisations attending plenary meetings reflected a shift in the dynamic of the urban social movement in Porto Alegre, towards a more decentralised pattern of organisation (Respondent/5 1992; Respondent/8 1992). During 1988, the profile of *users* attending plenary meetings changed. In the words of a participant, *users* representing large organisations, which had been involved in the commission before, were "professionals", almost a bureaucracy, unable to perceive the reality of the shanty towns. In contrast, those representing local organisations were more aggressive, more difficult to deal with, but more authentic, focusing their attention on problems and matters with which they were very familiar (Respondent/34 1992).

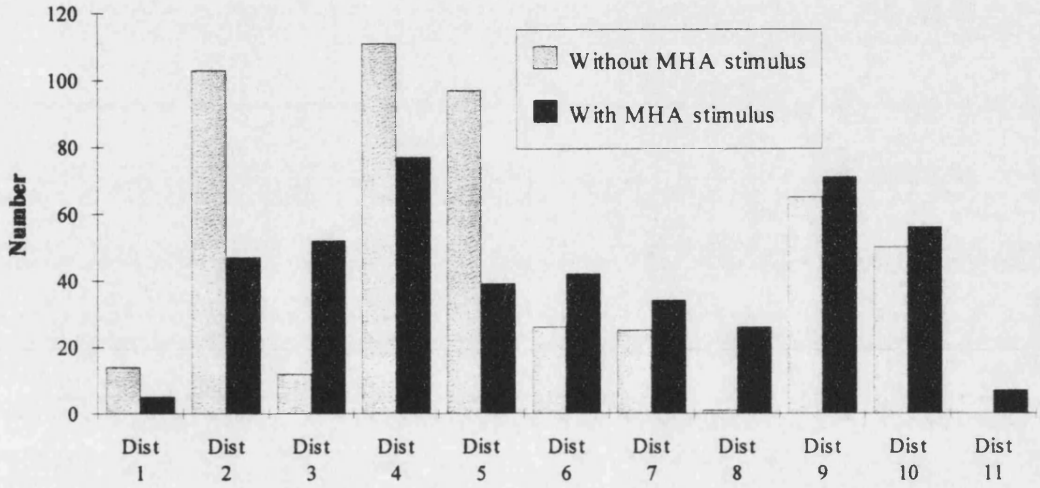
The tendency of urban social movements to rely less on central organisations was further stimulated by the policy of a Participatory Budget, implemented by the municipal

government after 1989, when the Workers' Party took office. From then on, all capital expenditure from the municipal budget in Porto Alegre was discussed in meetings in nine regions of the city, comprising social movement activists, individual residents, institutional representatives and politicians, among others. They aimed at establishing priorities and at electing the "councillors of the budget". The councillors, from all regions, would decide priorities together with councillors from other regions and, afterwards, would check whether what was agreed had been implemented. The Participatory Budget had stimulated the consolidation of regional popular councils (Conselhos Populares Regionais), which united urban social organisations in each region, and which had the legitimacy to speak on behalf of the region during the budget process (Giacomoni 1993, 130-6). The previous existence of the local health commissions in each region had, on the one hand, helped to strengthen the regional popular councils (Baierle 1992, 210-1). On the other hand, it had made those speaking on behalf of the local health commission respected and supported by the activists of the regional councils. The constant interrelation between the two participatory fora seems to have helped their mutual growth.

From May 1990, besides the dynamic of urban social movements and the influence of the Participatory Budget, there was a municipal policy of reinforcing local health commissions as participatory fora entitled to decide upon local issues. Public health professionals working at the local level had an important role in stimulating the involvement of urban social movement leaders in both local and municipal health commissions. Until 1986, only in health district four did some public health professionals, most of them working at the out-patient units of the state health secretariat, establish a close relationship with local urban social movement organisations. Between January 1987 and April 1990, in districts two and five also, the relationship between these two actors became strong. From May 1990, municipal health authorities had stimulated public health professionals, who worked at the municipal health secretariat, to become involved in the local and municipal health commissions (CIMS 1990, 3/5). Looking at Graph 6.5, it is possible to observe that, before municipal health authorities developed this policy, most of the users attending plenary meetings came from local organisations located in districts four, two and five. After May 1990, they came mostly from districts four, nine and ten. District four has been always the most concerned with health issues (Respondent/7 1992; Respondent/8 1992; Respondent/15 1992; Rosa 1989, 94-6). The constant attendance of *users* from organisations of this region reflects this. The attendance of *users* from other regions, however, could have been due to the encouragement of the municipal health secretariat. Graph 6.5 also demonstrates that, before May 1990 when this policy of encouragement was implemented, there was more concentration of users coming from a few regions. After then, the distribution became more

even (IQV until April 1990 = .93, IQV after April 1990 = .97). The municipal policies - the Participatory Budget and the incentive for public health professionals to become involved in the local and municipal health commissions - could have helped to widen the involvement of users in local health commissions throughout the city.

Graph 6.5 - Attendance of Users from Local Organisations at Plenary Meetings: Number by Health District - Porto Alegre - CIMS - September 1985 to April 1990 / May 1990 to December 1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

6.4. Involvement of User Representatives in the Decision-Making Process

The sub-periods that form this section were established taking into account the existence of particular patterns of user representative involvement in the decision-making process of the commission. In the first sub-period, between September 1985 and 11 May 1987, there was mainly "non-participation". The second sub-period began when the plenary named a working party, with a majority of user representatives, responsible for writing up a proposal for internal regulations. From then until the end of 1988, "negotiation" is the best classification for the type of involvement which user representatives had in the commission. The best classification for the third sub-period, between January 1989 and November 1990, is a combination of "participation" and "delegation". The revival of the co-ordinating committee, in

December 1990, would mark the beginning of the last period, when user representatives actually participated in the decision-making process of the commission.

6.4.1. A Participatory Forum Lacking User Participation: September 1985 to 11 May 1987

As mentioned before, during this period the commission did not have formal internal regulations. The **co-ordinating committee** would be created only in 1987. The agenda of plenary meetings was established by the municipal health authorities together with the representatives of the other main health institutions that were participating in the activities of the commission by then. The **technical secretariat** was made up of representatives of these institutions (CIMS 1985, 9/9). As was observed before, the **inspection commission** existed only on paper, since it did not actually meet or work.

There were some peculiarities in the way user representatives were involved in the activities of the municipal commission in this period. Firstly, their direct involvement was minimal. Users' demands were presented to the divisions of the commission - plenary and technical secretariat - mostly through health professionals working in the federal, state and municipal out-patient units (Respondent/23 1992). Secondly, when user representatives came to plenary meetings, they wanted to discuss the infra-structural problems of the region where they lived, such as access to drinking water or the construction of a sewage system. They also came to demand the creation of specific health services, to require improvements in a particular health unit or to complain about the quality or quantity of health care provided by certain services or professionals (Respondent/2 1992; Respondent/23 1992; Respondent/24 1992). Thirdly, they came to ask for solutions to some particular problems in the same way they could have done if they had directly asked the federal, state or municipal health authorities. These user representatives had no intention of forcing the forum to accept their regular participation in the decision-making process. They did not demand "deciding with". Depending on the political profile of the organisation they represented, they could wait for solutions from health institutions, as though waiting for a benefit since a favour had been asked, or they could wait impatiently for these institutions to provide the services they regarded as their right to have (Respondent/2 1992; Respondent/22 1992; Respondent/27 1992).

Participants in the commission have pointed out that, in 1985, the forum routine gravitated around issues related to the municipal emergency hospital (Hospital de Pronto Socorro de Porto Alegre). In 1986 and the beginning of 1987, the agenda was broader, including "environmental" matters, such as access to drinking water or sewage disposal

(Respondent/21 1992; Respondent/23 1992). During 1985, representatives of INAMPS had a strong influence over the forum. During 1986, co-ordination was clearly in the hands of the municipal health authorities (Respondent/24 1992). These differences can be related to the distinct political identifications and professional backgrounds of the municipal health authorities. The municipal secretary of health in 1985, Pedro Rushel, was mainly a "hospital doctor", representing an authoritarian government (Respondent/1 1992; Respondent/27 1992). In 1986, the municipal secretary, Cláudio Silveira, was a public health professional, supporting the Democratic Labour Party (PDT), by then newly elected for Porto Alegre's municipal government (Respondent/2 1992; Respondent/27 1992).

6.4.2. User Representatives Imposing Their Participation: 12 May 1987 to December 1988

The changes the municipal health commission underwent during 1987 and 1988 were due mostly to the pressures of user representatives to increase their influence in the forum. At the end of 1987, once internal regulations had been passed by the plenary, users could enjoy a majority in all divisions of the commission. They controlled the electoral process of the co-ordinating committee as well as the reshaping of the inspection commission. Nevertheless, in the same way that users did not become the major participants at plenary meetings, user representatives did not have an actual majority within the crucial divisions of the commission.

Until August 1987, when the internal regulations were passed by the plenary (CIMS 1987, 4/8), the forum had three sub-divisions: the plenary itself, the technical secretariat and the inspection commission. Following the provisions of the internal regulations, a **co-ordinating committee** was to be created. In September 1987, an electoral commission was created, in which users had a majority (CIMS 1987, 3/9). During the electoral process there were two conflicting propositions. One, supported mostly by user representatives, maintained that the co-ordinating committee should be made up of three representatives of public health institutions and four user representatives. The other, supported mostly by medical representatives, insisted that it should have three representatives of public health institutions, three user representatives and one representative of health professionals. Although there is no evidence attesting to who voted for each one, the minutes of the meeting registered that the first proposition won, with 30 votes against six. In November 1987, the first co-ordinating committee was elected (CIMS 1987, 1/11). The co-ordinator of the committee was the municipal secretary of health and the deputy co-ordinator was a representative of the INAMPS. The other health institution represented on the committee was the state health secretariat. Four users took part in the

committee, they represented two local health commissions, the UAMPA, and the CGT (CIMS 1987, 1/11).

Although user representatives should have had a majority of four out of seven on the committee, in practice they did not have. In the 46 meetings of the committee taking place in 1987 and 1988 there were on average two user representatives and four institutional representatives (Núcleo de Coordenação/CIMS 1987; Núcleo de Coordenação/CIMS 1988). Following the same pattern of plenary meetings, after July 1988, the majority of users present at these meetings represented local organisations and, after October 1988, users representing large organisations stopped attending.

According to the internal regulations, the **technical secretariat** did not need to have user representatives as members. Even so, during 1987 and 1988, user representatives were present at 44 per cent (31) of the 71 meetings held by the secretariat. In 30 meetings there were users representing local urban organisations, while in only one was there a user representing large organisations (Secretaria Técnica/CIMS 1987; Secretaria Técnica/CIMS 1988).

The **inspection commission** started work in March 1987. As was mentioned before, the commission had one user representative, from the UAMPA, and four from other interest groups and health institutions (CIMS 1987, 24/3). Nevertheless, no user attended the ten meetings the commission held in 1987. A new commission, nominated by the plenary in June 1988, had only user representatives, but health professionals were usually invited to take part in inspections (CIMS 1988, 9/6; Respondent/15 1992; Respondent/27 1992). In 1988, there was just one direct record of a meeting held in January. Nevertheless, during this year the commission was very active and many inspection visits to health services were recorded (CIMS 1988, 7/1, 9/6, 7/7, 18/8, 27/10, 1/12).

Apart from participation in the divisions of the forum, the relationship between the user representatives and the municipal health authorities was another element in determining the type of involvement users would have. During 1987 and 1988, the Democratic Labour Party (PDT) was still in the municipal government of Porto Alegre. Nevertheless, there was a new secretary of health. Olímpio Albrecht was a professional politician from a party with a strong populist tradition. He would not be expected, therefore, to favour user representatives taking part in decisions. Nevertheless, the deputy secretary, Mário Dantas, who became secretary in the last eight months of 1988, could be regarded as a Brazilian health system reformer (Respondent/4 1992).

A participant in the commission affirmed that the best illustration of the position of the municipal health authorities on user participation was the physical distribution of chairs during the plenary meetings. It was like a school class, where the municipal health authorities sat behind a table in a line a step higher than the representatives of interest groups and of other health institutions, who sat in the lower part of the room. This strongly suggests that the municipal health authorities did not intend sharing decisions (Respondent/28 1992). Another participant observed that user representatives were struggling to obtain more space within the decision-making divisions of the forum, but municipal health authorities still kept many political issues off the agenda (Respondent/27 1992). Even if the user representatives had increased their influence over agenda formation, some matters came to plenary meeting already agreed, with solutions and alternatives previously prepared before plenary appraisal (Respondent/20 1992).

There seem to have been two parallel reactions of user representatives to the restrictions placed on the scope of the agenda. The first was the revival, during 1988, of the practice of bringing to plenary meetings very local or personal problems related to health care (Respondent/16 1992; Respondent/18 1992; Respondent/21 1992; Respondent/23 1992; Respondent/27 1992). The second, highlighted by user participants, was the aggressive attitude of the user representatives towards the co-ordinator of the commission.

The second type of reaction was mentioned by a representative of the municipal health authorities, who observed that the user representatives had such an interest in increasing their participation that they tried unfairly to dominate the forum (Respondent/3 1993). The climate of tension, which some describe as a constant fight (Respondent/9 1992; Respondent/22 1922; Respondent/27 1992), resulted in changes in the dynamic of the forum, well documented above. These changes were brought about through constant negotiation between user representatives and resistant representatives of health institutions and of the medical profession. As an institutional representative affirmed:

> *"Some will say 'There was an incentive from such or such manager', but there was not that. In fact, they became more aware, they started to demand that their decisions be followed. Before they just asked if they could get this, asked if they could get that, asked, asked, asked. Then they began to demand what they saw as their right "* (Respondent/22 1992).

Three major changes were regarded by user representatives as signs of their increased influence: (1) the discussion and final approval of the internal regulations, (2) the creation of the co-ordinating committee and their actual participation in it, (3) the reshaping of the inspection commission (Respondent/11 1992; Respondent/12 1992; Respondent/13 1992;

Respondent/15 1992). If in practice they were not able to sustain a level of involvement that would guarantee their majority in all divisions of the forum, with the internal regulations, they increased their control over them. Even if user participants acknowledged that many problems discussed in the forum were not solved, there was a firm awareness that those participating in the co-ordinating committee had access to more information. They also felt that they had a higher status within the forum and could influence decisions and agenda formation (Respondent/11 1992; Respondent/12 1992). As one user representative, who participated in the co-ordinating committee during 1987 and 1988, observed:

> *"The co-ordinating committee... We co-ordinated the agenda. Sometimes they came with an agenda and we, users, told them 'No it will not be this one' we suggested additional items or the suppression of something we had already discussed. The agenda was the one we really thought would be suitable"* (Respondent/11 1992).

The activities of the inspection commission were a point of tension between user representatives and municipal health authorities. The directors of the municipal health secretariat in 1988 did not agree with the practice of the inspection commission of visiting hospitals without warning, accompanied by the press.

> *"He* [the municipal secretary of health] *had to explain to hospitals, and he felt very uncomfortable. He apologised because the inspection had been so tough. He felt uneasy, he did not seem to like what the inspection commission was doing, he did not support it"* (Respondent/15 1992).

The visits of inspection commissions to hospitals, the process leading to the approval of the internal regulations and the election of the co-ordinating committee have all caused tension between user representatives and municipal health authorities. Municipal health authorities, during 1987 and 1988, held the view that user representatives should become more involved in the municipal health commission, but that they should not have decision-making power. Even municipal health authorities in office during the eight final months of 1988, who were supporters of the idea of user participation, acknowledged that for them user representatives should offer and obtain information. The commission should be a consultative body for the municipal secretariat of heath (Respondent/4 1992). User representatives, however, had a conflicting view. They wanted to increase their power over municipal health policies, over agenda formation and over the decision-making process taking place within the commission. The result was not an overt or constant conflict, but a process of negotiation where user representatives partially obtained what they wanted while municipal health authorities kept trying to restrict their influence.

This process of negotiation was apparent even in small decisions relating to the ways the forum worked. During 1987, the meetings of the plenary and of the co-ordinating committee

took place in the working hours of the day. Plenary meetings had until October 1987 taken place in the mornings but, from 1 November 1987, meetings took place at 7 o'clock in the evenings. The co-ordinating committee had its first meetings in the afternoon, but user representatives protested, asking for their transfer to the evenings, because they had to work during the day. The negotiation about this transfer illustrates how disputes between user representatives and institutional representatives were solved then. One user representative described the negotiation:

> *"We won the transfer of plenary meetings to the evenings, but the meetings of the co-ordinating committee were at two o'clock in the afternoon. We proposed then to transfer them to 6 o'clock in the afternoon. We were divided, users wanting them at 6 and Dr. Mário* [deputy municipal secretary of health] *thinking it would be too late. Dr Olímpio* [municipal secretary of health and co-ordinator of the commission] *asked me and Mário to come and said 'Let's agree. How about 5 o'clock?' We both agreed. It was much better"* (Respondent/13 1992).

The changes in the commission's dynamic of work took place at the beginning of the process of decentralisation of the Brazilian health system. Since health services in Porto Alegre had not by then been municipalised, the real scope of influence of the commission was limited to health services financed through resources transferred from social security to municipality. Extension of the agenda beyond this limit would depend on the political commitment of health authorities to do so or they being forced to do so, due to intense political pressure. Even regarding these limitations, participants in the commission, particularly those representing users, considered that user representatives had a very active role in the commission during 1987 and 1988. The forum was open to some sort of user involvement, but user representatives were interested in extending the scope of decisions placed under the commission's discretion, as well as in increasing their own influence in the decision-making process taking place in the commission. Their activism did not always result in the actual numerical superiority in meetings of the co-ordinating committee, for instance. Nevertheless, user representatives could strongly influence the decision-making process of the forum in this period. Influence they have "conquered" (Respondent/13 1992) through a constant process of negotiation between them and municipal health authorities.

6.4.3. User Representatives Limit Their Involvement: January 1989 to December 1990

During 1989 and 1990, the municipal health commission worked regularly, but user representatives seemed to have lost the impetus they had shown during the former period. There was almost a consensus, however, among participants in the commission that municipal health

authorities had a strong interest in the participation of user representatives in the decision-making process of the commission.

The **co-ordinating committee** in office during most of 1989 was elected in September 1988 (CIMS 1988, 1/9). In this election again there were two proposals. Supported mainly by user representatives, there was a proposal for a committee made up of three representatives from the health institutions and four user representatives, one from a large organisation and three from local ones. The other proposal, supported mainly by representatives of the medical profession, called for the substitution of one user representative by one representative of health professionals. The first proposal won, by fifteen votes to eight.

The co-ordinating committee in office during the end of 1989 and most of 1990 was elected in September 1989 (CIMS 1989, 28/9). There was again a proposal to include a health professionals' representative on the committee. This time the representative of private hospitals voiced the idea specifying that it should be a representative of the medical profession. His proposal did not obtain support from the other participants and it was not even voted on. The co-ordinating committee elected then had one representative of the municipal health secretariat, one of the state health secretariat, and five user representatives, one from a large organisation and four from local organisations. This committee, nonetheless, did not meet or work during the first eleven months of 1990. Only in December 1990 would a newly elected committee meet again regularly, signalling the beginning of the new sub-period (Núcleo de Coordenação/CIMS 1990, 20/12).

The inactivity of the committee during most of 1990 demonstrates that the involvement of user representatives in the decision-making process of the commission decreased during this year. Considering together the committees elected in September 1988 (CIMS 1988, 1/9) and in September 1989 (CIMS 1989, 28/9), there were 24 meetings, all of them during 1989 (Núcleo de Coordenação/CIMS 1989). In 1987 and 1988, there were on average two user representatives and four representatives of health institutions present at meetings. In 1989, there were on average two user representatives and two representatives of health institutions, and in only one meeting, was a representative of a large organisation present. Hence, the co-ordinating committee only worked in 1989, but the meetings taking place then had proportionally more user representatives on average than in the previous period. This proportional increase, however, was not due to a growth in the average of user representatives attending these meetings but to a decrease in the average of institutional representatives present at them (Núcleo de Coordenação/CIMS 1989).

As was mentioned before, in June 1988 the plenary decided that the **inspection commission** would only be made up of user representatives (CIMS 1988, 9/6). In January 1989, the plenary decided to reshape it again. From then on, it should have had five user representatives: two from local health commissions, two from the large organisations (CUT, UAMPA) and one from the Porto Alegre Union of Rural Workers. It should also have two other representatives: one representing the council of nurses of Rio Grande do Sul and another representing the inspection department of the state health secretariat (CIMS 1989, 5/1). Although there was no register of the inspection commission meetings, many plenary meetings in this period discussed reports presented and inspections carried out by the inspection commission (CIMS 1989, 5/1, 16/2, 2/3, 4/5, 3/8, 5/10, 19/10, 30/11; CIMS 1990, 18/1, 17/5, 5/7, 19/7, 8/11, 22/11). There were also respondents of interviews, who have spontaneously highlighted the intensity of the activities of this commission in the period (Respondent/12 1992; Respondent/13 1992; Respondent/14 1992).

At the plenary meeting of 19 October 1989, a proposal was approved that the **technical secretariat** should enjoy the participation of representatives of health institutions, of non-medical health professionals and of users from local health commissions (CIMS 1989, 19/10). Nevertheless, in only four of the 88 meetings of this secretariat, during 1989 and the first eleven months of 1990, was there one user representative present (Secretaria Técnica/CIMS 1989, Secretaria Técnica/CIMS 1990). The technical secretariat did not necessarily have to have user representatives involved in its activities, since it was concerned mostly with preparing analyses and appraisals to guide decisions to be taken by the plenary. Nevertheless, the absence of user representatives who had previously promised to be there, can be considered a further indication that, in this period, user representatives had decreased their involvement in the decision-making process of the commission.

Between 1989 and 1991, the Workers' Party (PT) was in the municipal government in Porto Alegre. The sociologist Maria Luiza Jaeger, who was the first woman and the first non-medical doctor to be municipal secretary of health, was an active participant in the "policy community" of Brazilian health system reformers (Respondent/5 1992). She was a leading member of the department of health of CUT, in Rio Grande do Sul, which was made up of health professionals representing trade unions of health workers and health professionals. When the Workers' Party (PT) took office in Porto Alegre's city hall, most members of the department of health of the confederation would hold the highest managerial posts in the municipal health secretariat (CIMS 1989). The Workers' Party (PT), to which they were

affiliated, supported the reform of the Brazilian health system, defending the participation of user representatives in the decision-making process of municipal health commissions.

Respondents agreed unanimously that, during this period, the co-ordination of work was more democratic. They affirmed that it was easier, compared with former periods, for user representatives to participate. During plenary meetings, the chairs were arranged in a circle, everybody at the same level (Respondent/28 1992). New issues, related to the organisation of health services in Porto Alegre, appeared on the agenda. The forum began to discuss whether new health services should be opened, which services should be closed or where services should be placed (Respondent/27 1992). A user participant in the commission affirmed that by then

> *"Our role was no longer to claim for improvements. We could go beyond that and create things together, make proposals, develop a better work, a serious work"* (Respondent/7 1992).

There were some participants, however, who did not like the change. A representative of the medical profession affirmed that user participation had become more organised but also more radical. In his view, the growing influence of user representatives over the decision-making process of the forum would result in the medical professions' withdrawal (Respondent/16 1992). A representative of the private hospitals of Rio Grande do Sul was more emphatic. He affirmed that, during 1989, the intense participation of users made the work of the forum chaotic (Respondent/21 1992). However, only representatives of the medical profession and of private hospitals made this type of appraisal. Their criticism was probably related to the reduction in their influence over the decision-making process of the forum and to the actions of the inspection commission.

There was, on the other hand, another type of criticism from those who saw the efforts of the municipal health authorities to encourage the involvement of users in the commission. This was related to the inexperience of these authorities as managers. Respondents pointed out that their exclusive experience was as critics of governmental policies, when representing sectoral trade unions and the trade union confederation (CUT) on the health commission (Respondent/5 1992; Respondent/12 1992). Their inexperience was evident when, for instance, they placed problems on the agenda whose solution was beyond the sphere of influence of the commission or of the health institutions there represented. The discussion of such issues created expectations for a solution among user representatives. Since this did not materialise, it gave origin to a sense of frustration (Respondent/12 1992; Respondent/14 1992; Respondent/21 1992; Respondent/25 1992; Respondent/26 1992).

Another criticism was the frequency and extension of discussions related to financial matters (Respondent/11 1992; Respondent/26 1992). An institutional participant explained it very clearly.

> *"At some point, during 1989 - later we evolved from that - user representatives were very worried about the role of "administrative-inspectors", and I think their withdrawal from the forum was because of that. We discussed the pans and cutlery to be bought for the emergency hospital. I think people felt, even without knowing clearly why, that they would not lose two Thursdays per month to discuss the SUDS expenditure plans: 'We will buy that and that and that...'. I mean, the municipal managers went into such detail that it resulted in emptying the commission. The commission should decide over macro-issues. You cannot use the commission to discuss if you will buy a pan size 24 or 25"* (Respondent/26 1992).

In fact, in the second half of 1989 and the first half of 1990 for the first time, financial matters were the most frequently discussed issues in plenary meetings (CIMS 1989; CIMS 1990).

Some user representatives, however, seemed to have deliberately reduced their involvement in the commission (Respondent/5 1992; Respondent/7 1992; Respondent/15 1992; Respondent/17 1992; Respondent/28 1992). These municipal health authorities had participated in the commission before as allies of user representatives. It was not surprising that some of these users had thought they could delegate to them power to take decisions (Respondent/28 1992). This was so, particularly for users representing organisations located in district four, where many directors of the municipal health secretariat had worked before. As a very active user representative in this region explained:

> *"We thought they were people we could rely on. People who knew our needs. So, the community did not need to sacrifice itself participating there. Because, for the community participation is a sacrifice. We thought they would naturally speak the same language, they, as government, would take the decisions they have to take. But it was not what happened. We realised we would have to make things happen... do it together. It was not difficult work together with them, but we had to do it together, they would not do things on our behalf. Then the community began to participate again"* (Respondent/7 1992).

Hence, it was not only the disorganisation of the confederation of urban social movements, nor problems in carrying out the commission's work, that negatively affected user involvement in the forum. Some user representatives, especially those from the very active district of health number four, thought that the municipal health authorities were so close to them politically that they could delegate the decisions to them. Until they realised that this would not work.

6.4.4. The perspective of institutionalisation: December 1990 to December 1991

During this period, user representatives seem to have been intensely involved in the decision-making process of the municipal health commission. The **co-ordinating committee** elected on 6 December 1990, to be in office during 1991, was made up of two user representatives and one health professional from local health commissions, two institutional representatives from municipal and state health secretariats, a representative of the trade union of nurses of Rio Grande do Sul and another from the association of civil servants of the municipal health secretariat (CIMS 1990, 6/12). Unlike in previous periods, the official composition of this co-ordinating committee would have two user representatives for five representatives of other interest groups or institutions. Between December 1990 and December 1991, the average attendance of user representatives at meetings compared with other representatives' average was respectively two and four, which was the same as for 1987 and 1988 (Núcleo de Coordenação/CIMS 1990; Núcleo de Coordenação/CIMS 1991). As in 1989, nearly all user representatives attending the meetings of the co-ordinating committee came from local organisations. Hence, the formal reduction in the number of user representatives elected to take part in the co-ordinating committee did not signify a real decline in the number of user representatives actually participating in the committee meetings. This composition established a proportion in accordance with the actual number of user representatives who had been attending these meetings.

In this period, as in the previous one, user representatives did not participate directly in the activities of the **technical secretariat**. Nevertheless, the secretariat's official composition nominated by the plenary established that it should have the participation of a user representative from a local health commission (CIMS 1989, 19/10). In June 1991, however, the plenary substituted the user representative, who was constantly absent from meetings, with a representative of the physiotherapists' union (CIMS 1991, 6/6). In the previous period, the withdrawal of user representatives from the secretariat seemed to provide further evidence of the decline in users' involvement within the municipal commission. In this period, it seems to suggest that user representatives voluntarily withdrew their participation from this technical body.

Although there could be found no direct record of the work of the **inspection commission** in this period, many minutes of plenary meetings mentioned its activities (CIMS 1991, 24/1, 21/2, 2/5, 18/7, 7/11, 21/11). The incisive, but more "constructive", attitude of this commission in 1990 could be an indication that the municipal health commission was initiating a period of institutional consolidation, in which its divisions worked more efficiently

(Respondent/26 1992). The inspection commission still denounced irregularities to public opinion, inviting journalists to come on their surprise visits to health services. Nevertheless, towards the end of 1990 and during 1991, the commission seems to have taken a more practical approach, seeking commitments that could lead to improvements. As a result some hospitals signed agreements with the inspection commission agreeing to make reforms (Respondent/26 1992).

This shift in the strategy of the inspection commission possibly came together with a general change in the way that the municipal commission worked. By May 1990, the co-ordinators of the commission had realised that there were fewer users attending plenary meetings and user representatives were decreasing their participation in the decision-making divisions of the forum (Respondent/5 1992; Respondent/26 1992; CIMS 1990, 3/5). The best example of this decrease was the inactivity of the co-ordinating committee since the beginning of 1990. Although the co-ordinating committee would work again only in December 1990, during May and June of that year, there were discussions in plenary meetings about the weak involvement of users in the commission (CIMS 1990, 3/5, 7/6). These discussions resulted in the adoption of two main strategies aimed at increasing involvement.

Firstly, they changed the way financial matters were discussed. Instead of discussing an expenditure plan, for example, item by item, there was a presentation of the general aspects, making available the detailed plan for the scrutiny of any representative. The time saved by this new mode of discussion was used to debate more important issues, such as the plan for municipalisation of the health services, mechanisms of referral and counter-referral, quality of hospital care or quality of care provided by public out-patient services (Respondent/26 1992). This was also used, for the first time, to systematically discuss environmental problems, such as the quality of food and of drinking water, environmental pollution and sewage disposal (Respondent/19 1992).

The second strategy was aimed at strengthening the organisation of local health commissions. Local issues that could be solved by local health commissions, whose interest was limited to single health units or a few users, were returned to these commissions. The stimulus to make local commission claims more organised helped to "clean" the agenda of very specific issues. It forced local commissions to analyse and prepare issues before presenting them to the plenary (Respondent/27 1992). From the end of 1990, most issues placed on the agenda should have been of interest at least to a whole "*vila*", that is a whole shanty town area (Respondent/23 1992). At the same time, municipal health authorities stimulated the civil servants of the municipal health secretariat to participate in local commissions or, if relevant, to

help in the creation or in the organisation of local commissions (Respondent/17 1992; Respondent/27 1992; Respondent/28 1992). The directors of the municipal health secretariat themselves went to the meetings of local health commissions or promoted meetings where they were not organised (Respondent/7 1992; Respondent/9 1992; Respondent/10 1992; Respondent/12 1992). Also from 1990, the Participatory Budget further stimulated users' participation at the local level. An indication of the success of the strategy of strengthening the organisation of local fora was that, in 1991, users attending plenary meetings came from all regions of the city. Another indication was the occurrence, in the same year, of political disputes within some local health commissions, where there were different groups of activists competing to represent the local commission on the municipal health commission (Respondent/27 1992). For the first time, the municipal health authorities promoted a consistent policy of systematic organisation and strengthening of the local commissions. In 1987 and 1988 there were initiatives aimed at stimulating the organisation of local commissions, but it did not seem to have been a central aspect of municipal health policies then, as it was in 1990 and 1991.

The growing interest of user representatives in the health commission was also related to the health law passed by the Brazilian Congress in December 1990 (Brasil. Congresso 1990, Lei 8.142). This law institutionalised the involvement of user representatives in the organisational structure of the Brazilian health system. It stated that there should be health conferences every four years, when institutions and organisations of civil society should establish the guidelines that would direct policy implementation for the next four years. In September 1990, the municipal health commission organised and co-ordinated the first municipal health conference in Porto Alegre (I Conferência Municipal de Saúde/Porto Alegre). A few hundred people, representing many institutions and popular organisations, participated in the conference. Some urban social movement activists were deeply involved in its organisation (Respondent/5 1992; Respondent/15 1992, Respondent/27 1992). The law also established that each of the three levels of government should have health councils, with at least half of their members being user representatives.

The transformation of the commission into a council took place in May 1992, when it was instituted by municipal law (Porto Alegre. Câmara Municipal 1992, Lei Complementar 277). The date of the creation of the council put it outside the chronological limits of this research. Nonetheless, the debate surrounding it did not, which focused mostly on which organisations would be members of the council. The structure of the council would be similar to that of the commission, but the law should state which members would have the right to

participate in the council. After intense debate during which many organisations lobbied to guarantee their inclusion in the council, the law was passed by the municipal legislative chamber. It established that 76 representatives of institutions and organisations would take part in the council. Those represented included local health commissions, public and private health institutions, unions of health professionals and of health workers, unions of private hospitals and of private laboratories, environmental organisations, trade union and urban organisations, confederations and associations of sufferers of diseases, among others. Contradicting the health law, however, user representatives did not have half of the seats on the council. In reality, they had 31 seats while other representatives together had 45. Despite this, however, the number of organisations enrolled to participate in the council is impressive, demonstrating that there was widespread motivation among organised interest groups in participating. The motivation to ensure a place on the new council probably contributed to the increased involvement of users in the commission during this period.

The growing involvement of users in the commission in this period corresponded, in contrast, to a deliberate withdrawal of representatives of the medical profession and of private providers of hospital care. They had failed in successive attempts to include a medical profession representative on the co-ordinating committee and they could not maintain their representation within the inspection commission (CIMS 1987, 1/11; CIMS 1988, 1/9; CIMS 1989, 28/9). Not surprisingly, medical profession organisations ceased their involvement in the commission at the end of 1991. A medical profession representative on the commission justified the withdrawal on the grounds that, firstly, the internal regulations "politically" restricted the vote of health professionals to one per category. Secondly, they were systematically excluded from any decision-making division of the forum. This particular situation and the reality of the Brazilian health system reform, with which they could not agree, led to their formal withdrawal from this forum by the end of 1991 (Respondent/16 1992). A representative of the private hospitals of Rio Grande do Sul used similar arguments to justify their absence from 1991 (Respondent/21 1992). In fact, the attendance lists of plenary meetings confirmed that the last plenary meeting they attended was respectively in October and in April 1991 (CIMS 1991, 18/4, 10/10).

Hence, in this period, user representatives had participated intensely in the decision-making process of the municipal health commission. The co-ordinating committee resumed its work. User representatives did not have a majority of seats on the committee, but they participated constantly. The inspection commission was very active and the role of local health commissions as local channels for planning and decision-making was stimulated. This was been

achieved through the growing involvement of the directors and civil servants of the municipal health secretariat. There was also the mutual stimulus of the local health commission and the regional assemblies of the Participatory Budget. The reinforcement of decentralised health fora consolidated the decentralised basis for the involvement of users in the municipal commission. At the same time, the agenda of the forum became more concerned with issues of collective interest.

As the process of the municipalisation of health services did not start in Porto Alegre, the power of the commission over the organisation of health services remained limited. Nevertheless, the holding of the first municipal health conference, as well as the debate surrounding the creation of the municipal health council, seemed to have given to urban social movement activists the perspective that, sooner or later, municipalisation would also happen in Porto Alegre. When it did happen, the council would have strong powers over the organisation of health services in the city. Therefore, it was important to reinforce the consolidation of the forum as well as to guarantee a place there.

6.5. Summing Up

Considering the two indicator-variables of the involvement of users, *the number and types of users attending plenary meetings* and *the types of involvement of user representatives in the decision-making process of the commission*, it is possible to affirm that, between 1985 and 1991, the involvement of users increased significantly. Gradually, more users attended plenary meetings and user representatives intensified their involvement in the decision-making process. Users from local organisations made up the majority of users attending plenary meetings and the majority of user representatives participated in the decision-making divisions of the commission.

Between September 1985 and December 1991, taking into account which type of user representatives' involvement was predominant, it was possible to identify four sub-periods. In the first period, between September 1985 and 11 May 1987, there was **non-participation**. In this sub-period the commission had been recently created. The commission did not have formal internal regulations or a co-ordinating committee and its agenda was decided mostly by municipal health authorities. Users rarely attended plenary meetings.

Between 12 May 1987 and December 1988, the involvement of user representatives in the decision-making process of the commission can be classified as **negotiation**. On the first date, a working party was set up, with a majority of user representatives, to write the internal

regulations of the forum. The regulations, passed by the plenary in August 1987, guaranteed the majority of the co-ordinating committee's seats for users. In this sub-period, most decisions taken by the commission, as well as its agenda, were the result of a negotiation process among health authorities, user representatives and representatives of health professionals or health workers. Users had attended plenary meetings regularly and the majority of meetings had eight or more users present.

Between January 1989 and November 1990 the involvement of user representatives in the commission can be classified as **participation/delegation**. In this sub-period municipal health authorities had the clear intention of promoting user participation in the commission. Nevertheless, especially during 1990, leading user representatives had delegated power over decisions to municipal health authorities, because these representatives saw them as political allies. During 1989, most decisions and the agenda of the commission were agreed among health authorities, representatives of users and representatives of non medical health professionals or health workers. In 1990, however, the co-ordinating committee did not work and most user representatives withdrew from the commission's activities. As a result, the decisions and the agenda were decided mostly by health authorities and non medical health professionals or health workers. In both years, representatives of private providers and of the medical profession were almost totally excluded from the process of agenda formation and had minimal participation in decisions. In this sub-period, users had regularly attended plenary meetings, but in reduced numbers. In most meetings there were between three and seven users present.

Between December 1990 and December 1991, the involvement of user representatives in the decision-making process can be classified as **participation**. The co-ordinating committee resumed its meetings and worked regularly with the constant presence of user representatives. The decisions and the agenda of the commission were agreed mainly among health authorities, representatives of users and representatives of non medical health professionals or health workers. Representatives of private providers and of the medical profession still did not participate in the process of agenda formation and decision-making. It motivated their withdrawal from the forum by the end of 1991. In this period, users regularly attended plenary meetings and in nearly all meetings (27 out of 29) there were eight or more users present.

The most common *type* of user attending the first plenary meetings differs from the most common *type* attending the last. Throughout the whole period, there was a tendency to reduce the number and the proportion of users coming from large organisations representing trade unions or organisations of urban social movements. On the contrary, there was a tendency

to increase the number and the proportion of those coming from local organisations. These users from local organisations came increasingly from more regions of the city. During the last sub-period, the distribution of users from local organisations among the eleven health districts of the city was nearly homogeneous. It indicates, firstly, that there was a change in the profile of the user attending meetings. The more articulate representative of large organisations was gradually substituted by a representative who, although more aggressive, was more aware of the needs of the population s/he represented. It indicates as well that there was a double process of decentralisation. On the one hand, the organisation of the urban social movement tended to become more regionalised. On the other hand, the local health commissions tended to become increasingly important within the municipal health commission.

The growth in the influence of user representatives on the forum was a key element in the political tensions surrounding the reform of the Brazilian health system. The influence of users grew alongside decreases in the importance within the forum of representatives of the medical profession and of the private providers of hospital care. The Brazilian health system reformers supported the consolidation of this participatory forum because they defended the idea of "social control" and, in particular, of user control over the health system. Nevertheless, the political forces articulated in this forum had the potential to strengthen the reforms. The alliance between reformers and user representatives, cemented in this commission, could have reinforced their converging claims for more financial resources and more services, against the reluctance of mayors, state governors or federal government. This alliance could have helped in the confrontation with interest groups opposing the increase in public control over the health sector as well as sectors of the federal bureaucracy that were resistant to decentralisation. These reformers formed a loose policy community, whose members were united by a reform goal with a broad common ground. At the municipal level, in Porto Alegre, these reformers had, at diverse moments, acted as representatives of a confederation of trade unions, as representatives of federal, state or municipal authorities, as representatives of trade unions of health professionals or as public health professionals promoting the participation of users in local health commissions. In the next chapter, when analysing the actors and factors that could have influenced the involvement of users in the commission, the different personifications of these reformers will become clearer.

Chapter 7

Major Influences on the Involvement of Users in the Municipal Health Commission of Porto Alegre

7.1. Introduction

The previous chapter examined the involvement of users in the municipal health commission. This chapter analyses the major factors that could have influenced this involvement. Taking into account the literature on participation, the literature on the recent history of the Brazilian health system, and the specific case of the municipal health commission of Porto Alegre, it was possible to distinguish seven major factors that had possibly influenced this involvement: (1) recent changes in the institutional framework of the Brazilian health system; (2,3,4) the positions of the federal, of the state and of the municipal health authorities on user involvement in the municipal health commission of Porto Alegre; (5) changes in the relationship between public health professionals, who worked at local health units, and activists of urban social movements in Porto Alegre; (6) the organisation of urban social movements in Porto Alegre, regarding their centralisation or decentralisation; (7) the issues most frequently discussed at the plenary meetings of the municipal health commission of Porto Alegre. The analysis of each of these actors and factors, between 1985 and 1991, corresponds to each section of this chapter.

Although considered independently, these factors are closely interrelated. For example, the institutional framework influenced the behaviour of political actors such as health authorities. Conversely, this institutional framework is the result of an interplay of political actions in which health authorities certainly played important roles. Taking into account their mutual interdependence, they are not treated as if they were isolated, but they are examined separately to better analyse them. Looking at them separately permits an assessment of whether they had any impact on the involvement of users in the commission. Table 7.1 summarises the

description given in this chapter on how, throughout the period, these factors have changed. The changes were classified into three ordinal categories, corresponding to a specific period of time. This Table can help the understanding of this chapter, and of the next chapter, when the strength of the possible associations between each of these variables and the involvement of users will be considered.

Table 7.1 - Factors and Actors that Could Affect Users' Involvement in the Municipal Health Commission: Categories and Periods - Porto Alegre - CIMS - 1985/1991

Actors and Factors That Could Have Affected Users' Involvement	Types of Variation		
	1	2	3
Institutional Framework of the Brazilian Health System	Ações Integradas de Saúde (AIS)	Sistemas Unificados Descentralizados de Saúde (SUDS)	Leis do Sistema Único de Saúde
Period	Sep/85 to 9/Jul/87	10/Jul/87 to Dec/1990	Jan/91 to Dec/91
Position of Federal Health Authorities on Users Involvement in Municipal Health Commission Activities	Resistant to users' involvement	Indifferent to users' involvement	Interest in user representatives' participation in decision-making process
Period	Jan/90 to Dec/91	May/88 to Dec/89	Sep/85 to Mar/88
Position of State Health Authorities on Users' Involvement in Municipal Health Commission Activities	Non interest in users' involvement	Interest in user involvement, but not at **CIMS** or in Porto Alegre's **CIMS**	Interest in user representatives' participation in decision-making process
Period	Oct/91 to Dec/91	Sep/85 to Dec/90	Jan/91 to Sep/91
Position of Municipal Health Authorities on Users' Involvement in Municipal Health Commission Activities	Non interest in users' involvement	Interest in consultative participation	Interest in user representatives' participation in decision-making process
Period	Sep/85 to Dec/85	Jan/86 to Dec/88	Jan//89 to Dec/91
Relationship Between Public Health Professionals, Working at Local Level, and Activists of Urban Social Movements	Close in few regions of the city	Close in many regions of the city	Close in many regions of the city combined with municipal policy of support
Period	Sep/85 to Dec/86	Jan/87 to Apr/90	May/90 to Dec/91
Urban Social Movement Organisation	Tending towards centralisation	Tending towards decentralisation	Tending towards decentralisation with Participatory Budget
Period	Sep/85 to Jul/88	Aug/88 to 26/Sep/90	27/Sep/90 to Dec/91
Issues Discussed in a Higher Proportion of Plenary Meetings	*Financial*	Similar proportion *financial* and *organisation of health services in Porto Alegre*	*Organisation of health services in Porto Alegre*
Period	Sep/85 to Dec/ 85 Jul/89 to Dec/89	Jan/86 to Jun/86 Jul/90 to Jun/91	Jul/86 to Jun/89 Jul/91 to Dec/91

7.2. Institutional Framework of the Brazilian Health System and the Municipal Health Commissions

In chapter four the Brazilian health system was discussed at length. Here only the main turning points that could have had a direct influence on the municipal health commission will be highlighted. They were:

(1) The programme **Ações Integradas de Saúde (AIS)** of **1984**, which created the first municipal health forum. This programme also transferred financial resources from the INAMPS to state and municipal health secretariats and stimulated the integration of governmental agencies responsible for public health and health care provision.

(2) The programme **Sistemas Unificados Descentralisados de Saúde (SUDS)** of **10 July 1987**, which transferred health units, personnel and financial resources from INAMPS to state health secretariats. The programme universalised access to health care and established that there should be further transfer of state and federal services to municipalities. It also stated that municipal health commissions should monitor the planning and management of the new system at the municipal level.

(3) The **health laws - Leis do Sistema Único de Saúde** - of **December 1990**, which would regulate the health system created by the Brazilian Constitution in 1988. These laws reinforced the principles of integration, decentralisation and the universal right to health care. They also established that institutionalised municipal health councils would have planning and supervisory powers over municipal health services. These councils would become an institutionalised part of the structure of the municipal government as well as of the organisation of the national health system.

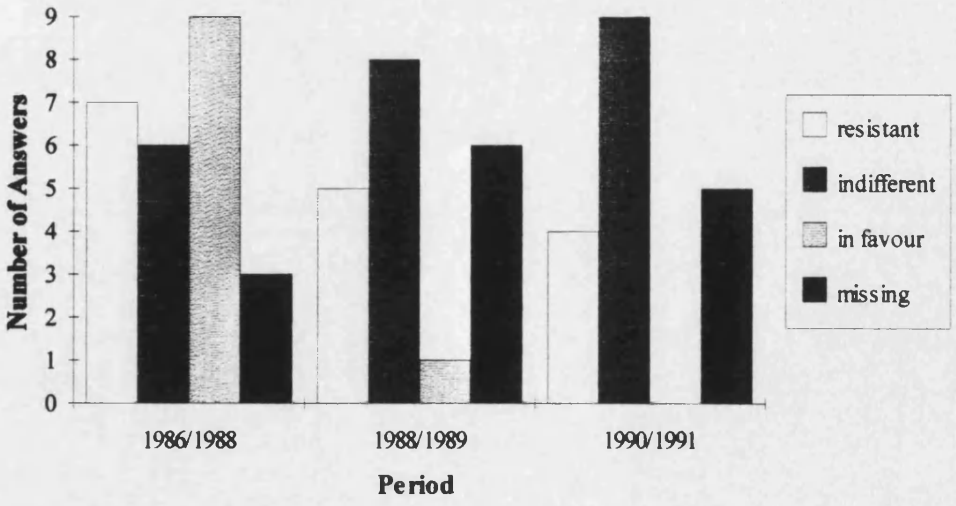
7.3. Position of Federal Health Authorities on the Involvement of Users in the Municipal Health Commission

Between **1985 and March 1988**, the main managerial posts in the Brazilian health system were occupied by professionals concerned with reforming the system. At first, this group of reformers saw the **AIS** programme as a useful means of gradually universalising, decentralising and integrating the system (Possas 1987, 246-51). At the beginning of 1986, the programme was transformed into policy, in which user participation became a central issue. Since the seventies, these professionals had been criticising the authoritarian regime and defending the involvement of users in decision-making processes in the sector. Beyond the objective of democratising the health sector, there was the goal of establishing alliances with leaders of trade unions and of urban social movements, since these leaders could support a

reform which universalised access and proposed to offer better quality care. In 1987, these professionals realised that the political alliance backing the federal government was increasingly relying on right wing politicians. As a consequence, they were losing support (Cordeiro 1988, 37). The **SUDS** programme, launched in July 1987, made the reform irreversible, speeding the process of decentralisation before they lost their posts. It reinforced the principle of the participation of user representatives in the sector, extending user representation - restricted before to local, municipal and regional levels of management - to state and federal health commissions. It is possible to affirm thus that, in this period, federal health authorities supported both the empowerment of municipal health commissions and the involvement of user representatives in these fora.

As can be seen in Graph 7.1, the majority of the respondents, who were participants in the municipal health commission of Porto Alegre during this period, agreed with the literature. Most of them thought that these authorities favoured the participation of user representatives in the decision-making process of the commission. One institutional representative has pointed out that the federal health authorities wanted user participation, but they did not know how to promote it (Respondent/23 1992), even if they seemed to "live for" promoting user participation (Respondent/2 1992).

Graph 7.1 - Opinion of Participants in the Municipal Health Commission about the Position of Federal Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991



SOURCE: Interviews with Participants in Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December of 1992, transcript, Interviewer Files, London.

There was, however, a difference of opinion between non-user and user respondents. As Graph 7.2 demonstrates, most non-user respondents considered federal health authorities resistant to the participation of user representatives in the decision-making process of the commission. Five of those who thought they were resistant to it (Respondent/4 1992; Respondent/18 1992; Respondent/20 1992; Respondent/25 1992; Respondent/28 1992) observed that federal health authorities only talked about user participation, being in practice indifferent to it. These answers, however, should be placed in the context of the politics of the Brazilian health system. These respondents were health professionals supporting a more radical reform of the system. They seemed to be criticising the non democratic way federal health policies had been decided, without prior discussion with civil society, rather than the specific attitude of federal health authorities towards user involvement in the municipal health commission of Porto Alegre.

Graph 7.2 - Opinion of Participants in the Municipal Health Commission about the

> *"They opened the door. They called us to do it, at the end they taught us how to do it, like in a school class. You go there because you were curious to see what they were discussing. You became a student in the house. At the end you stay in the house"* (Respondent/9 1992).

Another user respondent acknowledged the fact that the federal government had an ambiguous attitude towards the participation of user representatives. He explained, however, that if there was resistance, it was not among the representatives of the Ministry of Health and of the INAMPS in Rio Grande do Sul. He considered that these representatives had an "excellent" relationship with the user representatives in the municipal health commission of Porto Alegre (Respondent/13 1992). In fact, five respondents, both users and non-users, highlighted the role of the INAMPS' regional managers in promoting user representatives' participation in municipal fora (Respondent/5 1992; Respondent/6 1992; Respondent/12 1992; Respondent/13 1992; Respondent/22 1992).

The favourable view of user respondents about the position of federal health authorities on the issue is more relevant if it is borne in mind that the political parties of these federal managers did not have strong connections with the urban social movements in Porto Alegre, of which these respondents were activists. The faction of the Brazilian health system reformers running federal health policies, during this period, was identified with the central-left Party of the Brazilian Democratic Movement (PMDB) and with the Brasilian Communist Party (PCB) (Gallo and Nascimento 1989, 107). The urban social movement in Porto Alegre, then, was mostly influenced by the central left Democratic Labour Party (PDT) and increasingly influenced by the Workers' Party (PT) (Baierle 1992, 123-5).

On the one hand, it was mostly non-user respondents who, at the same time, criticised the federal health authorities' strategy of reform and were suspicious about the federal government's supposed support for user participation. On the other hand, it was mostly user respondents, without partisan connections with these authorities, who considered that they favoured the participation of user representatives in the decision-making process of the commission. Considering both respondents together, there was a slight majority who thought that federal health authorities favoured participation, as can be seen in Graph 7.1. Considering the fact that users were less affected by political disputes among the factions of reformers, and that they were the ones who were supposed to participate, it is reasonable to accept their view that these authorities favoured participation.

By then the municipal health services were not municipalised in Porto Alegre, and thus the municipal health commission had the right only to monitor the health care provision financed through social security resources transferred to the municipal health secretariat. As

further evidence that the federal health managers in Rio Grande do Sul, especially those in the INAMPS' regional administration, supported the involvement of users in Porto Alegre's commission, they had backed the work of the inspection commission, suspending contracts with private hospitals when this commission recommended it. It seems that federal policies could not have been very successful in stimulating user representatives' participation in the decision-making process of municipal health commissions throughout the country, but the regional managers representing the federal health authorities in Rio Grande do Sul had been particularly committed to the issue (Respondent/5 1992; Respondent/22 1992).

The group of health professionals in the main posts of the Brazilian health system, between **April 1988 and December 1989**, was not regarded as reformers (Diretoria Nacional do CEBES 1988, 5). They did not have a clear political commitment to the decentralisation of the system or to the promotion of user representatives' participation in it. Nonetheless, during this period, the federal government as a whole did not have the political strength to impose any dramatic change in policies that could have gone against the interest of directly elected governors and mayors. So, during this period, considering their political weakness, federal health authorities could be regarded as indifferent to the issue.

The views of the regular participants in the commission coincided with the assumptions of the literature. Nevertheless, the respondents seemed to be more interested in the process of decentralisation of the Brazilian health system that was under way than with the stance on user participation of these increasingly remote federal health authorities.

The majority of the respondents thought that the federal health authorities, in this period, were indifferent to the issue of users' involvement in the commission. When explaining their answers, the respondents usually focused on the difficulties of the process of decentralisation of the health system. Federal health authorities apparently were mainly concerned with transferring as many functions as possible to state and municipal spheres of government, although INAMPS' civil servants were resistant to it (Respondent/23 1992; Respondent/26 1992). Other respondents have focused their explanations on the difficulties of incorporating INAMPS into the state health secretariat (Respondent/5 1992; Respondent/25 1992; Respondent/27 1992).

There was no big difference between the answers of users and non-user, as can be seen in Graph 7.2. Nevertheless, this Graph also shows a particular characteristic especially in user respondents' responses: many of them did not answer the question. Out of ten users, four did not know what position the federal government had on the issue. It could be due to the

weakness of the federal health authority in office during that period. Even the representatives of health institutions could not recall who was the Minister of Health then (Respondent/5 1992). This "ignorance" or "lack of memory" could be both an indication of federal health authority indifference towards the issue or of the political weakness of federal health authorities in this specific period. It could also be due to the withdrawal, in 1989, of the direct representation of INAMPS from the commission. This institute was incorporated into the state health secretariat because of the implementation of the **SUDS**. Especially for user representatives, it was difficult to identify which were those authorities without direct representation in the forum and what was their position on user participation (Respondent/11 1992).

At the beginning of 1990, the first directly elected president since 1961 took office in Brasília. The legitimacy of the polls reinforced the role of central government on the political scene. It was a right wing government supporting privatisation policies, but resistant both to the devolution of political power from the central level to state and municipal levels of government and opposing institutional democratisation. In the health field, the Minister of Health affirmed that the main ministerial policy would be to consolidate the health system created by the new Constitution (Guerra 1990: 6). Nevertheless, when the **health laws** were passed by the Brazilian Congress in September 1990, the federal health authorities induced the President to veto articles that reaffirmed the constitutional principles of decentralisation of the health system and user participation. Although federal health authorities affirm to favour decentralisation and user participation, they in practice acted politically against them. Hence, the literature usually suggested that federal health authorities, in **1990 and 1991**, were against the involvement of user representatives in municipal health fora (Paim 1990, 7; Arouca 1990, 9; Escorel and Pavuna 1990, 16-7).

The perception of the regular participants concerning the position of the federal health authorities, broadly confirms the supposition in the literature that they were resistant or indifferent to the issue. As can be seen in Graph 7.1, the majority of respondents believed that these authorities were indifferent to the issue. Graph 7.2 demonstrates that user and non-user respondents have a similar pattern of distribution of answers. Looking at Graphs 7.1 and 7.2, it is possible to observe that the answers referring to the periods 1988/1989 and 1990/1991 were similar. When referring to 1990/1991 there were also many respondents who did not answer the question and most of them were users. There were respondents (six) who answered without further comments even when asked to explain their opinions. The "non-answers" could again be attributed to the withdrawal of the federal health authorities from the municipal political scene. Among the seven respondents who explained their answers, four - one user and three non-user

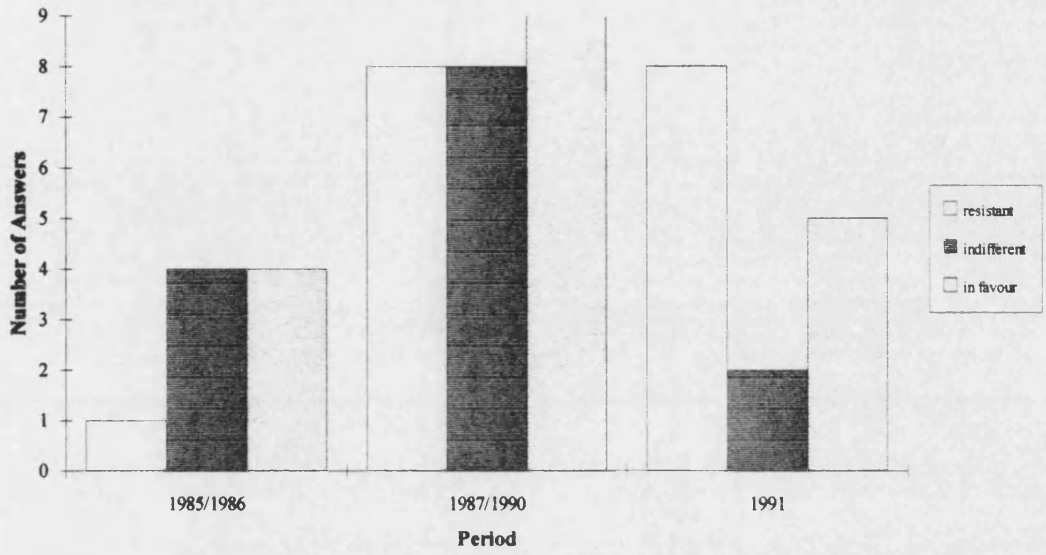
representatives - pointed out that, in 1990 and 1991, federal health authorities just talked about user participation, but that they were in reality resistant or indifferent to it (Respondent/5 1992; Respondent/12 1992; Respondent/18 1992; Respondent/28 1992). User respondents observed that if before federal health authorities had had any good will towards user representatives, in this period they had none (Respondent/7 1992; Respondent/10 1992). An institutional representative pointed out that, in contrast to former periods, in 1990 and 1991, federal health authorities in Rio Grande do Sul did not even acknowledge that there were user representatives participating in a municipal health forum (Respondent/26 1992).

7.4. Position of State Health Authorities on the Involvement of Users in the Municipal Health Commission

During **1985 and 1986**, the right wing Democratic Social Party (PDS), which had supported the military regime, was in charge of the state government in Rio Grande do Sul. The state health authorities were, therefore, identified with this party, and were not regarded as Brazilian health system reformers. The governor of Rio Grande do Sul at that time, who had chosen them to direct the state health secretariat, was Jair Soares, state secretary of health and Minister of Social Security during the military dictatorship. When he was Minister of Social Security he did not allow the PREVSAUDE programme to be implemented. As was seen in chapter four, this programme was the first comprehensive attempt at integrating the system and of promoting user participation. Because of this political background, state health authorities were not expected to favour the involvement of users in the municipal health commission of Porto Alegre.

However, state health authorities seem to have had a more complex relationship with user representatives than their partisan affinities would lead us to suppose. As can be seen in Graph 7.3, the majority of respondents considered that the state health authorities were indifferent to or favoured the participation of user representatives in the decision-making process of the commission. A non-user respondent explained that the state health authorities did not seem to have any conviction about promoting the participation of user representatives. He acknowledged, however, that representatives of the state health secretariat, in this period, had always participated in the activities of the municipal health commission, even if they often ignored the decisions taken there (Respondent/27 1992).

Graph 7.3 - Opinion of Participants in the Municipal Health Commission about the Position of State Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991



SOURCE: Interviews with Participants in Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December of 1992, transcript, Interviewer Files, London.

Nevertheless, user respondents believed that the state health authorities favoured the participation of user representatives in the decision-making process of the commission. A user respondent, who was a very aggressive activist from the urban social movement in district four, identified with left wing parties, affirmed that the state secretary of health, Germano Bonow, had the best ever relationship with the community (Respondent/7 1992). She affirmed that he was attacked by the community during his first years as secretary, when it was very hard to work with him. During the last three years of his administration, however, he became very close to the community, listening to and respecting their decisions (Respondent/7 1992). Another user respondent, from the same region, said that this secretary had tried to deal with the claims of the community objectively and respectfully, but he criticised his choice of political party (Respondent/8 1992).

The only respondent who thought that the state health authorities were against the involvement of user representatives in the municipal health commission was a representative of the federal health authorities (Respondent/22 1992). During 1985 and 1986, she maintained that the state health secretariat directors, and its representatives in the municipal commission, intended to hinder user participation and to undermine the forum itself. On the one hand, her view could be biased, because she supported the reform of the system promoted by the federal

health authorities. When considering the idea that the state health authorities were against user participation, she could be extending the state health authorities' criticism of the type of health system reform under way to a supposed opposition they would have towards the empowerment of user representatives. On the other hand, the state health authorities could have been supporting a type of user involvement in the health sector that was essentially different from the type of participation Brazilian health system reformers, like herself, defended.

State health authorities, during 1985 and 1986, seemed to favour incremental changes towards a better integration of the health system. They did not consider central to their project the administrative integration of the sub-sectors of public health and of social security health care, which, in contrast, were essential to the plan of the Brazilian health system reformers. A representative of the state health secretariat, in 1985 and 1986, illustrates their position.

> *"The Law, I knew the number by heart, 8,229 or 6,229, that one that in the early seventies divided the health between INAMPS and Ministry of Health. The Ministry was responsible for immunisations, sanitation and all these things, INAMPS for providing medical attendance. That dichotomy, that wonderful thing* [sarcastic]... *Everybody used to swear against it. Nowadays we do not have it any more. What is the result? Nothing! It is a catastrophe. There is no sanitation anymore, there is no immunisation, there is no medical attendance. There is neither one nor the other"* (Respondent/24 1992).

These authorities promoted the organisation of public health services into districts, and highlighted the disadvantages of centralised planning because of its distance from the communities. According to them local populations should participate in the system, presenting their needs and helping to increase the efficiency and efficacy of health services (Grupo de Apoio e Dinamização Setorial 1980, 2). Nevertheless, they did not consider that user representatives should participate in decision-making. The institutionalised and overt representation of interests in the municipal health commission was regarded by them as the pointless struggles of one community against another for scarce resources (Respondent/24 1992). Instead of helping to find more effective methods of running the forum, these health authorities reinforced direct individual links with social movement leaders. They promoted traditional forms of representation of users' interests, in which politicians or State bureaucracy would establish direct and informal relations with individuals, who were leaders of the urban social movements. Not surprisingly, when user respondents provided examples of the support that the state health authorities had given to community participation, they reported events where they interacted directly with social movement activists and never their actions in the municipal health commission itself.

Between 1987 and 1990, the central-left Party of the Brazilian Democratic Movement (PMDB) ran the government of Rio Grande do Sul and, consequently, the state health secretariat. The main managerial posts of this secretariat were held by health professionals closely identified with the reformers' faction in office at the Ministry of Health and INAMPS between 1985 and March 1988. So, it is reasonable to suppose that they would have promoted the decentralisation of the state health services and, at the same time, stimulated the empowerment of the municipal health fora as well as the participation of user representatives in the decision-making process of the commission.

This expected support for user involvement in the commission's decision-making was not confirmed by the views of the regular participants in the commission. As can be seen in Graph 7.3, among these participants, there was no predominance of a type of response about the views of the state health authorities on participation.

It is curious that the only user respondent who was a militant of the Party of the Brazilian Democratic Movement (PMDB), the political party running the state government in this period, affirmed that the state health authorities did not favour user participation. This urban social movement leader observed that state health authorities had only "talked" about participation. He recalled that only once did the state secretary of health receive community leaders, although they had tried many times to present their demands to him (Respondent/10 1992). Another respondent, who was a Brazilian health system reformer and a representative of the federal government, affirmed that the state health authorities favoured user participation, but only slightly. According to her, they neither helped to promote it nor worked to hinder it (Respondent/22 1992). The opinion of these two respondents is intriguing since they were both affiliated to parties supporting the state government and the reforms under way in the Brazilian health system. It is one among several indications that managers of the state health secretariat had an ambiguous attitude towards the issue.

There were further indications of this apparent ambiguity. Firstly, there was the already mentioned similar number of respondents affirming that the state health authorities favoured, were indifferent or resistant to the participation of user representatives in the decision-making process of the commission. Another indication of this ambiguity is that some respondents (three non-users and two users) distinguished between the position of the state secretary of health and the position of representatives of the state health secretariat in the commission. Apparently two different political strategies were in dispute within the state health secretariat. Some directors defended a similar strategy of widespread support to the consolidation of municipal participatory fora independently of partisan differences. Others defended more selective

support. For the latter strategy the empowerment of the municipal health commission of Porto Alegre was a non-priority. This was so because the municipal health secretariat, whose secretary was the co-ordinator of the commission, had been run by two political parties seen as rivals by the state health authorities: the central-left Democratic Labour Party (PDT) during 1987 and 1988, and the leftist Workers' Party (PT) during 1989 and 1990. Furthermore, the majority of user representatives on the commission came from organisations that had political connections with the two parties.

The directors of the state health secretariat were resistant to the empowerment of the commission, while a group of important managers of the secretariat favoured it (Respondent/4 1992). Representatives of the state health secretariat at the commission had clearly supported user participation in the decision-making process of the commission. These representatives participated regularly in the activities of the commission, trying to find a way of attending to the demands of users and of implementing decisions taken by the commission. A respondent observed that the representative of the state health secretariat at the commission during 1987 and 1988 tried to empower the forum. Her effort, nevertheless,

> *"had no consequence, because the state secretary of health did not 'embrace' the decisions, undermining the image of this representative inside the forum. (...) What does it mean? It means that she did not have power to represent the state health secretariat inside the forum. She came only because she was the director of out-patient units of the state located in Porto Alegre"* (Respondent/27 1992).

A representative of this secretariat explained that it favoured user participation but was resistant to it in Porto Alegre particularly when the Workers' Party (PT) was in the municipal government. With few exceptions, the directors of the state health secretariat, particularly the secretary, "abhorred" the municipal health commission of Porto Alegre. They did not want to help the consolidation of this forum not because they were against user participation, but because the municipal sphere of government was in the hands of the Workers' Party (PT) and because an increasingly large number of the leaders of urban social movements in Porto Alegre were supporting this party.

The competition was not only for votes, but also for ideological dominance within the health sector, and within the "policy community" of the Brazilian health system reformers. Those running the municipal health secretariat during 1989 and 1990 participated in this "community", both regionally and nationally. The attitude of the state health authorities seems to be part of the dispute dividing the Brazilian health system reformers at the national level. It was mostly polarised between those more closely identified politically with the communist parties and with leftist sections of the Party of the Brazilian Democratic Movement (PMDB),

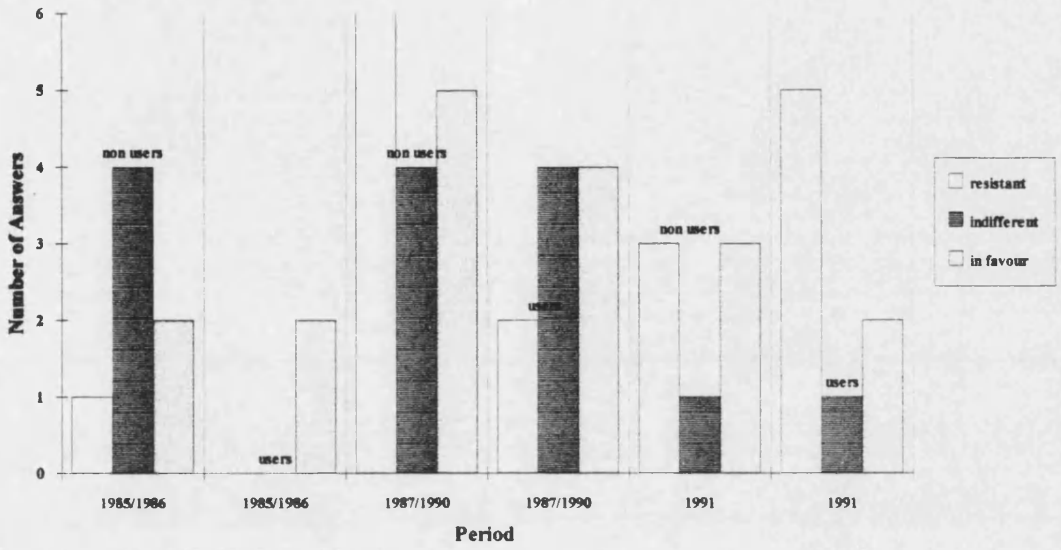
and those who were more closely identified with other left wing parties, particularly with the Workers' Party (PT) (Gallo and Nascimento 1989, 105-7).

In **1991**, the central-left Democratic Labour Party (PDT) took over the government of the state of Rio Grande do Sul. Militants and sympathisers of this party had strongly defended further decentralisation of the health system and its democratisation. So, it is possible to suppose that the state health authorities in this year would be supporting the participation of user representatives in the decision-making process of the municipal health commission of Porto Alegre and the empowerment of this commission.

During the first nine months of 1991 the state health authorities supported the empowerment of the forum, but from October of that year they went clearly against it. Official representatives of the state health secretariat participated irregularly in the forum during the first nine months of 1991 and after that just stopped coming (CIMS 1991, 17/01/1991 to 19/12/1991). A user respondent suggested that the good relationship established at first between the state health authorities and the community had deteriorated, and that the representative of the state health secretariat at the commission gave up working in, what this respondent called, an authoritarian administration (Respondent/7 1992). She observed that, from October 1991, state health authorities refused to participate in local and municipal health commissions because they thought they had been treated disrespectfully by user representatives there (Respondent/7 1992). Apparently the refusal to participate was the main impression that the state health authorities had left on regular participants in the commission, since many respondents (eight out of fifteen) regarded them as resistant to the participation of user representatives in the decision-making process of the commission. As can be seen in Graph 7.4, user respondents in particular considered that the state health authorities were resistant to participation.

Political competition between the Workers' Party (PT) and the Democratic Labour Party (PDT) partially explains why the state health authorities withdrew from this forum. The two parties had support in urban social movements in Porto Alegre. Nevertheless, the Democratic Labour Party (PDT) was losing ground. The Workers' Party (PT) was intensifying its influence over these movements (Baierle 1992, 123-5). Leaders of urban social movement organisations were active participants in municipal and local health commissions, whose role in the movement had been reinforced, since 1989, by the support offered to them by the administration of the Workers' Party (PT) in the municipal health secretariat. At first, the state health authority had tried to counterbalance this alliance between urban social movement activists and municipal health authorities. When they realised that it was not possible they had refused to legitimate the forum with their presence.

Graph 7.4 - Opinion of Participants in the Municipal Health Commission about the Position of State Health Authorities on User Participation: Number of Answers of User and Non-User by Period - Porto Alegre - CIMS - 1985/1991



SOURCE: Interviews with Participants in Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December of 1992, transcript, Interviewer Files, London.

Another reason for the failure of the state health authorities to consistently support the empowerment of the forum could be the dominance within the state health secretariat of the more traditional factions of the Democratic Labour Party (PDT) (Respondent/4 1992). Nevertheless, a major reason is probably the style of policy-making of this party, which usually relies on relations of patronage between politicians or bureaucrats and activists of social movements. The difficulty in dealing with organised interest groups in overt public spaces can probably help to explain their resistance in supporting the empowerment of the municipal health commission of Porto Alegre. When invited to attend a particular meeting of the commission, a director of the state health secretariat affirmed that he would not go because he did not want trouble. If user representatives had any demands they should seek direct contact with him at his office (Respondent/28 1992). A user respondent pointed out that they were very much resistant to user participation:

> *"moreover if the community participated in an organised manner. They had real fear of this. If it was non-organised, alienated participation, they welcomed and stimulated it, but in an organised manner they did not"* (Respondent/7 1992).

7.5. Position of Municipal Health Authorities on the Involvement of Users in the Municipal Health Commission

Municipal health authorities are probably one of the most influential actors in the participatory process taking place in the Brazilian municipal health fora. In the case of Porto Alegre, the commission was physically located inside the municipal health secretariat headquarters. The meetings took place there. The administrative and secretarial services were mostly provided by the staff of this secretariat. The municipal secretary of health has always been the co-ordinator of the forum.

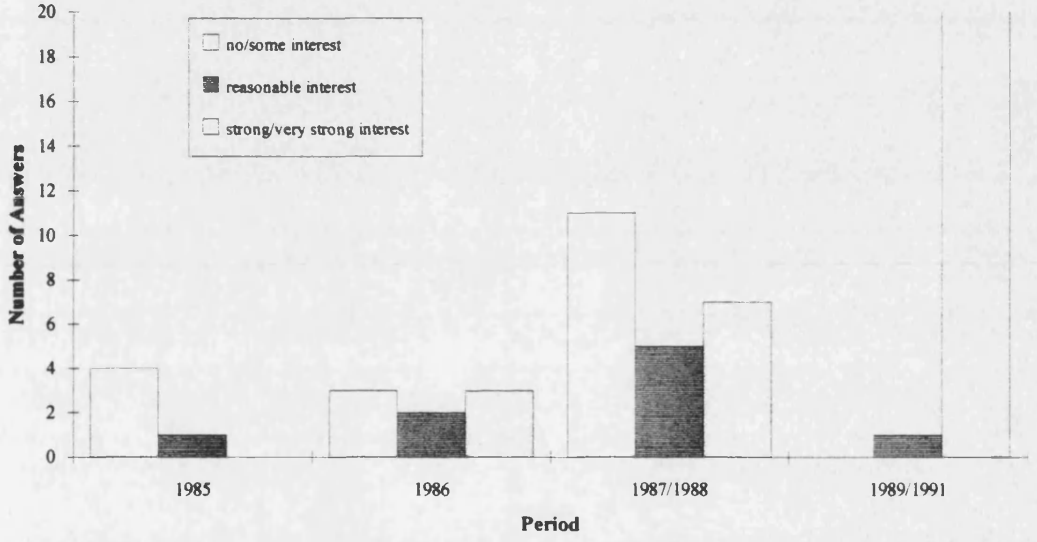
During **1985**, politicians identified with the authoritarian regime were in the municipal government of Porto Alegre. The secretary of health was the medical doctor Pedro Ruschel, who had worked for many years in the municipal emergency hospital (Hospital de Pronto Socorro de Porto Alegre) (Respondent/1 1992). According to a health professional who worked closely with him (Respondent/1 1992), his main interest was to promote this hospital. For him, public health matters as well as the municipal health commission were secondary issues. The commission was created during his administration because it was a means of obtaining financial resources from the social security system for this hospital (Respondent/27 1992). As a consequence, it is possible to suppose that, during this year, the municipal health authorities would not favour the participation of user representatives in the decision-making process of the municipal health commission.

Graph 7.5 demonstrates that the opinion of the majority of respondents confirmed this supposition. Most regular participants in the commission in 1985 considered that the municipal health authorities had little or no interest in promoting participation. Two respondents had highlighted the fact that the municipal secretary of health, given his hospital career, was not particularly interested in this participation (Respondent/1 1992; Respondent/27 1992). Other respondents had pointed out that, beyond the lack of interest of this general director, there was a generalised ignorance about how it would actually function, since the forum was a total novelty and had not yet established rules or a work routine (Respondent/23 1992; Respondent/24 1992).

In **1986**, the first directly elected government took office in the city hall of Porto Alegre since the beginning of the military dictatorship. The winning party was the Democratic Labour Party (PDT). As mentioned above, this party supported the further decentralisation of the health system and user involvement in its decision-making process. The new municipal secretary of health, the medical doctor Cláudio Silveira, was a public health specialist, who had worked for many years in public health institutions. His thoughts on public health were not influenced by

the Latin-American literature on social medicine, in contrast to the reformers of the Brazilian health system who took part in the production of this literature. His conception of public health and of health planning and administration came from English and American literature on inequality and equity. His other source of inspiration were the Latin-American classics on public health, such as planning methods recommended by PAHO and budgeting and programming techniques (Respondent/2 1992).

Graph 7.5 - Opinion of Participants in the Municipal Health Commission about the Position of Municipal Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991



SOURCE: Interviews with Participants in Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December of 1992, transcript, Interviewer Files, London.

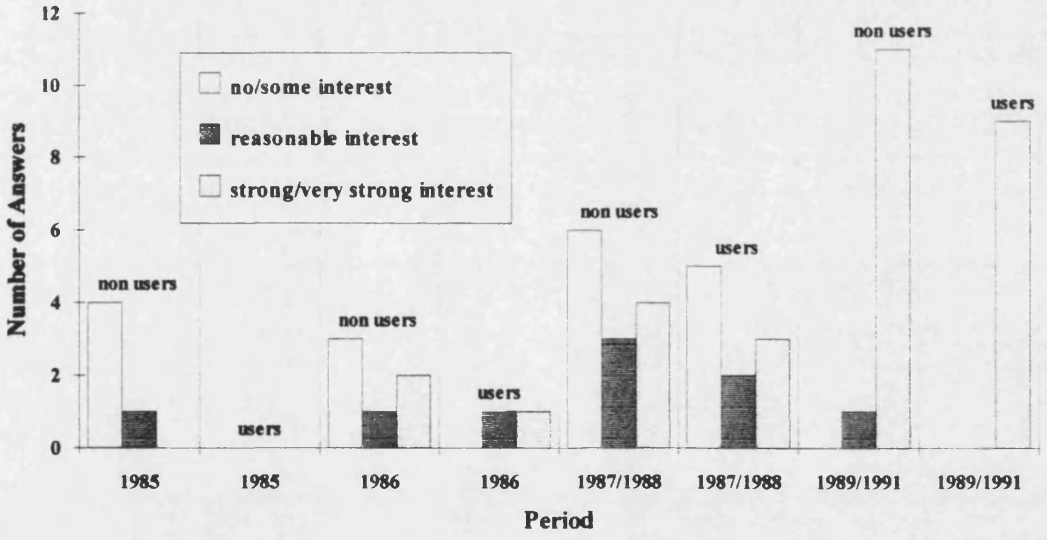
As regards user participation, the municipal health authorities seemed to be interested in promoting the involvement of user representatives in the commission but not in its decision-making process. The municipal health authorities' "great dream" was the consolidation of the municipal government's proposal to create popular councils distributed throughout the city. In these councils, representatives of urban social organisations would look at the problems without the bias of a particular sector, they would be concerned with the "whole" city (Respondent/2 1992). The municipal health commission, in this context, would be the "technical arm" of these councils. According to a representative of the municipal health secretariat this dream has never become reality. He also acknowledged that their views on the participation of user

representatives were rather technocratic. Participation should allow the exchange of information and not an involvement in the process of taking decisions (Respondent/2 1992).

Graphs 7.5 and 7.6 demonstrate that, among both user and non-user respondents, there was no clear predominance of one type of answer about the interest of municipal heath authorities in user participation. A non-user respondent explained this ambivalence among respondents, affirming that this municipal secretary of health had much more respect for user representatives than the former. Nevertheless, he also observed that he did not seem to be comfortable with the idea of user participation. The municipal secretary of health had

> *"a much better attitude, he was more respectful in plenary meetings, but he had, as well, the behaviour of a technician who was not used to working with the community"* (Respondent/27 1992).

Graph 7.6 - Opinion of Participants in the Municipal Health Commission about the Position of State Health Authorities on User Participation: Number of Answers of User and Non-User by Period - Porto Alegre - CIMS - 1985/1991



SOURCE: Interviews with Participants in Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December of 1992, transcript, Interviewer Files, London.

The only two users to participate regularly in the commission during 1986, however, believed that the municipal health authorities were interested in user participation in the commission. One affirmed that the secretary's co-ordination of the forum was more open and democratic than the former (Respondent/8 1992). The other, a very aggressive user representative, affirmed that the secretary had a strong interest in user participation. She

remembered an argument she had had with him once, when he had argued that she had shown disrespect towards a representative of the medical profession. She added that, even remembering this argument, she acknowledged that he had tried to involve the community in the activities of the commission (Respondent/7 1992).

During **1987 and 1988**, the Democratic Labour Party (PDT) was still in the municipal government of Porto Alegre. Nevertheless, the municipal secretary of health had changed. The new secretary, the medical doctor Olímpio Albrecht, was a professional politician, rather than a health professional. As a politician from a party with a strong populist tradition, he would not be expected to favour user representatives taking part in decisions. Nevertheless, the deputy secretary, the medical doctor Mário Dantas, who would became secretary in the last eight months of 1988, could be regarded as a Brazilian health system reformer. His ideas about public health, and the planning and administration of health services were deeply influenced by the works of leading reformers (Respondent/4 1992). In contrast to Olímpio Albrecht, the deputy director would be expected to favour users participating in the decision-making process of the commission.

A representative of Olímpio Albrecht's administration highlighted the incentives given, during this administration, to the organisation of the local health commissions, to the promotion of regular plenary meetings with intensive civil society participation and to the institutionalisation of the inspection commission. He pointed out, however, that user representatives wanted to control everything, which according to him, was not "right". Although it was a positive appraisal of the incentives given for the participation of user representatives, it also demonstrated that there was some tension between the municipal health authorities and the user representatives (Respondent/3 1993). A participant of Mário Dantas' administration had a more critical view on the issue. Municipal health authorities in this period, he observed, thought that user representatives should help in the inspection of the quality of health services, should make suggestions, and should obtain information about health services. They did not think that user representatives should take part in the decision-making process, since they regarded it as a prerogative of the municipal health secretariat. According to him, the dominant position within the Democratic Labour Party (PDT) was that they should stimulate user participation, since users agreed with what the executive had already planned. He also observed, however, that it was a traditional populist politician, Olímpio Albrecht, who had transformed the municipal health commission of Porto Alegre into a real participatory forum. Municipal health authorities in this period invited user organisations to participate and

eventually, he added, municipal health authorities lost control over user representatives (Respondent/4 1992).

Graph 7.5 shows that the majority of respondents thought that, during these two years, the municipal health authorities had no interest or some interest in the participation of user representatives in the decision-making process of the commission. Graph 7.6 demonstrates that the pattern of the answers was similar among user and non-user respondents.

Eleven respondents had described the attitude of the municipal health authorities as autocratic or manipulative, or affirmed that they tried to impose their views, only accepting the decisions they agreed with. A non-user respondent observed that the municipal health authorities did not place decisive issues on the agenda of the forum. He added that they did not want to share political power (Respondent/27 1992). This respondent argued that Olímpio Albrecht had an authoritarian style of co-ordinating the forum. According to him, this director

> *"was extremely domineering, he would never share power, he would never allow it"* (Respondent/27 1992).

Two user respondents pointed out that the municipal health authorities had to "swallow" the increasing influence of user representatives within the forum (Respondent/7 1992; Respondent/15 1992). Two others, in contrast, had praised their precise and objective style in conducting the meetings (Respondent/11 1992; Respondent/13 1992).

Seven respondents have compared the style of co-ordination of Olímpio Albrecht and Mário Dantas. They regarded the latter as more open to the involvement of user representatives in the commission (Respondent/4 1992; Respondent/7 1992; Respondent/8 1992; Respondent/13 1992; Respondent/18 1992, Respondent/22 1992; Respondent/27 1992). Nevertheless, five observed that he was a weak substitute, without the political strength to impose his own style over the work of the commission (Respondent/9 1992; Respondent/12 1992; Respondent/13 1992; Respondent/16 1992; Respondent/27 1992). Although respondents acknowledged that their co-ordination styles were different, the strong political bonds between these two directors and the permanence of the same team of professionals in both periods allows these administrations to be considered jointly.

During **1988, 1989 and 1990**, the Workers' Party (PT) was in the municipal government in Porto Alegre. The sociologist Maria Luiza Jaeger was the first woman and the first non-medical doctor to be municipal secretary of health. Her ideas about health policies, and the planning and administration of health services were influenced mainly by the reformers of the Brazilian health system (Respondent/5 1992). She was an active member of this "policy

community" of reformers. Between August 1986 and May 1987, she had participated in the national commission set up to produce a reform plan for the health system (Comissão Nacional da Reforma Sanitária). In this commission, she was the official representative of the trade union confederation CUT (Central Única dos Trabalhadores), which had strong connections with the Workers' Party (PT). This party, to which she was affiliated, supported a reform of the Brazilian health system based on state ownership of all health services or, at least, strict public control over them. They also defended immediate decentralisation of the health system, through municipalisation as well as the participation of user representatives in the decision-making process of municipal health commissions.

Graph 7.5 shows that nearly all the respondents thought that the municipal health authorities, during this period, had a strong or very strong interest in the participation of user representatives in the decision-making process of the municipal health commission. Graph 7.6 demonstrates that there was no important difference between the distribution of answers of users and non-users. Nevertheless, many respondents criticised their initial style of co-ordination. Some respondents maintained that municipal health authorities placed on the agenda of the forum too many small financial and administrative issues (Respondent/11 1992; Respondent/26 1992). A respondent observed that, as former members of the plenary, they did not know, at first, how to conduct the commission. At the same time, he pointed out that they suffered strong pressure from users to find solutions, since they were seen as former "companheiros" by user representatives (Respondent/12 1992). As a result, they brought up for discussion many issues whose solution did not depend on the forum or on the municipal health secretariat, generating frustration among participants (Respondent/7 1992; Respondent/25 1992). A participant in the administration of the municipal secretariat at that period admitted that they had had a difficult start. She observed that many of the directors of the secretariat were professionals who had participated in the commission as representatives of trade unions or trade union confederations. They had to learn the new role as municipal health authorities. After the first year, it became easier, especially when the local commissions were consolidated and the public health professionals of the municipal health secretariat's out-patient units became involved in promoting the participation of user representatives in local and in municipal health commissions (Respondent/5 1992).

Many respondents referred to the efforts of the municipal health authorities at decentralising the decision-making process through the support they gave to the organisation of local health commissions. They stimulated the participation of civil servants in local and municipal health commissions and helped to decentralise the process of decision-making,

pressurising local commissions to discuss and to solve their problems locally (Respondent/27 1992). Apparently, after the first half of 1990, the municipal health authorities managed to put together a strong interest in promoting the participation of user representatives in the decision-making process of the commission and a proper strategy to implement it. As a representative of the state health secretariat affirmed, their interest had always been strong, but the strategy had changed (Respondent/26 1992).

7.6. Relationship between Public Health Professionals, Working at the Local Health Units, and Urban Social Movement Activists

As was seen in the last chapter, the public health professionals who worked in the municipal, state and federal out-patient units, spread over the territorial area of the city, could have influenced the involvement of users in the municipal health commission. They had, in particular, helped to organise local health commissions and to promote user participation in these decentralised participatory fora. Based on the descriptions presented in chapters five and six, it was possible to distinguish three distinct periods with regard to the relationship between public health professionals and activists of urban social movements in Porto Alegre.

In the first period, **1985 and 1986**, only in district four was there a strong relationship between public health professionals working in local units and urban social movement activists. In 1980, in this region, the pre-existing interest of urban social movements in health issues (Respondent/8 1992, Respondent/15 1992) had benefited from the activism of some public health professionals, mainly those working in the out-patient health units of the state health secretariat. After that, this relationship was permanent and intense. In district two, from 1985, there was the mobilisation of some health professionals and of urban social movement leaders, when they created the local health commission of the district (Respondent/CLIS2 1993). Most of the health professionals, in this case, worked in the out-patient units of the programme of family medicine of the hospital Nossa Senhora da Conceição. Nevertheless, the involvement of urban social movement leaders was not very intense.

The second period was **between January 1987 and April 1990**, when, in many areas of the city, there was a close relationship between public health professionals and activists of urban social movements. In this period, besides districts four and two, in districts three, five, six, nine and ten there was a close relationship. These public health professionals could work in the out-patient units of a programme of family medicine, as in districts two and five, or they

could be federal, state or municipal civil servants, as in districts three, four, five, six, nine and ten.

In the third period, **between May 1990 and December 1991**, there was a close relationship between public health professionals and activists of urban social movements in all areas of the city except districts one and eleven. During this period, in contrast to the previous ones, there was a consistent municipal policy of stimulating the health professionals of the municipal health secretariat to enhance their relationship with the leaders of urban social movements. The main objective was to consolidate the local health commissions in regions of the city where these professionals worked. In 1987 and in 1989, the municipal health authorities had encouraged the public health professionals to approach urban social organisations in the area where they worked. These initiatives, however, lacked consistency and were not as systematic as they were after April of 1990.

7.7. Large and Local Organisations: the Trend towards Decentralisation of Urban Social Movements

Most users attending plenary meetings and most user representatives involved in the decision-making process of the commission came from local urban organisations. Nevertheless, **between September 1985 and July 1988**, many users came from large organisations representing urban organisations or trade unions.

Representatives of trade union confederations, particularly those representing the CUT (Central Única dos Trabalhadores), were among the leading user representatives on the commission. According to many respondents, representatives of this confederation actively participated in the commission (Respondent/4 1992; Respondent/27 1992; Respondent/28 1992). They had been present at nearly all the plenary meetings held between 12 May 1987 and 15 December 1988 (CIMS 1987/1988, 12/5/87 to 15/12/88). During this period, they took part in the inspection commission and occasionally attended meetings of the co-ordinating committee and technical secretariat.

Even if the documentation and other participants in the commission maintained that they were intensely involved in the commission, there were eleven out of the 23 respondents who considered that this confederation did not participate or that it had a very low profile within the commission. Intriguingly, six out of these eleven respondents had spontaneously highlighted the fact that Ricardo Collar and Miriam Rosa, the two most frequent representatives of this confederation, had played a remarkable role in the consolidation of the commission,

particularly due to their participation in the discussions about, and writing of, the internal regulations. These respondents thought that they represented a trade union of health professionals or the trade union of civil servants of the state health secretariat.

By 1988, in the state of Rio Grande do Sul, the department of health of the CUT was made up of health professionals representing trade unions of health workers and health professionals. Many respondents did not realise that these two health professionals were representatives of the trade union movement, because they had a "triple identity" as representatives. They were left wing reformers of the Brazilian health system, in terms of their opposition to the gradualist reforms of the federal government and their defence of State ownership of health services (Comissão Nacional da Reforma Sanitária/Emendas CUT, ABEN, CONAM, FNM 1989, 59-60). They were representatives of trade unions of health workers and health professionals. They represented the group of health professionals discussing health policies within the CUT in Rio Grande do Sul.

A participant in the municipal health commission was critical of this multiple identity, questioning whether they actually represented the interests of members of the trade union confederation.

> *"We identified people like them, we feel they were health professionals. Wherever you went you met the same person, with the same discourse, his discourse. He was the legal representative, there is no question about this, but there is a question about whether he was expressing his own thoughts or presenting the thoughts of those he represented"* (Respondent/23 1992).

The legitimacy of any representative could be questioned because there was always uncertainty about the boundary between an individual's personal views and the views of those s/he is supposed to represent. Substantive representation does not imply resemblance to average users or workers. It requires representatives whose better skills, if compared to those they represent, combined with their compatible political views, can be more effective in pursuing the interests of users or workers (Marmor 1983, 82). Nevertheless, due to the lack of widespread discussion of health issues within the confederation, these representatives were seen as defenders of their own ideas about reform rather than defenders of the confederation's plan. A health professional who took part in the department of health of the CUT, at that moment, acknowledged this and even questioned the lack of internal discussion in the confederation.

> *"For example, Miriam was CUT representative at CIMS. She was a health professional, she participated in the discussions of the department of health of CUT. There was a group of people trying to stimulate this discussion inside the CUT, but it was very difficult to promote this discussion inside the confederation as a whole. In some moments, during CUT congresses, the propositions of the department of health*

> *are presented. Nevertheless, I have never seen the directorate of the confederation treating health issues as a priority"* (Respondent/17 1992).

Apparently, the main issue for the trade union movement was health and safety at work (Respondent/5 1992) and not the reform of the Brazilian health system or the increased participation of user representatives in municipal health commissions. As mentioned in chapters four and five, the most highly mobilised categories of workers usually have special insurance schemes or access to out-patient care provided by health maintenance organisations or by the firms where they work. Therefore, improvement in the quality of the health care provided or financed by governmental institutions, which was one of the main goals of the municipal health commissions, was not among the political priorities of the trade union movement leaders representing them.

This lack of interest on the part of the confederation in these issues might explain the complete withdrawal of the CUT representatives from the municipal health commission after 1988. When the Workers' Party (PT) took office in the city hall of Porto Alegre, most members of the department of health of the confederation became directors of the municipal health secretariat. As a consequence, the department of health of the CUT in Rio Grande do Sul was weakened by so many defections. Only in 1992, when the commission began to discuss issues related to health and safety at work, did representatives of trade union confederations return to the forum. Then they would represent trade unions of workers not involved in the health sector (Respondent/5 1992).

During 1988, other large organisations withdrew their representatives from the municipal commission. Such was the case of the Rio Grande do Sul Federation of Community and Neighbourhood Associations (FRACAB) and of the Federation of Rural Workers of Rio Grande do Sul (FETAG). These two federations left the municipal commission, during this year, to participate in the state health commission which had been opened to civil society participation by the **SUDS** programme. More important, however, was the defection of representatives of the Porto Alegre Union of Residential Associations (UAMPA).

Representatives of this organisation played a leading role among the users in the commission (Respondent/15 1992). Most of the users from large organisations (81 out of 183) attending the plenary meetings came from UAMPA. Many urban associations joined this organisation after its creation in 1983 (Baierle 1992, 163). It gradually became the authorised voice of urban social movements in the city. During this period, representatives of UAMPA were among the user leaders in the commission. Nevertheless, from 1988, its representatives gradually withdrew from the forum, signalling a change in the organisation of urban social

movements in Porto Alegre. This change was characterised by a sharp reduction in the influence of UAMPA over urban social movements in Porto Alegre (Respondent/5 1992; Respondent/6 1992; Respondent/8 1992). In 1988, political cleavages culminated in the election of a new directorate through a divisive electoral process. This directorate did not seem to represent the interests of popular associations. On the one hand, partisan cleavages had hampered the ability of directors to promote joint action. On the other hand, the directors of UAMPA prioritised broader political issues, while grassroots associations demanded concrete solutions for local and specific problems (Baierle 1992, 172-5). Moreover, the general political climate had changed. Since the political liberalisation of the second half of the eighties, political parties would be concerned with broad political matters. In this new context, organisations, like UAMPA, lost their former broader political role and, sometimes, it was difficult to find a new one.

The crisis of UAMPA weakened its political role as the official "voice" of urban social movements (Baierle 1992, 170-97). The weakened UAMPA has affected the organisation of these movements, which from then on tended to become more decentralised and organised at the local or regional levels. Nevertheless, the decentralisation of the organisation of these movements seems to have already been under way, which could have undermined the basis of support of UAMPA (Respondent/5 1992; Respondent/8 1992). In any case, it is undeniable that, **between August 1988 and August 1990**, urban social movements in Porto Alegre tended to be organised on a decentralised basis. This change influenced the types of involvement users had in the municipal health commission, since the largest group of participants in the commission were users from urban social movements.

The consolidation of the decentralised basis of the urban social movement in Porto Alegre, however, took place **after August 1990**. The main means of this consolidation was the policy of the Participatory Budget promoted by the Workers' Party's government, which had been in office since 1989. As was seen in chapter six, this policy had its basis in the regional assemblies organised in nine areas of the city. The first time the policy was implemented, in 1989, leaders of urban social organisations did not regard it as a permanent instrument of participatory administration. The second Participatory Budget, whose process was initiated in September 1990, indicated that the policy would be consistent. The Participatory Budget had helped to consolidate the regionalised organisation of the urban movement.

7.8. Issues Discussed in Plenary Meetings

The types of issues placed on the agenda of the plenary meetings can be regarded both as an output of the work of the forum and as an element that could stimulate or inhibit the involvement of users in the commission. It is an output because it is the result of decisions previously made for placing such issues on the agenda of the plenary. It is an element that could promote or hamper the involvement of users because issues might or might not be of interest to users.

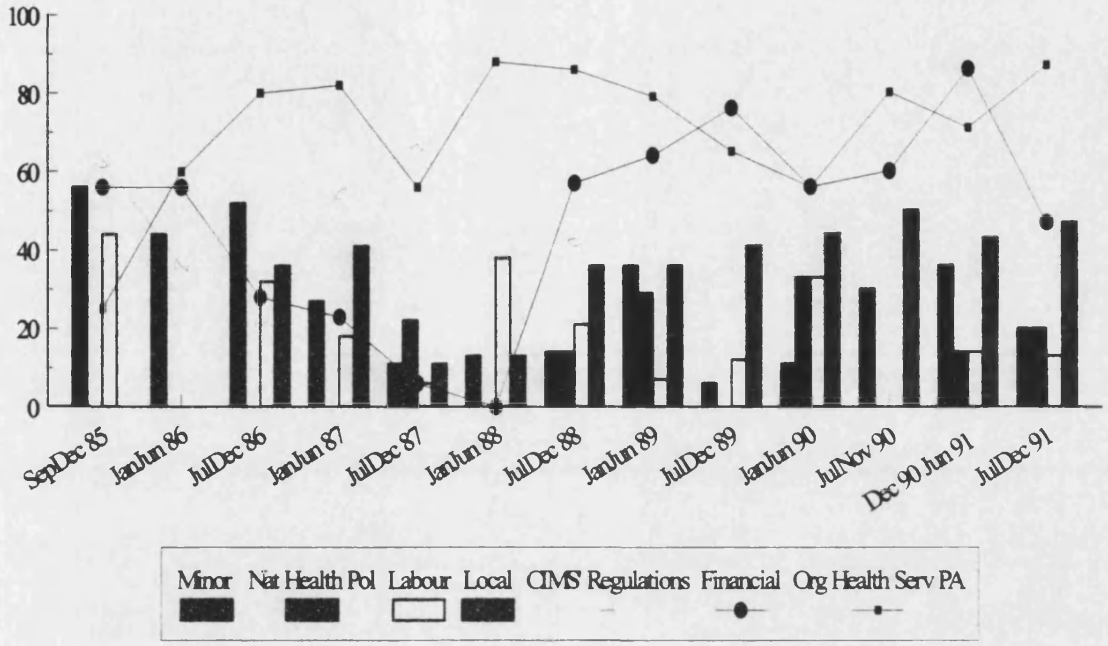
The issues on the agenda of plenary meetings were classified into seven groups: (1) **Minor**. This type of issue encompasses mainly the presentation of reports or of notes about events, programmes or conferences, related or not related to health issues. (2) **National Health Policies**. This classification includes discussions about national health policies and their relationship with the organisation of the state and municipal health services. (3) **Labour**. This comprises discussions, and sometimes the mediation, of issues related to employment relations in the health sector. (4) **Local**. This involves the discussion of issues related to local or individual problems, such as the transfer of, or need for, a professional, the lack of some specific medicine in a particular health unit or complaints about the ill or unlawful treatment of an individual user. (5) **CIMS' Regulations**. This type includes all issues related to creating or changing the working rules of municipal or local health commissions. (6) **Financial**. This comprises all issues related to financial matters, such as routine appraisals of the destination and accounts of financial resources transferred from the social security system to the municipal health secretariat, and new modalities of transfer of these resources or the municipal budget. (7) **Organisation of Health Services in Porto Alegre**. This includes all issues related to the organisation of public health and health care services located in the city of Porto Alegre. These could be discussions about plans, programmes or projects that would affect the organisation of health care or public health and sanitation in the city or in large areas of the city. They could be issues related to licensing, closing or opening health services, as well as to issuing or cancelling contracts between the social security system and providers. They were primarily issues related to evaluating, controlling and changing health care or public health and sanitation in the city.

Graph 7.7 demonstrates that, during 1985, the most frequently discussed issues in plenary meetings were the regulations of the commission. Since the forum was initiating its activities, the participants in that year were trying to agree on basic rules to guide the work of the forum. The organisation of health services in Porto Alegre, which would dominate the agenda after then, was discussed in only 25 per cent (four out of sixteen) of meetings. In 1986,

the organisation of health services in Porto Alegre was discussed in the majority of plenary meetings. It indicates that the forum started out to be mostly concerned with the provision of health care and sanitation in the city. During the second half of 1987, the issue most frequently discussed in plenary meetings was the commission's regulations. It corresponds to the period when the internal regulations had been discussed and passed by the plenary. Excluding this atypical period, the organisation of health services in the city had been the issue most frequently on the agenda until the first half of 1989. In the second half of 1989, for the first time since the commission was created, financial matters were the most frequently discussed issues in plenary meetings. The high proportion of meetings discussing financial issues confirms the appraisal made by some respondents of interviews that, during this period, the forum's agenda was overloaded with financial issues (Respondent/11 1992; Respondent/26 1992). Indicating a change in the way plenary meetings were run, the organisation of health services in Porto Alegre was the issue most frequently discussed in plenary meetings during the second half of 1990. Financial matters were again the issue most frequently discussed in plenary meetings during the first half of 1991. However, as the commission had changed its method of discussion of financial matters, making them more concise (Respondent/26 1992), it is possible to suppose that, even when this issue was present on the majority of the agendas, the discussions would not take up much time. The organisation of health services in Porto Alegre was most frequently discussed in plenary meetings in the second half of 1991.

Hence, there were some types of issues that were frequently on the agenda of plenary meetings. These were issues related to: (1) the organisation of health services in Porto Alegre, discussed in 70 per cent (144) of the 207 plenary meetings in the period; (2) financial matters, discussed in 46 per cent (96) of meetings; and (3) the regulations of the workings of the commission, discussed in 40 per cent (82) of meetings. The third issue was frequently on the agenda in specific periods, when the commission was created, when the internal regulations were discussed and passed by the plenary, or when the plenary was discussing more intensely its working procedures, due to a decrease in the involvement of users in the commission. The predominance on the agenda of one or other groups of issues could have had an influence over the number of users attending plenary meetings as well as over the type of involvement of user representatives in the decision-making process of the commission. Further analysis of this point will be undertaken in the next chapter.

Graph 7.7 - Issues Discussed in Plenary Meetings: Per cent of Meetings, During Each Six Month Period, by Different Types of Issues - Porto Alegre - CIMS - 1985/1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

7.9. Summing Up

The factors and actors that could have influenced user involvement in the municipal health commission of Porto Alegre were deeply interdependent. Looking at each actor and factor separately, however, enables the verification of the complexity of the relationships they established among them.

One factor was the cluster of policies and laws, during the period, that recommended or imposed the progressive institutionalisation of municipal participatory fora in the health sector, and extended the role of users within them. Nevertheless, the existence of strong urban social movements in Porto Alegre made feasible the consistent involvement of users in the commission. The dynamic of these movements, which by 1988 changed from a more centralised into a decentralised pattern of organisation, determined the growth in involvement of users from local organisations. Moreover, Brazilian health system reformers, particularly those working at the local level, together with the activists of the urban movements, had constructed a space for the mobilisation of users in local health commissions. This space was also strengthened by municipal policies that, from 1990 onwards, stimulated the local organisation of urban social

movements. From that time, local health commissions became the basis of the consistent involvement of users in the municipal health commission.

The position of health authorities on user participation or the forum's work dynamic could have determined changes in user involvement. The actions of Brazilian health system reformers - as federal, state and municipal health authorities and as health professionals working at local levels - were constantly behind the political-institutional changes that would affect the involvement of users in policy formulation and in the politics of the health sector. Urban social movements could offer reformers political support to confront the resistance of social sectors to the reform. Simultaneously, urban social movement activists, seeking to extend their influence over the policy-making of health institutions, could have direct access to health authorities in the commission or could influence the decisions taken there.

With regard to the whole period, it was possible to distinguish variations in the major factors influencing user involvement that allowed them to be classified into three ordinal categories (displayed in Table 7.1, Introduction), each corresponding to a specific period of time. The institutional framework of the Brazilian health system has progressed towards policies or laws which have deepened the process of integration and decentralisation of the system. In the case of the federal, state and municipal health authorities, although there were peculiarities, the evolution is towards the increasing interest of these authorities in the involvement of users in the forum. However, the progression of the category does not mean evolution in time. For example, federal health authorities between 1985 and March 1988 favoured user involvement in the commission, and in 1991 they did not. The relationship between public health professionals and activists of urban social movements progresses towards a close relationship in more areas of the city, which culminates in policies stimulating this. The organisation of urban social movements takes into account the evolution towards a more decentralised pattern of organisation, which also culminates in the Participatory Budget, which promoted an additional incentive for decentralisation. Many regular participants in the commission had highlighted the fact that the decrease in the involvement of users, especially during 1989 and 1990, was related to the overload of financial issues on the agenda. Because of this, in the case of issues discussed more frequently in plenary meetings, the progression is towards less frequency of discussion of financial issues and more frequent discussion of the organisation of health services in Porto Alegre.

In the next chapter, the major influences on the involvement of users will be correlated with the two indicator-variables described in chapter six: *the number of users attending plenary meetings* and *the types of involvement of user representatives in the decision-making process of*

the commission. It will then be possible to verify whether the analysis of these factors could help to explain the types of involvement users have had in the municipal health commission of Porto Alegre between 1985 and 1991.

Chapter 8

Explaining the Involvement of Users in the Municipal Health Commission of Porto Alegre

8.1. Introduction

This chapter examines the possible existence of linkages between user involvement, and the institutional-political factors that could have influenced this involvement, in the municipal health commission of Porto Alegre. The variations in the two main indicators of involvement - *the number of users attending plenary meetings* and *the types of involvement of user representatives in the decision-making process of the commission* - and variations in the behaviour of major factors that could influence user involvement are briefly summarised.

The most objective indicator of involvement is the attendance of users at plenary meetings, each meeting being regarded as a basic "case". Hence, for each of the 207 plenary meetings, there is a particular register (category) which provides evidence for each indicator of the involvement of users and the behaviour of each factor or actor at that moment.

8.2. The Relationship Between User Involvement and the Factors that Influenced this Involvement

Taking into account the description of the dependent and independent variables, discussed in chapters six and seven, it is possible now to establish whether they are correlated. Before doing so, however, the behaviour of these variables, throughout the period, will be summarised into a number of categories to facilitate the verification of possible correlation among them.

The ***dependent variable***, in this research, has two indicators, which could be treated as two variables themselves.

The first one, **the number of users attending plenary meetings** does not express, on its own, whether users had any political influence over the forum. Nevertheless, it is a very

objective means of indicating whether users were involved at all in the activities of the forum, since it is used in combination with other types of evidence. The attendance of users at the 207 plenary meetings of the period, had a significant (Sigf = .00) growth (r^2 = .44) during the period. Nevertheless, this growth was not very regular, and there was one sub-period - between January 1989 and December 1990 - when the attendance did not increase.

The number of users attending meetings varied between none (zero) and 27. Aiming at verifying whether there is an association between this variable (attendance) and other variables, the observed count of users in each plenary meeting were distributed in bivariate Chi^2 tables. All tables displayed many cells (varying between 81 and 90 per cent of cells) with an expected frequency of less than five, making the use of this test questionable. To overcome this difficulty, this continuous variable was transformed into a categorical ordinal one. The criterion used in this transformation was related to the number of existing health districts, since the majority of user participants came from local organisations in these districts. Three categories were created. (1) The first encompasses plenary meetings that had none (zero) to two users present, corresponding to a maximum potential presence of users from two out of the ten health districts. (2) The second category encompasses plenary meetings that had between three and seven users in attendance, corresponding to a maximum potential presence of users from seven out of the ten health districts. (3) The third category encompasses plenary meetings that had more than seven user participants, corresponding to a potential presence of users from at least eight out of the ten health districts. Once these three categories were constructed, it was possible to verify the relation of this indicator-variable to the other variables.

The second indicator of the dependent variable, **the types of involvement of user representatives in the decision-making process of the commission**, is not as objective as the first, but it can offer a substantive account of how user representatives were actually involved in the activities of the forum. As was explained in chapter six, there were four different phases of the involvement of user representatives in the decision-making process of the commission. These phases were defined taking into account the predominant type of involvement that user representatives had in the forum. Taking into account the literature on participation and a preliminary survey, this research originally assumed that these types could be: non-participation, manipulation, delegation, negotiation and participation, as defined in chapter two. The types of involvement found were: (1) **non-participation**, between September 1985 and 12 May 1987; (2) **negotiation**, between 12 May 1987 and December 1988; (3) **delegation/participation**, between January 1989 and November 1990; (4) **participation** between December 1990 and December 1991. Negotiation and participation are qualitatively

distinct modalities of involvement of the user representatives. While the former implies that there was reasonably overt tension between the user representatives and the municipal health authorities, who were the co-ordinators of the forum, the latter indicates that they acted together harmoniously. Although this difference is highly relevant, it did not affect the intensity of involvement of user representatives. For instance, in both cases, they participated in agenda formation. Thus these two types of user representative involvement were collapsed into one single category to make it easier to verify whether it was related to other variables. Hence, the three categories of the variable user representative involvement in the decision-making process of the forum, when verifying its possible association with other variables, were: (1) **non-participation**, (2) **delegation/participation** and (3) **negotiation** or **participation**. These categories are qualitatively distinct, but there was an order between them, regarding the intensification of the involvement of the user representatives in the decision-making process.

These two "indicator-variables" of the dependent variable user involvement in the decision-making process should have a relationship between them. Most user representatives were activists of trade union or of urban social movements. They could represent large organisations of these movements or, more frequently, local organisations of the urban social movements. In any case, if they were more intensely involved in the decision-making process of the forum, they would influence the membership of their organisations to participate in the open decision-making division of the commission: the plenary. The opposite would be also true: if they were less involved in the decision-making process, they would not stimulate members of their organisations to come to plenary meetings. As can be seen in Table 8.1, this assumption was confirmed, since there is a strong positive association between the two variables (Somers' D with *Attendance* dependent = .726).

Table 8.1 - Attendance of Users at Plenary Meetings by Types of User Representatives' Involvement in the Decision-Making Process - Porto Alegre - CIMS - 1985/1991

	Users' Attendance at Plenary Meetings			
	(1) Meetings with 0-2 users N (%)	(2) Meetings with 3-7 users N (%)	(3) Meetings with 8-more users N (%)	
User Representatives' Participation in the Decision-Making Process				**Chi² Pearsons = 153.746 4 DF Sig = .000**
(1) Non Participation	**67** (82.7)	**12** (14.8)	**2** (2.5)	**Cramer's V = .612 Approx Sig = .000**
2) Delegation-Participation	**5** (10.2)	**27** (55.1)	**17** (34.7)	**Gamma = .895**
(3) Negotiation or Participation	**2** (2.7)	**18** (24)	**55** (73.3)	**Somer's *d* with ATTENDANCE dependent = .726**

The ***independent variables*** in this research are those described in chapter seven. These variables are related to each other, particularly those that are strongly associated with the indicator-variables of users' involvement in the commission. They are treated as independent variables, however, to highlight the strength of the association of each of them with this involvement.

The first independent variable is **the institutional framework of the Brazilian health system.** This represents the complex of programmes, policies and laws that created and consolidated the municipal health commissions in Brazil. The existence of these commissions, their role within the health system, and who would be their members were defined by this cluster of policy and legal provisions, which would strongly influence the possibilities of long run involvement of users in these commissions. As was analysed in chapter four, since the beginning of the eighties, the Brazilian health system has been restructured. There were three institutional landmarks of the changes. (1) The first was the programme **Ações Integradas de Saúde** of 1984, which created the municipal health forum and stimulated the integration of the governmental agencies responsible for public health and health care provision. This programme transferred financial resources from the social security system to the state and municipal health secretariats. (2) The second was the programme **Sistemas Unificados Descentralisados de Saúde** of 1987, which transferred to states the structure, financial resources and functions of the INAMPS. The programme universalised access to health care and established that there should be further transfer of state and federal services and administrative bodies to municipalities. It also encouraged municipal health commissions to participate in the planning and management of the new system. (3) The third landmark of this reform was the health laws - **Leis do Sistema Único de Saúde** - passed by the Brazilian Congress by the end of 1990, which would regulate the health system created by the new Brazilian Constitution set up in 1988. The new laws reinforced the principles of integration, decentralisation and universal right to health care, empowering the municipal fora which would have planning and supervisory powers over the municipal health services. The municipal commission would become institutionalised municipal councils regulated by federal, state and municipal laws. They would become an institutionalised part of the structure of municipal government as well as of the organisation of the national health care system. Each new landmark or category represents progress towards the level of integration and of decentralisation of the Brazilian health system. It also implies further possibilities of the involvement of users in the municipal health commissions.

The changes to the institutional framework were responsible for the very existence of the forum, as well as for its general "shape" and role within the system. The next two variables determined whether there was "someone" to participate and how this political actor would participate in the commission and not somewhere else.

The first variable is **the organisation of urban social movements.** To maintain the involvement of user representatives on a sustained basis there should be organisations behind them providing expertise and resources to make their participation consistent. Large Brazilian cities, such as Porto Alegre, did have civil society organisations, mainly from trade union and urban social movements, whose structure could sustain such participation. The trade union movement was better structured than urban social movements. Members of the most active trade unions, however, had access to health care provided through special arrangements, reducing, therefore, the interest of the membership and of the leaders in getting involved in municipal health commissions. Their traditional areas of concern had been wages and, since the seventies, issues related to health and safety at work and not to the provision of health care (Respondent/5 1992). On the contrary, members of organisations of urban social movements - residential, community or neighbourhood associations and the confederations representing them - had no access to services other than those provided by the public sector. Since 1987, when the **SUDS** programme was set up, all citizens had access to health care provided by the INAMPS. The extension of health care coverage by social security to populations traditionally excluded could have stimulated the organisations that represented their interest, which were the organisations of urban social movements, to become involved in the participatory fora of the health sector. In fact, user representatives from organisations of urban social movements had been involved in the decision-making process of the commission and 86 per cent (1,077 out of 1,251) of the users attending plenary meetings, between 1985 and 1991, came from this type of organisation. Because of this, urban social movements in Porto Alegre did influence the way in which users would be involved in the commission.

During the first half of the eighties, there was a tendency towards centralisation of the organisation of these movements. An expression of this tendency was the creation, in 1983, of the Porto Alegre Union of Residential Associations (UAMPA) (Baierle 1992, 54). In 1988, the organisation of urban social movements was becoming more decentralised (Respondent/5 1992, Respondent/8 1992). In addition, or reflecting that, in July 1988 the UAMPA went through successive political crises related to partisan disputes, which culminated in a divisive electoral battle for the directorate of this organisation. After this election, this central organisation lost influence among the urban social movements. The weakened UAMPA illustrates, and possibly

influenced, the inversion of the tendency reflected in the types of users attending plenary meetings. As was seen in chapter six, the tendency of urban social movements to rely less on central organisations was further stimulated by the Participatory Budget implemented by the municipal government, after 1989, when the Workers' Party (PT) took office.

Hence, regarding this tendency towards the decentralisation of the organisation of the urban social movements in Porto Alegre, three categories were created. (1) The first one corresponds to the period when this organisation was **tending towards centralisation**, between 1985 and July 1988. The last date refers to the election of the directorate of the UAMPA, which is usually regarded as an important causal factor in the decrease of the centralised organisation of the urban social movements of Porto Alegre. (2) The second, between August 1988 and September 1990, corresponded to a period when the organisation of the urban social movements was **tending towards decentralisation**, but there were no consistent governmental policies stimulating or hindering this trend. (3) The third category is applied to the period when the organisation of the urban social movements was **tending towards decentralisation**, with the additional influence of a consistent municipal policy stimulating it. Although the **Participatory Budget** had been in force since 1989, urban social movement activists became convinced that it was a permanent policy during its second period, which began in September 1990.

The institutional framework created the forum and defined its working rules. The organisation of the urban social movements could have been responsible for "creating" a social actor able to become involved in the activities of the forum. Nevertheless, this potential ability could have been channelled to areas other than health. If issues related to health care had become a major concern for the activists of these movements, they could have chosen other forms of political action in which to be involved than in the activities of the municipal and local health commissions. They could have promoted direct action to pressure governments into agreeing with their demands, as they did many times. Nevertheless, the question to be asked is not only how health became one of the most mobilised areas for urban social movements in Porto Alegre, but also how the municipal and local health commissions became the major channels for this mobilisation. The forum was open to civil society participation. The strength of the urban social movements in Porto Alegre made it feasible for users to participate in this forum. There were, however, the direct actions of public health professionals. These professionals, especially at the local level, helped to promote the participation of the urban social movement activists in local and municipal health commissions.

The third variable is, therefore, the **relationship between public health professionals working at the local level, and urban social movement activists**. This relationship can help to explain how the political actors "users", mainly through their representatives, would channel their demands in the health sector to the municipal and local health commissions. As was described in chapter six, this relationship had an important role in consolidating these commissions, particularly the local ones.

This variable expresses, at the local level, the influence which the "policy community" of the Brazilian health system reformers had over the involvement of users in the municipal health commission. It is an important but limited expression of the action of this social actor, who was constantly behind other actors or promoting political-institutional changes that would affect this involvement. This "policy community", however, cannot be identified as a formal actor in the municipal health forum. As was highlighted in chapter three, there were covert political alliances and confrontations that occurred within and around the formal spaces of policy making. The main actors involved in deciding policies can be other than leaders of interest groups or officials acting formally in the forum. This "policy community", in all its factions, sought informal alliances with the leaders of urban social movements, in order to enlarge the social basis of support for the reform. They defended user participation in the decision-making process in the health sector as a principle. Nevertheless, the participation of these leaders could offer them the necessary political support to confront social sectors resistant to the reform. They could have an advantage when competing for financial resources with other policy areas within the government.

In a type of corporatist arrangement there were advantages for both actors: Brazilian health system reformers and urban social movement leaders. Reformers were interested in obtaining support for the reform of the system, as well as in maximising the budget and sphere of influence of their agencies. Leaders of urban social movements were interested in improving the quality of health care and in making it really accessible to members of their organisations. They were also looking for the expansion of their influence over the members of their organisations. The regular participation in local and municipal health commissions opened, to these leaders, formal and informal channels to influence the policy-making of health institutions. It made accessible to them services that would otherwise be only formally available. The connections established through the commission with health authorities, could not only benefit them personally but also the members of their organisations.

The construction of this variable allows an explanation of how the Brazilian health system reformers - in the case of public health professionals working at the local level - could establish in Porto Alegre a strong relationship with activists of urban social movements. The health professionals, working at the local level, together with the urban social movement activists made the local health commissions the basis of the consistent involvement of users in the municipal health commission.

Until 1986, some public health professionals, most of them working at the out-patient units of the state health secretariat located in health district four, had established a close relationship with the organisations of urban social movements of the region. Only in 1987 did public health professionals and urban social movement activists begin also to work together in other health districts. This was the case in health districts two, five, six, nine and ten. Nevertheless, between January 1987 and April 1990, districts four, two and five seemed to have had the best organised local health commissions, where the relationship between these two actors was strongest. From May 1990, the municipal health authorities had strongly stimulated the public health professionals who worked at the municipal health secretariat to become involved in local and municipal health commissions. From that time, in nearly all the health districts of Porto Alegre, there was a strong relationship between the public health professionals, working at local units, and the urban social movement activists. Hence, this relationship, regarding the increasing bonds between these two social actors, can be classified into the following three categories: (1) when there was a **close relationship in a few regions of the city**, (2) when there was a **close relationship in many regions of the city**, and (3) when there was a **close relationship in many regions of the city and a municipal policy stimulating this.**

Tables 8.2 and 8.3 demonstrate that there is a strong positive association between the three variables described above and the dependent indicator-variables. The institutional framework of the Brazilian health system had the strongest association, being the most influential variable among all the others (Somers' D with *Attendance* dependent = .750; Somers' D with *URP* dependent = .823). The other two, the relationship between public health professionals working at the local level, and urban social movement activists and the organisation of urban social movements, were respectively the second (Somers' D with *Attendance* dependent = .641; Somers' D with *URP* dependent = .691) and the third (Somers' D with *Attendance* dependent = .582; Somers' D with *URP* dependent = .561) strongest influence on the two dependent indicator-variables.

Table 8.2 - Attendance of Users at Plenary Meetings by Variables that Could Affect Attendance - Porto Alegre - 1985/1991

	Attendance of Users at Plenary Meetings			
	(1) Meetings with 0-2 users N (%)	(2) Meetings with 3-7 users N (%)	(3) Meetings with 8-more users N (%)	
Institutional Framework of the Brazilian Health System				
(1) Ações Integradas de Saúde (AIS)	68 (77.3)	16 (18.2)	4 (4.5)	Chi² Pearsons = 145.661 4 DF Sig = .000
(2) Sistemas Unificados Descentralizados de Saúde (SUDS)	6 (6.7)	40 (44.4)	44 (48.9)	Cramer's V = .596 Approx Sig = .000 Gamma = .936
(3) Leis do Sistema Único de Saúde	0 (0)	1 (3.7)	26 (96.3)	Somer's *d* with ATTENDANCE dependent = .750
Relationship Between Public Health Professionals, Working at Local Level, and Urban Social Movement Activists				
(1) Close in a few regions of the city	55 (84.6)	9 (13.8)	1 (1.5)	Chi² Pearsons = 111.145 4 DF Sig = .000 Cramer's V = .520 Approx Sig = .000 Gamma = .851
(2) Close in many regions of the city	19 (19.9)	36 (37.1)	42 (43.3)	Somer's *d* with ATTENDANCE dependent = .641
(3) Close in many regions of the city combined with stimulus of municipal policy	0 (0)	12 (27.9)	31 (72.1)	
Organisation of Urban Social Movements				
(1) Tending towards centralisation	69 (59)	26 (22.2)	22 (18.8)	Chi² Pearsons = 82.970 4 DF Sig = .000 Cramer's V = .449 Approx Sig = .000 Gamma = .780
(2) Tending towards decentralisation	5 (9.3)	25 (46.3)	24 (44.4)	Somer's *d* with ATTENDANCE dependent = .582
(3) Tending towards decentralisation with Participatory Budget	0 (0)	6 (17.6)	28 (82.4)	

Table 8.3 - Types of User Representative Involvement in the Decision-Making Process by Variables that Could Affect this Involvement - Porto Alegre - CIMS - 1985/1991

	User Representatives' Participation in the Decision-Making Process			
	(1) Non Participation N (%)	(2) Delegation-Participation N (%)	(3) Negotiation or Participation N (%)	
Institutional Framework of the Brazilian Health System				
(1) Ações Integradas de Saúde (AIS)	82 (92.1)	0 (0)	7 (7.9)	Chi² Pearsons = 224.479 4 DF Sig = .000
(2) Sistemas Unificados Descentralizados de Saúde (SUDS)	0 (0)	50 (54.9)	41 (45.1)	Cramer's V = .736 Approx Sig = .000 Gamma = .938
(3) Leis do Sistema Único de Saúde	0 (0)	0 (0)	27 (100)	Somer's *d* with URP dependent = .823
Relationship Between Public Health Professionals, Working at Local Level, and Urban Social Movement Activists				
(1) Close in a few regions of the city	66 (100)	0 (0)	0 (0)	Chi² Pearsons = 192.197 4 DF Sig = .000
(2) Close in many regions of the city	16 (16.3)	36 (36.7)	46 (46.9)	Cramer's V = .681 Approx Sig = .000 Gamma = .879
(3) Close in many regions of the city combined with stimulus of municipal policy	0 (0)	14 (32.6)	29 (67.4)	Somer's *d* with URP dependent = .691
Organisation of Urban Social Movements				
(1) Tending towards centralisation	82 (69.5)	0 (0)	36 (30.5)	Chi² Pearsons = 153.398 4 DF Sig = .000
(2) Tending towards decentralisation	0 (0)	45 (81.8)	10 (18.2)	Cramer's V = .608 Approx Sig = .000 Gamma = .666
(3) Tending towards decentralisation with Participatory Budget	0 (0)	5 (14.7)	29 (85.3)	Somer's *d* with URP dependent = .561

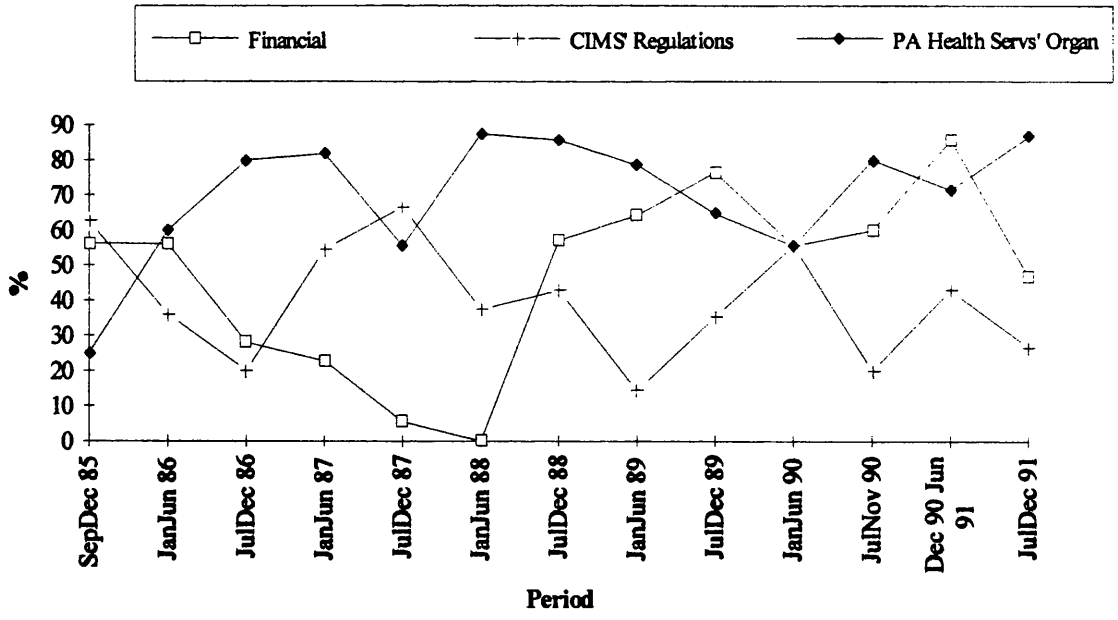
Beyond these variables, there are four others that have influenced the involvement of users in the commission, although in a less decisive way,. Among those, the most influential was the **position of municipal health authorities** on this involvement. The interest of these authorities could be classified into three ascending categories. (1) The first category is **non-interest** in the involvement of users. The municipal health authorities in office during 1985 could be classified as not interested in this involvement both because of the political position of these authorities, identified with the political party supporting the authoritarian regime, and because then the very idea of a participatory forum was a novelty for the majority of the managers of the Brazilian health services. (2) The second category is **interest in consultative participation.** Municipal health authorities, during 1986, 1987 and 1988, can be classified within this category. Although in this period there were three different municipal secretaries of health, they all had in common an identification with the central left Democratic Labour Party (PDT). They stimulated the involvement of users in the municipal health commission, but they considered that user representatives should only have a consultative role in the municipal health commission. (3) The third category is **interest in participation of user representatives in the decision-making process.** Between 1989 and 1991, municipal health authorities in office supported the Workers' Party (PT). These authorities had shown an interest in stimulating the participation of user representatives in the decision-making process of the commission.

As can be observed in Tables 8.4 and 8.5, the position of the municipal health authorities on this participation had a moderate to strong positive association with both indicator-variables (*Attendance*: Somer's $d = .516$; *URP*: Somer's $d = .409$).

The other variable is **issues most frequently discussed in plenary meetings.** As was seen in chapter six, the agendas of plenary meetings were decided by their main actors, particularly by the municipal health authorities, the co-ordinators of the forum. Nevertheless, in some periods, user representatives took part in the setting of the agenda. The agenda of a plenary meeting can be seen as an outcome of the work dynamic of the commission. It can also be seen as a factor influencing the involvement of users in the forum, since users can have a variable interest in issues discussed there. Some regular participants in the commission had pointed out in particular the overloading of financial issues on the agenda, which could lead to the reduction of the involvement of users in the commission (Respondent/11 1992; Respondent/26 1992).

Graph 8.1 shows the three issues most frequently discussed in plenary meetings. They were issues related to the organisation of health services in Porto Alegre, to the financing of health services and to the regulations of the commission. The categories were constructed taking into account the combination of the two most commonly discussed items, which were *the organisation of health services in Porto Alegre* and *financial issues*. (1) The first category is applied to periods of six months when there were more meetings discussing **financial issues** than meetings discussing *the organisation of health services*. This was the case, for example, in 1985 and the second half of 1989. (2) The second category is applied to periods of six months when there was a **similar proportion** of plenary meetings discussing both issues. This was the case, for instance, in the first half of 1986 and in the first half of 1990. (3) The third category corresponds to the periods of six months when there were more meetings discussing **the organisation of health services in Porto Alegre** than meetings discussing *financial issues*, as in 1988 and the second half of 1991.

Graph 8.1 - Types of Issues Most Frequently Discussed in Plenary Meetings - Porto Alegre - CIMS - 1985/1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

The predominance of financial issues on the agenda would result in less attractive meetings, from the users' point of view. A higher frequency of discussions about the organisation of health services would make the meetings more attractive. Tables 8.4 and 8.5 demonstrate that the association between this variable and the two dependent indicators-variables is weak to moderate (*Attendance*: Somer's $d = .283$, *URP*: Somer's $d = .273$), although very significant (Sig = .000).

This variable seems to have had a particular influence on the decrease, or slower growth, in the attendance of users at plenary meetings and the reduction of the involvement of users in the decision-making process of the commission, during 1989 and 1990. Nevertheless, during the first half of 1991, there were more meetings discussing financial issues than there were meetings discussing the organisation of health services in Porto Alegre, and a growing number of users was attending plenary meetings and user representatives were actively participating in the decision-making process of the commission. As a participant of the forum affirmed (Respondent/26 1992), during 1990, financial issues were still discussed in most plenary meetings, but the method of discussion had changed. Details would be discussed by the technical secretariat.

Another variable is **the position of state health authorities** on the involvement of users in the commission. The three categories presented below summarise their position on the issue.

(1) The first category is **non interest** on the involvement of user representatives in the commission. This corresponds to the three last months of 1991, when the state health authorities withdrew their representatives from the forum. This was due to partisan disputes between the state health authorities, identified with the Democratic Labour Party (PDT), and the municipal health authorities, who were supporters of the Workers' Party (PT). It was also due to the political "style" of the state health authorities, whose populist tradition would lead them to avoid open political disputes in a public forum.

(2) The second category is **interest in user involvement, but this involvement should not take place in overt public fora nor in Porto Alegre's commission**. The first period that this category is applied to was between 1985 and 1986, when state health authorities, although not against user participation, neither promoted the consolidation of institutionalised participatory fora within the health sector, nor supported the idea of user representatives taking part in the decision-making process of the commission. They established good relationships

with the leaders of urban social organisations. They seemed to be resistant to the consolidation of these fora, mainly because they were created and gradually institutionalised by policies they did not agree with. The second period was between 1987 and 1988. Then, the state health authorities, although strongly supporting the reform of the system, due to partisan disputes had an ambiguous position towards the consolidation of the forum. They were supporters of the central-left Party of the Brazilian Democratic Movement (PMDB) and saw both the municipal health authorities and the leaders of the urban social movement as political rivals. Nevertheless, some of the directors of the state health secretariat, particularly those responsible for the management of health services in Porto Alegre, had a different understanding. They had actively supported the forum's consolidation and the participation of user representatives in the decision-making process of the commission. Differences within the team of professionals controlling the state health secretariat have generated a dubious position regarding the issue.

(3) The third category was **interest in participation of user representatives in the decision-making process**. This corresponds to the first nine months of 1991, when the state health authorities, representing the newly elected Democratic Labour Party (PDT), had demonstrated a real interest in reinforcing the forum and in promoting the participation of user representatives in the decision-making process.

It was not possible to verify whether there is an association between this variable and the indicator-variables of the involvement of users in the commission. As can be seen in Tables 8.4 and 8.5, the Chi^2 tables (resultant of the attempt at association) had a high percentage of cells with an expected frequency of less than five (33 and 44 per cent). Nevertheless, the position of the state health authorities should have had a weak influence over the involvement of users in the commission, because most of the time, from 1985 to 1990, they had a neutral position. This long period of ambiguous support has probably neutralised the positive or negative impact which the position of these authorities would have had on the involvement of users in the commission.

The last variable to be associated with user involvement in the commission is **the position of federal health authorities**. The position of the federal health authorities on the issue can also be classified into three categories. (1) The first corresponds to the period 1990 and 1991, when they were **resistant** to it. The government elected in 1989 was not committed to institutional democratisation. In practical terms, federal health authorities tried to hinder the process of decentralisation of the Brazilian health system and to avoid the institutionalisation of health participatory fora. Although these authorities did not seem to favour the reform of the

system, the process was too advanced by then. Throughout the country, federal health services, especially units and hospitals of the former INAMPS, were already under the management of state health secretariats. In places where health services had been municipalised, most of these services were under municipal administration. The decline of the direct influence of the federal health authorities on the commission is illustrated by the withdrawal, in 1989, of the direct representation of the federal health authorities on the commission. (2) The second category corresponds to the last eight months of 1988 and 1989, when the federal health authorities were **indifferent** to the issue. As described in chapter seven, the authorities directing the federal health services, during this period, were neither supporters of the reform of the Brazilian health system nor defenders of participatory mechanisms in the system. However, they did not seem to have the will or enough political strength to promote policies opposing it. (3) The third category corresponds to the period between September 1985 and April 1988, when federal health authorities **had an interest in promoting user representatives' participation in the decision-making process** of the commission. During this period, reformers of the Brazilian health system were directing the INAMPS and the Ministry of Health. They initiated the process of reform that had stimulated the consolidation of participatory fora at the municipal, state and federal levels of government.

Tables 8.4 and 8.5 demonstrate that there was a strong negative relationship between the position of the federal health authorities on the involvement of users in the commission and the attendance of users at plenary meetings (Somer's *d* with *Attendance* dependent = - .556) and types of user representatives' involvement in the decision-making process of the commission (Somer's *d* with *Attendance* dependent = - .533). Nevertheless, it was not because greater interest by the federal health authorities in this involvement would provoke less involvement of users or vice versa. It was mainly because, when these authorities had a favourable position regarding the issue, the municipal health commission of Porto Alegre was initiating its activities. Then, the reform of the health system was beginning, and neither leaders of urban social movements nor public health professionals saw the forum as an important element of the health system. Furthermore, the municipal health authorities were not particularly interested in promoting the involvement of users in this forum. On the contrary, during 1990 and 1991, when the federal health authorities were not interested in promoting participatory policies, all the other influential factors and actors were favourable to the consolidation of the forum and to the involvement of users in the commission.

Table 8.4 - Attendance of Users at Plenary Meetings by Variables that Could Affect Attendance - Porto Alegre - CIMS - 1985/1991

	Attendance of Users at Plenary Meetings			
	(1) Meetings with 0-2 users N (%)	(2) Meetings with 3-7 users N (%)	(3) Meetings with 8-more users N (%)	
Position of Municipal Health Authorities on Users' Involvement in Municipal Health Commission				
				Chi² Pearsons = 65.718
(1) Non interest in users' involvement	**16** (100)	**0** (0)	**0** (0)	**4 DF Sig = .000**
				Cramer's V = .400
(2) Interest in consultative participation	**53** (47.7)	**28** (25.2)	**30** (27)	**Approx Sig = .000**
				Gamma = .722
(3) Interest in user representatives' participation in decision-making process	**5** (6.4)	**29** (37.2)	**44** (56.4)	**Somer's *d* with ATTENDANCE dependent = .516**
Issues Most Frequently Discussed in Plenary Meetings				
				Chi² Pearsons = 18.883
(1) Financial	**19** (59.4)	**10** (31.3)	**3** (9.4)	**4 DF Sig = .000**
				Cramer's V = .215
(2) Similar proportion financial and organisation health services	**25** (42.4)	**16** (27.1)	**18** (30.5)	**Approx Sig = .000**
				Gamma = .416
(3) Organisation health services	**30** (26.3)	**31** (27.2)	**53** (46.5)	**Somer's *d* with ATTENDANCE dependent = .283**
Position of State Health Authorities on Users' Involvement in Municipal Health Commission				
(1) Non interest in users' involvement	**0** (0)	**0** (0)	**8** (100)	
(2) Interest in user involvement, but not at CIMS or in Porto Alegre CIMS	**74** (41.6)	**56** (31.5)	**48** (27.0)	***33 % cells with Expected Frequency less than 5***
				Gamma = .375
(3) Interest in user representatives' participation in decision-making process	**0** (0)	**1** (5.3)	**18** (94.7)	**Somer's *d* with ATTENDANCE dependent = .266**
Position of Federal Health Authorities on Users' Involvement in Municipal Health Commission				
				Chi² Pearsons =79.160
(1) Resistant to users' involvement	**2** (4.1)	**15** (30.6)	**32** (65.3)	**4 DF Sig = .000**
				Cramer's V = .439
(2) Indifferent to users' involvement	**3** (6.5)	**18** (39.1)	**25** (54.3)	**Approx Sig = .000**
				Gamma = - .742
(3) Interest in user representatives' participation in decision-making process	**69** (62.7)	**24** (21.8)	**17** (15.5)	**Somer's *d* with ATTENDANCE dependent = - .556**

Table 8.5 - Types of User Representatives' Involvement in the Decision-Making Process by Variables that Could Affect this Involvement - Porto Alegre - CIMS - 1985/1991

	User Representatives' Participation in the Decision-Making Process			
	(1) Non Participation	(2) Delegation-Participation	(3) Negotiation or Participation	
	N (%)	N (%)	N (%)	
Position of Municipal Health Authorities on Users' Involvement in Municipal Health Commission				
(1) Non interest in users' involvement	**16** (100)	**0** (0)	**0** (0)	**Chi² Pearsons = 143.473 4 DF Sig = .000**
(2) Interest in consultative participation	**65** (58.6)	**0** (0)	**46** (41.4)	**Cramer's V = .590 Approx Sig = .000**
(3) Interest in user representatives' participation in decision-making process	**0** (0)	**50** (63.3)	**29** (36.7)	**Gamma = .512** **Somer's *d* with URP dependent = .409**
Position of State Health Authorities on Users' Involvement in Municipal Health Commission				
(1) Non interest in users' involvement	**0** (0)	**0** (0)	**8** (100)	
(2) Interest in user involvement, but not at CIMS or in Porto Alegre CIMS	**81** (45.3)	**50** (27.9)	**48** (26.8)	***44 % cells with Expected Frequency less than 5*** **Gamma = .407**
(3) Interest in user representatives' participation in *d*ecision- making process	**0** (0)	**0** (0)	**19** (100)	**Somer's *d* with URP dependent = .516**
Issues Most Frequently Discussed in Plenary Meetings				
(1) Financial	**16** (50.0)	**16** (50.0)	**0** (0)	**Chi² Pearsons = 42.404 4 DF Sig = .000** **Cramer's V = .320**
(2) Similar proportion financial and organisation health services	**25** (42.4)	**20** (33.9)	**14** (23.7)	**Approx Sig = .000** **Gamma = .391**
(3) Organisation health services	**41** (35.3)	**14** (12.1)	**61** (52.6)	**Somer's *d* with URP dependent = .273**
Position of Federal Health Authorities on Users' Involvement in Municipal Health Commission				
(1) Resistant to users' involvement	**0** (0)	**20** (40.8)	**29** (59.2)	**Chi² Pearsons = 54.273 4 DF Sig = .000** **Cramer's V = .362**
(2) Indifferent to users' involvement	**0** (0)	**30** (63.8)	**17** (36.2)	**Approx Sig = .000** **Gamma = - .657**
(3) Interest in user representatives' participation in decision-making process	**81** (73.6)	**0** (0)	**29** (26.4)	**Somer's *d* with URP dependent = - .533**

8.3. Summing Up

In summary, it is possible to state that the changes in the institutional framework of the Brazilian health system, over the past ten years, were strongly associated with variations in the attendance of users at plenary meetings and with variations in the types of user representatives' involvement in the decision-making process of the forum. The perception that a reform was under way had probably encouraged political actors, users in particular, to participate in the municipal health forum and gradually increased their influence over the organisation of health services in Porto Alegre.

Changes in policies and in institutional organisation could not however guarantee that there were autonomous and independent user representatives able to become involved in the commission. These actors could be found in large Brazilian cities, where there were strong urban social movements and trade union movements. Trade unions, due to special arrangements between employers and employees, did not regard improvements in publicly financed health care as a priority. In Porto Alegre, the main representatives of the users were urban social movement leaders and activists. The organisation of these movements, from 1988 onwards, has tended towards decentralisation. Municipal policies, promoted by municipal health authorities and municipal officials, further stimulated the decentralised organisation of urban social movements in Porto Alegre. During 1990, the municipal health secretariat reinforced the consolidation of the local health commissions in the health districts, while the municipal government carried out the programme of the Participatory Budget. The latter was organised by regions of the city whose territorial limits were similar to the health districts, facilitating the integration and mutual reinforcement of both participatory local fora. The variation in the organisation of urban social movements was also strongly associated with variations in the involvement of users in the local health commissions and, through them, in the municipal health commission.

At the same time the, at first rare close, relationship between the public health professionals, working at the local level, and the urban social movement activists became a widespread feature of the health districts in Porto Alegre. By 1986, only in district four did these social actors enjoy a close relationship. In 1988, it could be found in other regions, such as district two and district five. From May 1990, however, there was a municipal health policy stimulating the articulation between municipal health secretariat civil servants and urban social movement activists. As the relationship between public health professionals working at the local level, and activists of urban social movements, grew closer, the involvement of users in the municipal health commission increased as well.

The position of the municipal health authorities regarding the involvement of users in the commission was strongly to moderately associated with the level of users' involvement in the commission. Nevertheless, when these authorities had a strong interest in participation they also promoted policies stimulating the civil servants of the municipal health secretariat to promote the consolidation of the local health commissions. They had also supported the municipal programme of the Participatory Budget, which has helped to reinforce the organisation of urban social movements on a decentralised basis. Hence, beyond the influence of their own interest in the involvement of users, there was their indirect influence over the configuration of these other two variables.

Other factors and actors apparently did not have a strong influence over the involvement of users in the commission. The influence, which variations in types of interest that federal health authorities had in the participation of user representatives in the forum seemed to have, decreased as the process of decentralisation of the health system deepened. Nevertheless, it was due to mainly the initiative of the federal health authorities that the **SUDS** programme was launched. As has been seen, this programme was the major turning point towards a deep decentralisation of the system. Hence, especially between 1985 and the beginning of 1988, the political actions of the federal health authorities led to changes in the system that decisively affected the organisation of the municipal health forum. Since then, as the system has become more decentralised, the role of the state and municipal spheres of government have increased, at the same time as the political role of federal health authorities has decreased.

Especially since the **SUDS** programme was set up, in 1987, the state health authorities should have increased their influence over the municipal commission due to the decentralisation of the system. Nevertheless, between 1985 and 1990, the position that the state health authorities adopted towards this participatory forum was ambiguous. From 1987, the state health authorities had supported the Brazilian health system reform under way and, in particular, defended the participation of users in the decision-making process of the system. Partisan disputes, however, made the main directors of the state health secretariat resistant to the empowerment of the commission of Porto Alegre, even if some of these directors actively supported the commission. A regular participant in the commission has affirmed that the state health authorities, in this period, did not hinder but did not stimulate the involvement of users in the commission (Respondent/22 1992). Their ambiguity apparently had neutralised their influence over the involvement of users in the forum.

The types of issues most frequently on the agenda, whether they were financial issues or the organisation of health services, had a significant but moderate influence over the involvement of users in the commission. Probably, the impact the types of issues had on this involvement was restricted to 1989 and 1990. The style of direction of the meetings, as well as the time spent discussing different types of issues, probably had more influence on the involvement of users than the mere presence of such issues on the agenda.

As was highlighted in chapter two, underneath the formal process of policy-making there were actors, alliances and confrontations that there were not easily identified. There was the case, for instance, of the relationship between public health professionals, working at local level, and activists of the urban social movement. It was just a dimension of the broader, if more diffuse, alliance between the Brazilian health system reformers and these activists. Looking at the case of the municipal health commission of Porto Alegre it is possible to identify these reformers who were behind many changes in the institutional framework of the health system, as well as assuming the role of several different actors. Alliances with user representatives established in the municipal health commissions could help to pressure central governments, at municipal, state and federal administrative levels to allocate more financial resources to the health sector. User representatives could also offer political support for the reform, counterbalancing the powerful resistance from private providers, the federal bureaucracy and medical professionals. At the same time, user representatives, when participating in the forum, could influence the definition of policies. They could also increase their prestige within their organisations through the connections established in the commission with health authorities. In particular the actions of the inspection commission empower them to demand for members of their organisations access to the otherwise inaccessible health services. A user representative has explained

> *"I said to Ricardo* [deputy co-ordinator of **CIMS** during 1989-1992]*: 'Even when I am not around participating in CIMS work, if there is any problem in my "vila", I take my identification card, as a member of the inspection commission of CIMS, go to the hospital and in seconds there is a bed available. (...) I think I am not perpetrating any crime. Because unfortunately in our country, in our state it is like this. Through this identification I can, I do... If you go and simply ask, you can fall asleep waiting"* (Respondent/12 1992).

Users' representatives, empowered as participants of the commission, could help users to obtain real access to health care. However, users who did not know these representatives or the work of the municipal commission still found it difficult to obtain access to services that in theory would be available to them. The reform of the health system did not make health care actually accessible to all Brazilians, but it has at least guaranteed them the right to it. It has empowered

user leaders to represent the interests of social sectors traditionally excluded from the benefits of development, before health authorities and health care providers. Whether it could lead to a system were all people will in fact have access to health care of good quality, remains to be seen.

Chapter 9

Conclusions and Recommendations

The aim of this thesis has been to examine the nature of user participation in the municipal health commission of Porto Alegre, Brazil. The main questions on which it focused are (1) *how were users involved in the municipal health forum?* and (2) *what major factors have conditioned their involvement?* The starting point for answering them was sought in the origins of the idea of participation as a policy issue. During the last two decades in developed countries, the institutionalisation of participatory mechanisms has been seen as a complement or as an alternative to traditional forms of political representation in liberal democracies. In developing countries, since the seventies, International Agencies have emphasised self reliance and popular or community participation as a means of achieving development. In the health field, since 1978, primary health care has been seen as the main strategy for improving health conditions both in developed and developing countries. One of the principles that this strategy promoted was community participation in the health sector.

Different participants can become involved in a participatory process and the "quality" of this process can have sharp variations. As can be seen in chapter two, the literature may refer to popular participation, community participation, consumer participation, citizen's participation and user participation. This research adopted the concept of *user participation* because it seemed to be the most relevant when the focus was on the involvement of substantive representatives of a particular group of health service users in a specific territorial area. Studies of participation have used different criteria to build up classifications that have helped in the analysis of participatory processes, identifying diverse degrees of participation. The classification this research utilises was a result of a compound of other typologies offered by the literature, which was built up considering the empirical case upon which it focused. Chapter two shows the typology adopted by this study, which uses the notions of *non-participation, manipulation, negotiation, delegation* and *participation.*

Using two indicator-variables of users' involvement within the municipal health commission of Porto Alegre - *the number and types of users attending plenary meetings* and *the types of involvement of user representatives in the decision-making process* - it is possible to affirm that, between 1985 and 1991, user involvement increased significantly. More users attended plenary meetings and user representatives intensified their involvement in the decision-making process. The majority of user representatives participating in the decision-making divisions of the commission and attending plenary meetings came from local organisations. It was also possible to verify that these two indicator-variables were associated, showing that the number of users attending plenary meetings reflected the intensity of the involvement of user representatives in the decision-making process.

Regarding the types of involvement of user representatives in the decision-making process of the commission it was possible to distinguish four sub-periods. In the first, between September 1985 and December 1991, user representatives' involvement in the commission can be classified as **non-participation**. Then, very few users attended plenary meetings, there were no internal regulations, co-ordinating committee or inspection commission.

In the second sub-period, between May 1987 and December 1989, user representatives were most of the time involved in a process of **negotiation** with the health authorities. They imposed their participation on reluctant health authorities. They obtained a formal majority on the working party that wrote the internal regulations and on the co-ordinating committee. The internal regulations came into force at the same time as the user representatives controlled who would be nominated to take part in the technical secretariat. They became exclusive members of the inspection commission although, at their discretion, health professionals could take part. In this sub-period, users regularly attended plenary meetings, in the majority of which there were eight or more users present.

In the third sub-period, users' involvement in the commission decreased. This could be classified as something in between **participation** and **delegation**. Although the internal regulations were in force, user representatives seemed to have partially lost their impetus to participate. Representatives of local health commission four, which was the most active among the local commissions, had apparently delegated to municipal health authorities the right to decide on the issues discussed by the municipal commission. The co-ordinating committee did not meet during the first eleven months of 1990, and there were fewer users present at plenary meetings when compared with the previous sub-period. In most meetings, there were between three and seven users present.

In the last sub-period, between December 1990 and December 1991, the involvement of users in the commission reached its climax, permitting it to be classified as **participation**. The internal regulations were followed and the co-ordinating committee worked regularly with the participation of user representatives. More users regularly attended plenary meetings than in any former sub-period. In 27 out of 29 meetings there were eight or more users present.

There are many factors that could have affected the participatory process. Given the case this research examined and its focus, the factors considered most influential in the participatory process of the Porto Alegre municipal health commission were: (1) *recent changes in the institutional framework of the Brazilian health system;* (2,3,4) *the position of federal, state and municipal health authorities on user participation*; (5) *the relationship between public health professionals who worked at local health units, and urban social movement activists*; (6) *the organisation of urban social movements in the city*; (7) *the types of agenda of the commission.*

Recent changes in the institutional framework of the Brazilian health system could be regarded as the most influential factor determining the nature of the participatory process taking place in Porto Alegre's municipal health commission. It also had a decisive influence over all the other factors related to this process. These changes in the Brazilian health system, during the last decade, were amalgamated into a cluster of programmes, policies and legal provisions. The main turning point in these changes came between 1984 and 1990, when the programmes **AIS** and **SUDS** were set up and the **health laws** created and regulated the United Health System (SUS). These programmes and legal provisions were the cornerstone of an articulated policy that has made the Brazilian health system (1) better **integrated**, through the unification of the public health sub-sector (Ministry of Health, state and municipal health secretariats) and the social security sub-sector of health care (INAMPS' own and contracted services); (2) more **decentralised**, devolving functions and transferring federal financial resources to state health secretariats, aiming at further devolution to municipal health secretariats; and (3) **universalised**, formally covering the entire Brazilian population.

In this context, during the second half of the eighties, the municipal sphere of government gradually became more important within the health system at the same time as municipal health commissions became a widespread feature of the system. These fora had planning and supervisory powers over the financial resources transferred from the federal to the municipal sphere of government. The municipalisation of health services would virtually place under their control those state and social security financial resources transferred to

municipalities to run ex-state and ex-social social security health services, and to pay for social security contracted out private services. Municipal health commissions have been key elements in the reform of the Brazilian health system as municipal governments have gradually increased their planning and supervisory roles over health services located within their territorial jurisdiction. In large cities, due to the support of strong social and trade union movements, participatory schemes could achieve better results. This was the case in Porto Alegre.

Another very influential factor determining users' involvement in the commission was the dynamic of urban social movements in Porto Alegre. During the second half of the eighties, this movement changed from a more centralised to a decentralised pattern of organisation, influencing the increased involvement in the commission of users from local organisations. These local organisations were local health commissions, mothers' clubs, residential or community associations, among others. Another factor was the combined action of the Brazilian health system reformers working at the local level, and the urban social movement activists. The "policy community" of reformers - made up mainly of public health professionals and academics - was constantly behind other actors or promoting political-institutional changes that would affect the involvement of users in the policy formulation and politics of the health sector. These reformers defended user participation not only because they believed in democratising state organisations, but also because social movements could offer them the political support to challenge the resistance by those with vested interests to the reform and competing policy areas inside government.

Alongside this type of corporatist arrangement were urban social movement activists seeking to extend their influence over policy-making by health institutions. Direct access to health authorities in the commission could help these activists to exert pressure for improvements in the quality and accessibility of the health care provided for the poor populations they represented. As the Brazilian health system reformers acknowledged the legitimacy of their claims, these activists could reinforce their leading positions within their organisations. The process of the exclusion of the medical profession and private sector representatives from the decision-making divisions of the commission illustrates the results of this alliance. In this case, health authorities and other professionals defending the reform, in alliance with urban social movement activists, systematically excluded the medical profession and private sector representatives from the decision-making process of the commission. In protest against this strategy of exclusion, and against the reform with which they did not agree, in 1991 medical profession and private sector organisations formally withdrew their representatives from the commission. Nevertheless, as was mentioned before, their lack of

influence over the participatory forum did not mean that they exercised little power over the decision-making processes in the health sector. It could mean, on the contrary, that they exerted their influence over policy formulation and implementation through concealed, privileged channels. In this case, even if they did not directly affect the degree of user participation in these fora, they could influence the formation of their agenda and contribute to determining the role of these fora within the health sector.

There were other factors that influenced the involvement of users in the commission, such as the position of the municipal, state and federal health authorities on user participation, and the forum's work dynamic. The position of the municipal health authorities on user participation was a very influential factor because they were the co-ordinators of the forum and of the co-ordinating committee, exercising direct influence on the formation of the agenda and the overall functioning of the forum. The other factors, however, had apparently determined only short term changes in user involvement. The forum's work dynamic could help to explain in particular why, in 1989 and 1990, there were fewer users attending plenary meetings and why, in 1990, the co-ordinating committee did not function.

Although this research has been concerned with the participatory process itself, it seems relevant to ask about the role of this participatory forum in the decision-making process of the health sector. If user representatives increased their involvement in the health commission, did this actually influence the decision-making process in the health sector? The delay in the municipalisation of health services in this city limited the power that the municipal health authorities had to extend the agenda of the commission. While the management of health services in the city was not under municipal control, the decision-making power of the commission itself would be limited; that is, increasing control over the forum did not necessarily signify greater control over health services in the city. Even taking into account the delays in the case of Porto Alegre and in other state capitals, a growing number of municipalities are taking control of health services in their territory. The growing number of municipalisations favoured the idea that, sooner or later, all cities would have most of their health services under municipal management. User organisations and other interest groups, aware of the inevitability of the devolution process, tended to renew their efforts to increase their influence over municipal councils.

However, the way municipalisation was carried out has lead to a fragmentation of public health services instead of an organised decentralisation. Policy recommendations state that federal financial resources should be distributed according to demographic,

epidemiological or efficiency criteria. Instead, political affinities or rivalries among politicians at federal and municipal levels have sometimes determined the allocation of these resources. Often, the SUS has paid private providers and has transferred scarce financial resources for public health services and for public providers of health care. As a consequence, the municipalities had to finance the latter. Decentralisation can therefore have the perverse effect of accentuating regional inequalities in income distribution in Brazil, since richer cities would be more able to finance the health services, out-patient and hospital care provided by public services, while the poorer cities would be less able to do so.

The formal extension of universal health care coverage to all Brazilians, which started during the seventies and culminated with the **SUDS** decree in 1987, did not result in substantially improved access to health care. There was an expansion in primary health care units during the early eighties. Their capacity to resolve health problems, however, was very low, due mostly to the lack of financial and human resources. Hospital and out-patient services contracted by the social security system, which should have been providing free care for all, often compelled patients to pay illegal charges. In small and poor municipalities, the process of municipalisation, during the second half of the eighties, restricted instead of expanded the capacity of these services to resolve health problems. It has become popular among mayors to use SUS financial resources to buy ambulances to transport as many cases as possible to the already overloaded health services of large cities. Very complex services are constantly burdened with relatively simple cases restricting the access of those who really need to use them.

The sectors of the population which did not have access to special insurance arrangements, or which could not pay directly for health care, had no option but to rely on public services. Their potential interest in improving these services did not mean automatic participation in local and municipal health commissions. The role of the Brazilian health system reformers can help to explain the involvement of urban social movement activists in these fora. They stimulated user involvement when working as public health professionals in out-patient health units near Porto Alegre's shantytowns or when, as federal, state or municipal health authorities, they favoured user involvement in participatory fora. In some areas in Porto Alegre, as in the case of district four, the already existing mobilisation around health issues was channelled to these fora. In other areas, such as district ten, where health issues were not regarded as a priority by urban social organisations, without the encouragement of public health professionals the involvement of urban social movement activists with health issues would

probably have been less intense, and their political action would not necessarily have converged on these fora.

From 1989, when the Workers' Party (PT) took office in the municipal government, local and municipal health commissions were further strengthened by the Participatory Budget implemented by the city hall of Porto Alegre. The regular activities of these participatory fora mutually reinforced each other. They consolidated spaces for the involvement of the representatives of civil society organisations in the decision-making process of the municipal government, as well as opening up this government to public scrutiny and increasing its accountability. These fora were run by municipal officials who had close political relations with urban social movement organisations. The policy of strengthening these participatory fora resulted in support for the municipal government. In the case of health commissions, the involvement of urban social movements in these fora resulted in political support for the Brazilian health system reformers, who were running the municipal health secretariat, against interest groups opposing the reform of the health system and against other governmental areas competing for financial resources. In the case of the Participatory Budget, urban social movements involved in the budgetary process offered precious political support to a government without a majority in the municipal legislative chamber.

Hence, on the one hand, the municipal health commission had limited influence over the health sector, due to delays in the municipalisation process and to the actual division of the health system into two tiers, which made only poorer population groups interested in influencing the decision-making of publicly financed health services. On the other hand, the urban poor living in large cities in Brazil, who since the seventies had had their interests represented through urban social movements, were stimulated by public health professionals to channel their health demands through the user representatives participating in the municipal and local health commissions. Taking this into account, is it accurate to question the very existence of a participatory experience in Latin America? Has it resulted in the mere manipulation of the poor by a national or local elite? The case being studied does not seem to confirm Ugalde's claim that, in Latin America, experiences of participation in the health field inspired by primary health care principles have only contributed to the additional exploitation of the poor by extracting free labour, and contributing to their cultural deprivation and to political violence by the outing and suppression of leaders and the destruction of grassroots organisations (Ugalde 1985, 43). However, it is possible to question whether the municipal health fora in Brazil could be classified as participatory experiences inspired by primary health care principles. Although the primary health care approach formed part of the reform of the Brazilian health system, and

thus was behind the creation of the first commissions, since their institutionalisation through the **SUDS** programme they bear more resemblance to statutory fora in liberal democracies than to "participatory experiences" inspired by these principles. It is interesting to observe that Stiefel and Pearse (1982, 156), at the beginning of the eighties, perceived, in contrast to Ugalde, that, despite widespread authoritarianism, there were in Latin America favourable conditions for the promotion of social movements and participation.

Grindle and Thomas (1991, 63) affirmed that, in developing countries, large proportions of the population - including urban shantytown residents - are not organised for sustained political activity. They also maintained that, in these countries, societal interests are often likely to be represented through informal processes rather than through more public forms of lobbying (Grindle and Thomas 1991, 63). In the case being studied, it is possible to affirm that organisations representing shantytown populations sustained enduring involvement of their representatives in the overt political spaces of the local and municipal health commissions. Clientelism and patronage still pervade relations between the government and interest groups in Brazil, especially in small cities, in rural areas and in less industrialised regions of the country. Moreover, as mentioned above, even if a participatory forum became central in the decision-making process of a government, the sector in which it takes place cannot be central in government political strategy, as the health sector is usually not (Walt 1994, 86-8). The openness of participatory mechanisms within the government is often restricted to areas regarded as non strategic, such as those dealing with social policies. Even considering this, the case examined here indicates the gradual formation of an alternative type of political relationship in the health sector of a Brazilian urban centre, where the interests of the urban shantytowns residents are represented formally and publicly.

Grindle and Thomas (1991, 32-4) linked the weakness of mechanisms for interest group representation in developing countries to the strong role policy communities would have in policy formulation and in reform implementation. In the case examined here, the policy community of the Brazilian health system reformers had a central role in attracting urban social movement activists to become involved in these formalised fora. They can be regarded as policy formulators as well as an active part of an alliance established between them and urban social movement activists. Nevertheless, instead of taking decisions through informal processes of consultation within a weakly organised civil society, they promote the normalisation of mechanisms of interest group representation in the health sector in Porto Alegre.

Hence, we can question whether it is possible to affirm that user involvement in the municipal health commission of Porto Alegre could represent an auspicious sign for the consolidation of democracy in Brazil through the construction of channels for effective participation, which could articulate the political institutions and social demands of those previously excluded (Moisés 1990, 33). Democracy in this sense would imply the opening up of decision-making processes to political and social sectors traditionally excluded from the political process (O'Donnel 1988, 43) and, moreover, in sharing in the benefits of development (Paul 1987, 3). With reference to this particular case, when user representatives increased their involvement in the municipal health commission of Porto Alegre, we must ask whether this would result in these representatives taking part in decisions about policies that could determine whether users would have access to better health care or would improve their health.

Firstly, the provision of health care is only a minor factor contributing to the social inequalities in Brazil and alone it would not improve the quality of life, or the health, of Brazilians living in poverty. Secondly, the participatory process in Porto Alegre's health commission does not guarantee any reduction in inequalities in the health care provision for the different social sectors in Brazil as a whole. However, the consolidation of participatory fora can assist in the democratisation of Brazilian institutions, giving voice to social sectors traditionally excluded from the political system. The representatives of those having no option but to use publicly financed health care can, through these fora, obtain information and, at least partially, influence policy formulation and supervision of the quality of health care provision.

As was seen in chapters six, seven and eight, user representatives clearly aimed at exerting pressure for better care for those they represented. They imposed their participation upon the decision-making divisions of the commission and they insisted on participating in agenda formation because they wanted to influence the policies decided in this forum. Even if the major health service policies in Porto Alegre were not decided there, there were many other important issues being decided, and they had unprecedented power to influence them. This was the case, for instance, when they asked for, and obtained, the suspension of hospital contracts with the INAMPS, through the inspection commission, or when they pressured for, and obtained, the opening of emergency services in some areas of the city. As was explained above, increased participation does not necessarily mean the better health for the people, as it would depend on other factors. Neither does it imply, without other policy measures, the end of the division between the provision of better services for those who can afford to pay for them directly or through insurance arrangements, and the provision of poor quality care for those depending on publicly financed services. Nevertheless, as Hall (1994, 1805) pointed out, policy

results are determined not only by structural and institutional factors, but also by involved groups developing their own socio-political strategies and organisational practices which may exert strong influence upon the course of events. Through their involvement in the commission, these representatives were increasing the responsiveness of publicly financed health services to the needs of users who, individually, lacked the political power to sustain their demands.

The focus of this research was on the participatory process itself and not on the effects of participation upon the quality of health provision. However, it would be interesting to examine whether increased user participation leads to improved access, improved health care or better health. The method used in this research to assess user involvement can be utilised in municipal or local health commissions, combined with the analysis of the impact of a successful participatory process on the quality of health care or on health indicators. One difficulty would be to identify and isolate other factors that could affect the quality of health care and health status. Another problem would be to assess the quality of health care, especially in Brazil where the data on health service provision are not reliable, and health indicators are calculated only for large regions and cities. Even considering these constraints, such a study could be carried out if adaptations were made taking into account the types of empirical data available and, for instance, improvements that were a direct result of the participatory process.

The "methodology" developed in this research for the assessment of user participation in statutory fora was based on the systematic analysis of meeting attendance lists, meeting minutes, interviews with regular participants in the forum, and other sources of information. The analysis combined these data to build up indicators of participation and of factors influencing the participatory process. The method, described in detail in Appendix I, uses two main sets of variables: (1) The first is concerned with the ways in which users participated in the commission. Two indicators were created to assess this participation: the attendance of users at weekly plenary meetings of the commission (the decision-making division of the forum) and the types of involvement of user representatives in the decision-making process. (2) The second set of variables refers to the factors that could have most influenced the participation of users. The method can be used in the analysis of other participatory processes taking place in statutory fora. In order to apply it, the main requisites are: the forum should have regular meetings, there should be minutes of meetings and lists of those attending meetings stating the institutions or organisations they came from. These sources of information help to construct the sets of dependent and independent variables, as well as to select who were the most frequent participants in the meetings to be interviewed about the participatory process.

The results of this research, as it is a case study, cannot be generalised to other municipal health commissions in Brazil. Nevertheless, as was seen in chapter five, there are studies indicating that participatory patterns in municipal health commissions will vary according to the regions of the country and, mainly, according to the size of the cities (IBAM and others, 1991; IBAM and others, 1993; Carvalheiro and others 1992, 41-52, 95-133). An interesting line of investigation would be the application of the methodology developed in this research - or part of it, given possible restrictions in time or financial resources - to municipal health commissions in state capitals in other regions of the country. Another study using this method would be to analyse participatory processes within commissions in medium and small cities, or in small cities where levels of social activism vary.

Considering that policy makers in the Brazilian health sector intend to evaluate this central aspect of sectoral reform, that is, user involvement in the municipal health commission, the lines of research mentioned above could be developed in the future. Taking into account the particular case of the municipal health commission of Porto Alegre, and considering that health authorities have an interest in promoting user participation in the decision-making process of municipal health commissions, the analysis undertaken by this study suggests some recommendations.

Firstly, the commission's work dynamic should be organised in order to leave to the decision-making divisions of commissions - the plenary and the co-ordinating committee - most policy decisions. Administrative matters should be dealt with by the health institutions and by the technical secretariat. The overload of administrative and financial details, instead of creating administrative openness to public scrutiny, could create interminable meetings where decisions related to the organisation of health services are hastily discussed during the remaining time.

Secondly, local health commissions should be consolidated in all areas of a city. A decentralised approach to participation encouraged enduring user participation and more homogeneous representation of user organisations from several areas of the city. Once local health commissions become the local planning and supervisory body in the region, the issues related to the organisation of health services in the whole city could occupy a central place on the agenda of the municipal health commission. The articulation between municipal and local health commissions could form the basis for implementing the health system reform ideal of organising a comprehensive network of health services in the city.

Thirdly, the health authorities and user representatives in Porto Alegre should rethink their strategy of excluding the medical profession and private providers from the decision-making divisions of the commission. As was seen, the absence of these social actors does not mean that they have less influence over health sector decision-making. On the contrary, it could mean the reinforcement of concealed channels of policy-making and the undermining of the health commission's influence over the health sector. These important actors will seek other channels through which to make their demands upon policy makers, weakening the political strength of the commission within the sector.

The main policy recommendation is for the municipalisation of health services, that is for health care provision to be placed under the control of municipalities. While these services are under the management of several institutions, the real power of the municipal health commission, and thus of user representatives, over them will be restricted. However, the municipalisation of health services in this city, and increased user control over them alone will not guarantee better health care for users. It would be necessary first to reduce the fragmentation of the system, creating federal and state mechanisms for monitoring the system, along with other measures which are related to the overall organisation of the health system in Brazil.

Appendix I

Methodology

I.1. Research Problem

I.1.1. Main Questions and Propositions

The main ***questions*** of this research are: (1) *how were users involved in the municipal health forum of Porto Alegre?* and (2) *what major factors have conditioned their involvement?*

The research regarded as main indicators of involvement: *the number and types of users present at plenary meetings* and *the types of user representatives' involvement in the commission's decision-making process.* Chapter six shows that, given the statutory nature of the commission, it was possible to know the number and types of users attending plenary meetings, which offers a very precise but limited account of user involvement in the forum. Analysis of documents and interviews allows us to examine the way in which user representatives were involved in the commission. This second indicator is not as objective as the first, but it offers a substantive account of how user representatives were actually involved in the activities of the forum. As was explained in chapter two, this research uses the following typology for defining *types of user involvement:* (1) *Non-participation,* (2) *Manipulation,* (3) *Delegation,* (4) *Negotiation,* (5) *Participation.*

The main research ***propositions*** were based on the assumption that some factors could have more influence on the involvement of users than others. The selection of major influences takes into account the suggestions of the literature on the subject, discussed in chapter three. It also considers the reality of the Brazilian health system and Porto Alegre's political and social particularities, which are analysed in chapters four and five. As a result, this research considers

as major factors influencing user involvement in the municipal health commission of Porto Alegre: (1) *recent changes in the institutional framework of the Brazilian health system;* (2,3,4) *the position of federal, state and municipal health authorities on user participation*; (5) *the relationship between public health professionals, who worked at local health units, and activists of urban social movements*; (6) *the organisation of urban social movements in the city*; (7) *the types of agenda of the commission.* The analysis of these factors throughout the period are discussed in chapter seven.

I.1.2. Population and Period

Municipal health commissions have been key elements of the reform of the Brazilian health system over the past thirteen years. Through this reform municipal health commissions have become a widespread institutional feature of the health system. They have gradually increased their planning and supervisory roles over health services located within their territorial jurisdiction. Participatory schemes of municipal health commissions can achieve better results in areas where they have the support of strong social and trade union movements. As was seen in chapter five, this is the case in the southern region of Brazil and, in particular, in Porto Alegre.

The study examines the workings of the *municipal health commission of Porto Alegre, between 1985 and 1991.* The commission was created in September 1985 (CIMS 1985, 2/9). As the field work for this research was carried out during 1992, the period of study begins with the creation of the commission and ends in the year immediately before the field work.

I.2. Research Methods

I.2.1. Sources of Information

Literature, Statistical Reports and Documents

Information on the Brazilian economy, society and health sector were obtained from published and unpublished studies, statistical reports and documents. Unpublished documents were mainly obtained through a systematic search for studies on related subjects carried out from the last decade until 1992, which were listed by the main Brazilian research agencies. Lists of PhD and MS dissertations presented in the main Brazilian universities were also searched, aiming at selecting those related to the subject of study. These systematic searches resulted in a list of works, most of which could be obtained in the libraries of USP (University

of São Paulo) and UNICAMP (University of Campinas). Other studies were obtained in the library of the Public Health School of Porto Alegre (Escola de Saúde Pública da Secretaria de Saúde e Meio Ambiente). This was especially so in the case of studies related to the involvement of urban social movements with health issues in Porto Alegre and to the public out-patient network in the city.

The census and the annual statistical reports (Anuário Estatístico) of the Fundação Instituto Brasileiro de Geografia e Estatística (IBGE 1941, 1951; FIBGE 1982, 1983, 1987, 1989, 1991, 1993) also offered information related to the economy, society and health sector in Brazil. Research reports, particularly those carried out in collaboration with the Instituto Brasileiro de Administração Municipal (IBAM and others 1991, 1993), offered valuable information on the evolution and distribution throughout the country of municipal health fora. Documents such as laws, decrees, bills and plans were used together with the literature to obtain information on the economy, society and health sector in the country, as well as to define the main variables of the research.

Nevertheless, the **minutes** and **attendance lists** of (a) the plenary meetings (mainly), (b) the technical secretariat, (c) the co-ordinating committee and (d) the inspection commission were treated as central for: (1) the reconstruction of the way the forum worked throughout the period, (2) the reconstruction of the forum's agenda, (3) the verification of whether user representatives participated in agenda formation, and (4) the definition of dependent and independent variables. The documents related to local health commissions, which were found among the files of the municipal health commission, were used to reconstruct their history.

Interviews

Selecting Interviewees among Participants in the Municipal Health Commission

In trying to encompass most institutions and interest groups that were regularly involved in the activities of the municipal health commission, different types of respondents were interviewed. They were: (1) main directors of the municipal health secretariat, who had co-ordinated the commission; regular participants in the commission who represented: (2) users from local organisations; (3) users from trade unions excluding health sector workers; (4) users from trade union confederations; (5) health professionals or health workers; (6) private providers; (7) federal health authorities; (8) state health authorities; (9) other regular participants in the commission whose knowledge was referred to by other respondents; (10) participants in the commission who were well informed about local health commissions. As most of the respondents were prominent public figures in the Brazilian, Rio Grande do Sul or

Porto Alegre political life, due to ethical reasons, their identity was not revealed. However, the list with the interviewees' names, and the institutions they represented is available for those privately interested in obtaining further information about them.

(1) The *main directors of the municipal health secretariat,* who had co-ordinated the commission from its creation until the end of 1991, were easily selected, because they led the municipal health secretariat in each period.

(1) Respondent/1: representing the municipal health secretariat in 1985;

(2) Respondent/2: representing the municipal health secretariat in 1986 and January 1987;

(3) Respondent/3: representing the municipal health secretariat in 1987 and in the first four months of 1988;

(4) Respondent/4: representing the municipal health secretariat in most of 1988; and

(5) Respondent/5: representing the municipal health secretariat in 1989 and 1992.

The selection of the other respondents was based on the assumption that those who most frequently participated in the plenary meetings were the most able to represent the views of their institutions or of their organisations about user participation taking place in the municipal health commission. A longer period of participation could enable them to compare the attitude of different social actors towards user involvement in the commission and the quality of this involvement itself. When the interviews were carried out in the second half of 1992, the provisional assumption was that, as regards the types of user involvement in the forum, there were four sub-periods: 1985/1986, 1987/1988, 1989 and 1990/1991. The interviewees should be those present at plenary meetings in as many sub-periods as possible. Considering these two criteria together - frequency at as many meetings as possible during as many sub-periods as possible - the attendance lists of plenary meetings were systematically examined. This examination have permitted the identification of respondents to be interviewed.

(2) Considering the subject of this research, it seemed important to know the opinion of user representatives about their own involvement in the forum. As was seen in chapters six and eight, there were more *users from urban social organisations* in plenary meetings than there were other types of users. At the same time, these organisations' representatives were more actively and consistently involved in the activities of the commission than were other types of user representatives. The idea was to interview more user representatives than any other type of representatives, and those users from urban social organisations should make up the majority of the user respondents. There were, however, so many users from urban social organisations who

had been present at several plenary meetings that it was necessary to use an additional criterion for selection. That is, user representatives from local organisations to be interviewed were those present in three or four sub-periods, attending at least two meetings in each of these three or four sub-periods (1985/1986, 1987/1988, 1989 and 1990/1991). Among 31 reasonably regular user participants, 8 (25 per cent) were selected using this criterion. User respondents from urban social organisations were:

(1) Respondent/6: representative of Porto Alegre Union of Residential Associations (UAMPA);

(2) Respondent/7: user representative of health district four;

(3) Respondent/8: user representative of health district four;

(4) Respondent/9: user representative of health district four;

(5) Respondent/10: user representative of health district six;

(6) Respondent/11: user representative of health district ten;

(7) Respondent/12: user representative of health district two; and

(8) Respondent/13: user representative of health district five.

(3) The *user from trade unions excluding health sector workers* most frequent at plenary meetings throughout most periods was very easily selected. She was the only regular participant of this type attending plenary meetings. She participated regularly in plenary meetings between 1987 and 1991.

(1) Respondent/14: representative of the trade union of rural workers of Porto Alegre.

(4) *Users from trade union confederations* participated in plenary meetings only during 1987 and 1988. From the only two regular participants the most frequent was selected.

(1) Respondent/15: representative of CUT (Central Única dos Trabalhadores).

(5) As there were many participants representing *health professionals or health workers*, in this case also an additional criterion was used. Those to be interviewed should be present at meetings in three or four sub-periods (1985/1986, 1987/1988, 1989 and 1990/1991). Using this criterion, of 47 reasonably regular participants, five (ten per cent) were selected.

(1) Respondent/16: representative of the union of medical doctors of Rio Grande do Sul;

(2) Respondent/17: representative of the union of civil servants of the state health secretariat;

(3) Respondent/18: representative of the union of nurses of Rio Grande do Sul;

(4) Respondent/19: representative of the union of veterinarians of Rio Grande do Sul; and

(5) Respondent/20: representative of the union of civil servants of the municipal health secretariat.

(6) It was easy to select the respondent representing *private providers*. There were only two regular participants of this type during the whole period. One was present at nine meetings in 1985, another participated in 87 meetings, between 1985 and 1991. Because of his more frequent presence at meetings over a longer period, the latter was selected to be interviewed.

(1) Respondent/21: representative of the association of private hospitals of Rio Grande do Sul.

(7) *Federal health authorities* came to meetings representing the Ministry of Health, the Ministry of Education and the INAMPS. Those representing the Ministry of Health were only present at few meetings during 1985 and 1986. Participants representing the Ministry of Education and the INAMPS, however, regularly attended plenary meetings, during the whole period. Two participants representing the Ministry of Education regularly attended plenary meetings. One was present at 26 meetings, during 1990 and 1991, and the other attended 74 meetings, between 1985 and 1990. Due to his more consistent participation the latter was selected to be interviewed. Representing the INAMPS there were three reasonably regular participants. One was present at 17 meetings, during 1986 and 1987, another attended 23 meetings in 1985 and 1986, and the other participated in 28 meetings between 1986 and 1988. Due to her more frequent presence at meetings for a longer period, the latter was selected to be interviewed.

(1) Respondent/22: representing the INAMPS, and

(2) Respondent/23: representing the Ministry of Education.

(8) Official representatives of the state health secretariat at the commission were selected as *state health authorities* to be interviewed. They were also the most consistent participants, coming from this secretariat, during the period when they were official representatives.

(1) Respondent/24: representing the state health secretariat during 1985 and 1986;

(2) Respondent/25: representing the state health secretariat in 1987, 1988 and during part of 1989; and

(3) Respondent/26: representing the state health secretariat during part of 1989, in 1990 and 1991.

(9) Several respondents spontaneously named *two health professionals* to be interviewed. According to these respondents, these health professionals had constant involvement in the commission's activities and could offer valuable information about user involvement.

(1) Respondent/27: who had been a regular participant in the technical secretariat since 1985; and

(2) Respondent/28: a health professional closely related to urban social movement activists in health district four.

(10) Respondents were asked about *participants in the commission who could produce information specifically related to the local health commissions*. Two participants were selected following the indications of interviewees:

(1) Respondent/27: who had been regular participant in the commission since 1985; and

(2) Respondent/15: who took part in the co-ordination of the commission between 1989 and 1991.

Selecting Interviewees among Representatives of the Brazilian Health System Reformers and the Medical Profession

Trying to assess the Brazilian health system reformers' and the medical profession's political role in the commission as well as their views on user participation, well-known representatives of both groups were interviewed. Some "key" respondents were asked about the most legitimate representative of both groups in Porto Alegre, regarding the different factions of reformers and the different organisations representing the medical profession. They suggested people, who were contacted and interviewed.

Respondents representing Brazilian health system reformers were:

(1) Respondent/5: representing the Workers' Party (PT) (also interviewed as municipal health authority);

(2) Respondent/4: representing the Democratic Labour Party (PDT) (also interviewed as municipal health authority);

(3) Respondent/30: representing the Communist Party of Brazil (PC do B);

(4) Respondent/31: representing the Brazilian Communist Party (PCB); and

(5) Respondent/32: representing the Party of the Brazilian Democratic Movement (PMDB).

Respondents representing the medical profession were:

(1) Respondent/33: representing the union of medical doctors of Rio Grande do Sul;

(2) Respondent/34: representing the medical association of Rio Grande do Sul; and

(3) Respondent/35: representing the council of medical doctors of Rio Grande do Sul.

Selecting an Interviewee among the Informers at National Level

Trying to obtain additional information about the municipal health fora throughout the country the president of the National Council of Municipal Secretaries of Health (CONASEMS) was interviewed.

(1) Respondent/36: representing the CONASEMS.

Designing Questionnaires for Interviews

There were six types of questionnaires, each of them applied to the following types of respondents:

(1) main directors of the municipal health secretariat,

(2) users,

(3) other participants in the commission,

(4) respondents representing Brazilian health system reformers and the medical profession,

(5) participants in the commission able to inform about local health commissions,

(6) respondent representing CONASEMS.

For respondents of types (1), (2) and (3) of respondents, the questionnaires asked only about the period that each respondent actually participated in the activities of the commission. When asking about the position of different actors towards user involvement in the commission, the questions took into account the political changes. For instance, when inquiring about the stance of federal health authorities on user participation, the question referred to three periods: (1) 1985,1986,1987 and the beginning of 1988; (2) between May and December of 1989; and (3) 1990 and 1991. As there was not yet a precise definition of the periods corresponding to different types of users' involvement, when asking about the strength of their involvement and about the "quality" of their participation, each single year was referred to. For the remaining types of respondents the questions were not directly related to the commission's works. Appendix II presents models of the six types of questionnaire.

Interviews aimed at obtaining different types of information, according to the type of interviewee. *Users, health professionals and health workers, private providers, respondents representing municipal, state and federal health authorities* and the *two health professionals* (nominated to be interviewed by other respondents) were asked (a,b,c) about the position on user participation of municipal, state and federal health authorities, (d) about how users participated, (e) about the quality of the relationship between user representatives and municipal health authorities and (f) on how the forum's agenda was established. *Respondents representing municipal health authorities* were also asked about (g) the role of user participation in their policies.

Users and r*espondents representing Brazilian health system reformers and the medical profession* were asked (a) about the quality of the relationships between user leaders and the medical profession and between user leaders and the Brazilian health system reformers. *Respondents representing the Brazilian health system reformers and the medical profession* were also asked (b) about the role of user participation in their plans for the health sector.

The interview with the *respondent representing the CONASEMS* aimed at obtaining information (a) about the historical evolution of municipal health commissions and of user involvement in these commissions, and (b) about possible differences in the type of user involvement when considering different regions and city size in Brazil. *Informants on local health commissions* were asked about the history of, and how users were involved in, each commission.

Carrying out Interviews

Questionnaires guided the structured interviews which were carried out during the second half of 1992 in Porto Alegre, Brazil. However, it was impossible to interview Respondent/3 at that time, due to his intense political activity. This specific interview was carried out by a research assistant in July 1993. For each interview, an individualised had been previously prepared, because: (1) distinct respondents could produce different types of information and (2) the period during which respondents had participated in the commission varied. Two pilot interviews were carried out, in August 1992. They helped in the rephrasing of some questions and expressions, before the actual interviews took place. During the interviews, the questionnaire was systematically followed. Sometimes, however, after repeating a question, if the respondent could not understand the meaning - which happened especially when interviewing users - the question was rephrased. All interviews were tape recorded. In addition to tape recordings, notes were taken during the interviews. The interviews lasted approximately

between half an hour and one hour and 40 minutes. As can be observed in the list of respondents presented above, the same person would have been interviewed twice. In these cases, the two interviews could be carried out during the same meeting or in two meetings, depending on the preference of the respondent.

Preparing Interviews for Analysis

All the tapes from the interviews were transcribed. Each interview's transcription was systematically read to highlight the points which could help to answer the main questions of this research. The relevant parts of each interview were selected and summarised on a form. Apart from the identification of the respondent, these forms have fields for two main sets of information. The first was on how users were involved in the forum, in each year between 1985 and 1991, summarising the respondent's views on:

(1) how users were involved in the commission's activities;

(2) how was the relationship between health authorities and users, especially user representatives;

(3) how the agenda was established.

The second set of information summarised in these forms refers to the determinants of user involvement. Respondents were directly asked about some possible factors influencing this involvement or were asked to suggest which influences they regarded as determinant. They were directly asked about:

(1, 2, 3) the position of *municipal*, *state* and *federal* health authorities on user involvement;

(4) the position of trade union confederations on user participation;

(5) relationships between medical professionals (especially the leaders of medical organisations) and users (especially user representatives);

(6) relationships between Brazilian health system reformers and users (especially user representatives);

(7, 8, 9) importance of user participation in the plans for the health sector of *municipal health authorities*, *Brazilian health system reformers* and the *medical profession*;

(10, 11, 12) why user attendance at plenary meetings grew in *1987/1988*, dropped in *1989/1990*, and grew again in *1991*.

The summary of each of these points was stored in a database of interviews, which was organised by interviewee and by year. The personal computer programme Access 1.0 for Windows was used for storage of the information. These summaries were used as a general guide, the original transcriptions being constantly used when dealing with the data obtained through the interviews.

Questionnaires on Local Health Commissions

Complementing the information obtained from the two interviews about the history of the involvement of users in local health commissions, a questionnaire (Appendix II) was sent to each local commission co-ordinator to be filled in by its the most long-standing participants. Among the eleven active commissions, numbers *two*, *three*, *four*, *six*, *nine*, *ten* and *eleven* returned the questionnaire. Additional information about commissions *five*, *one*, *seven* and *eight* came from other interviews and documents.

I.2.2. The Analysis

As was seen before, the literature, statistical reports and documents were the main sources of information used to build up the discussion on (1) participation, (2) major factors that could influence user participation in an institutionalised participatory forum, (3) the Brazilian health system, (4) the spread of municipal participatory fora in the Brazilian health sector over the past ten years, and (5) health services and urban social movements in Porto Alegre.

Nevertheless, the main focus of the research was on the participatory process taking place in the municipal health forum of Porto Alegre. The main challenge was to find ways of assessing this process, given the main research questions and the types of data available. Aiming at answering the two main research questions, it was necessary: (1) to reconstruct the work pattern of the municipal forum, (2) to analyse how the users were involved in the commission, (3) to analyse the factors that could have most influenced user involvement, and (4) to verify which factors had most influenced user involvement in the commission. Table I.1 summarises the main questions, analytical strategies and sources of information described in this section.

Table I.1 - Summary of the Main Research Questions, Analytical Strategies and Sources of Information

Main Questions	Analytical Strategies	Sources of information
How were users involved in the municipal health commission?	*To reconstruct the work pattern of the municipal forum throughout the period, documents and interviews were analysed focusing on:* .legal provisions and internal regulations that guided the work of the commission, .divisions of the commission and what were their functions/powers .legal role of user representatives in the main divisions of the commission, .social actors entitled to vote/decide about agenda formation and controversial issues, .legal functions/power of the commission within the health system.	-main policy documents and legislation concerning municipal commissions in the period -minutes and attendance lists of meetings of the plenary, of the co-ordinating committee, of the technical secretariat and of the inspection commission -documents in the commission's files -interviews with the participants in the commission
	To verify the number and types of users attending plenary meetings throughout the period, attendance lists of plenary meetings were analysed considering: .who attended meetings: **providers, health professionals and health workers, users** or **others,** .types of organisations users came from: **large, local urban, trade unions, others,** .regions of the city users from local organisations came from: **health districts.** *To analyse how user representatives were involved in the decision-making process throughout the period, documents(mainly attendance lists and minutes of the decision-making and technical divisions) and interviews were analysed considering:* .types of involvement: **non-participation, manipulation, delegation, negotiation, participation.**	-minutes and attendance lists of meetings of the plenary, of the co-ordinating committee, of the technical secretariat and of the inspection commission -interviews with the participants in municipal and local commissions -documents in the commission's files
What major factors have conditioned their involvement?	*To identify the factors that could have most influenced user involvement, the literature, documents (particularly the minutes of the decision-making and technical divisions of the commission) and interviews were analysed, considering:* .suggestions of the literature on the subject, the reality of the Brazilian health system and Porto Alegre's political and social particularities. *Since major influences were identified, to examine variations in their behaviour throughout the period, the literature, documents and interviews were analysed, considering:* .major turning points in their behaviour.	-policy documents, legislation and literature concerning the commission, health authorities, the Brazilian health system, and urban social movements in Porto Alegre -minutes of meetings of the plenary, of the co-ordinating committee, of the technical secretariat and of the inspection commission -interviews with the participants in the commission
	To verify which factors had most influenced user involvement, relationships were established between these factors and the number of users attending plenary meetings and the types of user representatives' involvement in the decision-making process.	- data above mentioned

The Forum's Work Pattern

The reconstruction of the forum's work pattern throughout the period focused on the following aspects: (a) the legal provisions and internal regulations that guided the work of the commission, (b) the divisions of the commission and their functions/powers within the commission's general organisation, (c) the legal role of user representatives in the main divisions of the commission, (d) social actors entitled to vote/decide on agenda formation and controversial issues, (e) legal functions/powers of the commission itself within the health system.

The systematic examination of these aspects allowed the reconstruction of the work pattern of the commission carried out in chapter six. The sources investigated were the main policy documents and legislation concerning municipal health commissions, minutes and attendance lists of meetings of the plenary, of the co-ordinating committee, of the technical secretariat and of the inspection commission, other documents in the commission's files and the interviews with the participants in the commission during the period.

The Analysis of How Users Were Involved in the Commission

As mentioned before, the analysis of how users were involved in the commission took into account the forum's ways of working and two main indicators: *the number and types of users attending plenary meetings* and *the types of user representatives' involvement in the commission's decision-making process.*

The number and types of users attending the plenary meetings seemed to be a significant indicator because the plenary was the decision-making division of the commission. The number and types of users were identified through the analysis of the attendance list of each plenary meeting. Together with each meeting's minute there was a list of the participants. The list displays the name, the signature and the institution/organisation from where each participant came. Examination of the attendance lists of 207 meetings, taking place between September 1985 and December 1991, resulted in a proportion of only 4.7 per cent of names whose institution or organisation of origin was not identified. The remaining 95.3 per cent of the participants were classified and stored in a personal computer spread sheet programme (Excel 4.0 for Windows) and in the database of a statistical programme (Statistical Package for the Social Sciences - SPSS 6.0 for Windows). These data are displayed in Tables III.3 and III.4 of Appendix III. The statistical and graphical processing of these data utilised these two

software resources and for some particular graphs the resources of the personal computer graphical programme Freelance (Freelance Graphics 2.0 for Windows).

The participants were classified into four large categories: (1) **providers**: those coming from health institutions, regardless of whether they were health professionals, health workers or senior managers; (2) **health professionals or health workers**: those coming from associations or trade unions of health professionals or of health workers; (3) **users**: those coming from organisations such as residential, community or neighbourhood associations, trade unions representing non-health sector workers, confederations of trade unions or confederations of urban social organisations; (4) **others**: those who could not be classified into the last three categories. This classification allowed the identification of: (a) which categories of participants made up the majority in the meetings of a given period, (b) what were the "oscillations" in the proportion of each category's participation in meetings throughout the period, (c) what was the mean (the median was very similar to the mean) and mode of each category of participants throughout the period, highlighting the user category, and (d) whether there was a trend towards the increase, stabilisation or decrease of the presence of users in these meetings. To verify the last point, a liner regression was applied considering the number of users present at each meeting by the succession in time of meetings. The scarcity of meetings and the high fluctuation in the number of users present at meetings invalidated the power of prediction of the regression. Nevertheless, it did not invalidate the possibility of the verification of a past trend.

To identify whether user participants came from centralised or decentralised organisations they were further classified into four categories according to the type of organisation: (1) *large* organisations, such as confederations of trade unions or of urban social movement organisations; (2) *local* urban organisations, such as residential, community and neighbourhood associations; (3) *trade unions*, excluding those representing health sector professionals and workers; (4) *others*, such as associations of sufferers of particular diseases - AIDS, diabetics or haemophiliacs - or associations concerned with environmental issues. This classification permitted the verification of: (a) the proportion of users coming from each of these types of organisation throughout the period, (b) whether there was a change in these proportions.

Local organisations were situated in particular areas of the city. In 1991 Porto Alegre was divided into eleven health districts, each one corresponding to one local health commission. Users attending plenary meetings were usually participants in local health commissions or in some urban organisation in the area. Since the location of grassroots organisations was identified, it was possible to distribute users from them according to each

district. This further classification helped to verify: (1) whether this distribution was uniform, indicating whether these users came from many or few areas of the city, (2) from which regions most of these users came and (2) whether patterns of distribution changed throughout the period. Graphs helped to describe the distribution of the results, as can be seen in chapter six. Another way of verifying the degree of homogeneity was the appliance of *an index of qualitative variation (IQV)* to the distribution of users by regions during the successive years. This index is

> *"essentially the ratio of the amount of variation actually observed in a distribution of scores to the maximum variation that could exist in that distribution. The index varies from 0.00 (no variation) to 1.00 (maximum variation)"* (Healey 1993, 93).

The computational formula for the IQV is

$$\text{IQV} = \frac{k\left(N^2 - \Sigma f^2\right)}{N^2(k-1)}$$

where k = the number of categories

N = the number of cases

Σf^2 = the sum of the squared frequencies (Healey 1993, 95).

The types of user representatives' involvement in the commission's decision-making process was the other indicator of user involvement in the commission. As explained in chapter two, this research works with the following concepts of types of user involvement: (1) *non-participation,* (2) *manipulation,* (3) *delegation,* (4) *negotiation,* (5) *participation.* The analysis stressed the participation of users in the processes of agenda formation and of decision-making. Strong indications of their participation in both processes can be drawn through the verification of whether users participated in or had control over the decision-making and technical divisions of the forum. The main sources of information in the analysis of the involvement of user representatives were the commission's internal regulations and other legal or policy provisions, minutes and attendance lists of meetings of the plenary, of the co-ordinating committee, of the technical secretariat and of the inspection commission and interviews with the participants in the commission.

The interviews were the main source of information for describing how users were involved. However, internal regulations and other legal or policy provisions, as well as minutes of the commission's varied divisions, were also systematically analysed, highlighting mainly the information related to the processes of agenda formation and of decision-making. Attendance lists of the meetings of the co-ordinating committee, of the technical secretariat and of the inspection commission helped to check whether the formal composition of these divisions

corresponded to their "real" composition. The focus was on the actual participation of user representatives in these meetings.

The Analysis of Factors that Could Have Most Influenced Users' Involvement

As mentioned above, this research regarded as factors that could have most influenced the quality of users' involvement: (1) *recent changes in the institutional framework of the Brazilian health system;* (2,3,4) *the position of federal, state and municipal health authorities on user participation*; (5) *the relationship between public health professionals, who worked at local health units, and activists of urban social movements*; (6) *the organisation of urban social movements in the city*; (7) *the type of agenda of the commission.*

(1) Turning points in the recent changes in *the institutional framework of the Brazilian health system* were identified through the examination of the literature and documents.

(2,3,4) The "expected" *position of federal, state and municipal health authorities on user participation*, during a particular administration, was compared to the respondents' opinions about the position of these authorities. The "expected" position was obtained from the literature or by taking into account the political affiliations of the authorities. The respondents' opinions were established through the analysis of the interviews. Two types of opinions were taken into account.

The first type refers to respondents' answers to the closed questions about whether they classified the municipal health authorities' in interest in the participation of user representatives in the decision-making process as: "non interest", "some interest", "reasonable interest", "strong interest" or "very strong interest". When asking about state and federal health authorities' interest, the question was whether they had "supported", had "been indifferent to", or had "resisted" the participation of user representatives in the decision-making process. To facilitate comparisons it would have been better if there had been a single type of question for all the authorities. However, the realisation of this unevenness among the questions came only when all the interviews had already been carried out. Aiming to make them comparable, the answers referring to the municipal health authorities were collapsed into three categories: "non-interest/some interest", "reasonable interest" and "strong/very strong interest". The small quantity of interviewees, as shown in Tables III.5, III.6 and III.7 of Appendix III, did not allow the verification of the significance of the answers using chi square or other non parametrical tests. Even taking this into account the absolute number of answers was examined, highlighting the comparison between the answers of user and non-user interviewees.

The second type of respondents' opinion taken into account was their explanations given for the answers. It was the analysis of these explanations that offered a qualified chart for the comparison between health authorities' expected and actual positions on the participation of user representatives in the commission's decision-making process.

(5) *The relationship between public health professionals, who worked at local health units, and activists of urban social movements* was analysed considering whether: (a) there was a close relationship between them, (b) this close relationship, where there was one, was confined to a particular region of the city or was spread throughout many health districts and (3) there was a policy stimulating their approach. Although the literature was also utilised, the main sources of information for answering these questions were the interviews and the questionnaires about local health commissions.

(6) *The organisation of the urban social movements in Porto Alegre* was examined, highlighting the existence of trends towards centralisation or decentralisation. Whether there were policies stimulating the centralisation or decentralisation of the organisation these movements was also investigated. The main sources of information were: the literature, the minutes and attendance lists of plenary meetings, and the interviews and questionnaires about local health commissions.

(7) *The agenda of the commission* was reconstructed through the analysis of the minutes of the plenary meetings. Although it was not possible to know how much time was spent on the discussion of each issue, it was possible to discern whether an issue was discussed or not. After the reconstruction of each meeting's agenda, the issues were classified into seven groups: (1) *Minor.* This type encompasses mainly the presentation of reports or notes about events, programmes or conferences, whether or not related to health issues. (2) *National Health Policies.* This classification encompasses discussions about national health policies and their relationship to the organisation of state and municipal health services. (3) *Labour.* This classification includes discussions, and sometimes the mediation, of issues related to employment relations in the health sector. (4) *Local.* This group involves the discussion of issues related to local or individual problems, such as the need of a health professional or the lack of some specific medicine in a particular health unit, or the denunciation of ill or unlawful treatment of an individual user. (5) *Commission's Regulations.* This type includes all issues related to creating or changing the working rules of municipal or local health commissions. (6) *Financial.* This group comprises all issues related to financial matters, such as routine appraisals of plans for expenditure and accounts of financial resources transferred from the

social security system to the municipal health secretariat, new modalities of transfer of these resources or the municipal budget. (7) *Organisation of Health Services in Porto Alegre*. This group comprises all issues related to the organisation of public health and health care services located in the city of Porto Alegre. These issues could be discussions about plans, programmes or projects that would affect the organisation of health care and public health services in the city or in large areas of the city, issues related to licensing, closing or opening health services, as well as to contracting or cancelling contracts between the social security system and providers.

The issues, classified in this way, by each meeting, are displayed in Table III.8 of Appendix III. The calculation of the percentage of meetings in which each type of issue had been discussed each half year, led to the conclusion that two types of issues were most frequently discussed in plenary meetings. They were those related to the organisation of health services in Porto Alegre and to the financing of health services. Categories were constructed taking into account whether, during each period of six months, the majority of plenary meetings discussed financial issues, discussed the organisation of health services or a similar proportion of both issues.

The large variety of items required their classification into thematic groups in order to make it possible to distinguish the nature of the issues and to compare the frequency of each type of issue to the others. Although it was found to be the best way found to deal with this type of data, there was a constraint. The literature did not offer examples of the classification of the themes discussed in participatory meetings. Hence, it was necessary to create one. The establishment of the basic agenda was rather objective, since most minutes had a sub-title before any subject that was discussed. The construction of the groups had the initial intention of stressing (1) the complexity of issues (minor/local versus organisation of health services/national health policies) and (2) whether they referred to very local or to larger areas/problems (local versus organisation of health services). There were, however, many issues related to the commission's self regulation (commission's regulations), to disputes between employers and employees in the health sector (labour) and to financial concerns. The establishment of this classification can be regarded as arbitrary. Nevertheless, it was successful in encompassing all the matters discussed in plenary meetings in a summarised way.

Which Factors Had Most Influenced the Ways Users Were Involved in the Commission?

In order to answer this question, the dependent and independent variables were analysed and organised into categories. The **dependent variable** was analysed through the two indicators mentioned above: *the number of users attending plenary meetings* and *the types of user representatives' involvement in the decision-making process. The number of users attending plenary meetings* varied between none (zero) and 27. To verify whether there was an association between this indicator-variable and other variables, the observed count of users in each plenary meeting was distributed in chi square tables. The tables displayed many cells (varying between 81 to 90 per cent of cells) with an expected frequency of less than five, making the use of this test questionable. To overcome the difficulty, this continuous variable was transformed into a collapsed ordinal-level variable. As was explained in chapter eight, the criterion used in this transformation was related to the number of districts of health in existence, since the majority of user participants came from local organisations located in these districts. The categories for *user attendance at plenary meetings* were defined as follows:

(1) **meetings with 0 - 2 users**

(2) **meetings with 3 - 7 users**

(3) **meetings with 8 - more users**

The types of user representatives' involvement in the decision-making process were also classified into three categories that considered the increase in the intensity of the involvement of the user representatives. They are:

(1) **Non Participation**

(2) **Delegation/Participation**

(3) **Negotiation** or **Participation**

As was explained in chapter eight, negotiation and participation are qualitatively distinct modalities of involvement of user representatives. While the former implies that there was reasonably overt tension between the user representatives and the municipal health authorities, who were the co-ordinators of the forum, the latter indicates that they acted together harmoniously. Although this difference is highly relevant, it did not affect the intensity of involvement of user representatives. Thus these two types of user representative involvement were collapsed into one single category to make it easier to verify whether it was related to other variables.

As was explained in chapters seven and eight, the **independent variables** - factors that could have affected user involvement - also had an ordinal level of measurement and their variation was classified into three categories.

Recent changes in the institutional framework of the Brazilian health system were classified into the following categories:

(1) **Ações Integradas de Saúde (AIS)**

(2) **Sistemas Unificados Descentralizados de Saúde (SUDS)**

(3) **Leis do Sistema Único de Saúde**

The position of the federal health authorities on user participation was classified into the following categories:

(1) **Resistant to users' involvement**

(2) **Indifferent to users' involvement**

(3) **Interest in the participation of user representatives in the decision-making process**

The position of the state health authorities on user participation was classified into the following categories:

(1) **Non interest in users' involvement**

(2) **Interest in user involvement but not in institutionalised fora (commissions) or in the commission of Porto Alegre**

(3) **Interest in the participation of user representatives in the decision-making process**

The position of the municipal health authorities on user participation was classified into the following categories:

(1) **Non interest in users' involvement**

(2) **Interest in consultative participation**

(3) **Interest in the participation of user representatives in the decision-making process**

The relationship between public health professionals, who worked at local health units, and activists of urban social movements were classified into the following categories:

(1) **Close in a few regions of the city**

(2) **Close in many regions of the city**

(3) **Close in many regions of the city combined with the stimulus of municipal policy**

The organisation of urban social movements in the city was classified into the following categories:

(1) **Tending towards centralisation**

(2) **Tending towards decentralisation**

(3) **Tending towards decentralisation with the Participatory Budget**

The types of agenda of the commission were classified into the following categories:

(1) **Financial**

(2) **Similar proportion of financial and organisation of health services**

(3) **Organisation of health services**

There were some points to be highlighted about this "categorisation". First, the construction of categories implies "reducing" the complexity of the information, resulting in the loss of detailed and valuable data. Nevertheless, it facilitates the investigation of possible relationships between the variables, and helps the understanding of the essential characteristics of the variables. Second, the "independent" variables were actually related to each other. They are treated as independent variables to stress a possible hierarchy of the strength of the association between each of them and the dependent indicator-variables. Third, the variables were collapsed or organised into three categories. Although it was perhaps not ideal, it facilitated the realisation of valid statistical tests among them. As they were "categorical" variables, the category could be thoroughly defined, reconstructing the most complete figure as possible of the phenomena to which it referred. The exception was in the case of the number of users present at plenary meetings which, on the other hand was a very objective, if limited, measure of users' involvement in the commission.

In order to study the possible association between the variables, bivariate tables were constructed (Tables 8.1, 8.2, 8.3, 8.4, 8.5, chapter eight) and the variables were tested for independence as well as for the existence, strength, and direction of their possible relationships. Each plenary meeting was regarded as a "record" because: (1) the "date" of each meeting gave precise information about the position of all other actors at that time, (2) the most objective information, which was the number of users attending the meeting, was organised by the date of the meeting, and (3) the meetings regularly covered all the period of the study. The following tests were applied:

(a) Chi Square Pearsons

> *"As is the case with all tests of hypothesis, the test with chi square consists of computing a test statistic, X^2 (obtained), from the sample data and placing that value on the sampling distribution of all possible sample of outcomes. Specifically, X^2 (obtained) will be compared with the value of X^2 (critical) that will be determined by consulting a chi square table for a particular alpha level and degrees of freedom"* (Healey 1993, 256).

The computational formula for the chi square is:

$$X^2 \text{ (obtained)} = \sum \frac{(f_o - f_e)}{f_e}$$

where f_o = the cell frequencies observed in the bivariate table

f_e = the cell frequencies that would be expected if the variables were independent (Healey 1993, 256).

(b) Cramer's *V*

Using the chi-squared-based measure of association was the first step in assessing the strength of the relationship between the variables. In tables with three or more columns and three or more rows the form of statistic generally used to assess this strength is the Cramer's *V* (Healey 1993, 334, 341).

> *"To calculate V, find the square root of chi square divided by the quantity N multiplied by the number of rows minus 1 or the number of columns minus 1, whichever is the lower (or 'minimum') value. Cramer's V has an upper limit of 1.00 for any table and, like phi, can be interpreted as an index that measures the strength of the association between two variables"* (Healey 1993, 334).

The formula for Cramer's *V* is:

$$V = \sqrt{\frac{X^2}{(N)(\text{minimum of } r-1, c-1)}}$$

where $(\text{minimum of } r-1, c-1)$ = the minimum value of r - 1 (number of rows - 1) or c - 1 (number of columns - 1)

N = the number of cases (Healey 1993, 334).

(c) Gamma

The variables had an ordinal level of measurement. Gamma is a measure of association appropriate for ordinally measured variables organised into table format, particularly for measuring the association between two collapsed ordinal variables (Healey 1993, 350, 368). Gamma measures the proportional reduction in error (PRE) gained by predicting one variable while taking the other into account (Healey 1993, 350).

> *"In the case of gamma, we predict the order of pairs of cases. That is, we predict whether one case will have a higher or lower score than the other on the variable in question. The first prediction rule is to predict the order of a pair of cases on one variable while ignoring their order on the other. The second rule is to predict the order of a pair of cases on one variable while taking their order on the other variable into account"* (Healey 1993, 350).

By computing gamma, we get in a single number a summary measure of the existence, strength, and direction of the relationship.

The formula for computing gamma is:

$$G = \frac{N_s - N_d}{N_s + N_d + T_y}$$

where N_s = the number of pairs of cases ranked the same as both variables

N_d = the number of pairs of cases ranked differently on the two variables (Healey 1993, 355).

(d) Somer's *d*

Somer's *d* is a measure of association appropriate for collapsed ordinal-level variables that have been arrayed in a bivariate table. It is interpretable by the logic of PRE and, computationally, it is based on a comparison of the number of pairs of cases ranked in the same order on both variables (N_s) with the number of pairs ranked differently (N_d) (Healey 1993, 356).

> *"The difference between these statistics and gamma lies in their treatment of pairs of cases that are tied. Gamma represents the proportional reduction in error in prediction for pairs of cases that are not tied. (...) Somer's d includes pairs that are tied on the dependent variable but not the independent"* (Healey 1993, 356).

The formula for Somer's *d* is:

$$d = \frac{N_s - N_d}{N_s + N_d + T_y}$$

where N_s = the number of pairs of cases ranked the same as both variables

N_d = the number of pairs of cases ranked differently on the two variables

T_y = the number of pairs of cases tied on the dependent variable (Healey 1993, 356).

The influence of Brazilian health system reformers over user involvement in the commission was demonstrated through the influence of the variables: *the recent changes in the institutional framework of the Brazilian health system*, which were mainly promoted by reformers, *the position of federal, state and municipal health authorities on user participation*, who in some periods were reformers, and *the relationship between public health professionals, who worked at local health units, and activists of urban social movements*, since these

professionals were often reformers. Sometimes, these professionals could be also representing unions of health professionals or health workers and trade union confederations. Focusing on the role of these reformers in the participatory process, the issue of whether there was a political alliance between them and social movement leaders was investigated also. Taking into account the well-known influence of the medical profession within the health sector, their role in the participatory process was investigated also. This investigation allowed us to verify:

(1) whether the Brazilian health system reformers took part in the forum activities;

(2) if they did, which interest groups, organisations or institutions they formally represented;

(3) what was the importance of user participation in the plans for the health sector of both the Brazilian health system reformers and the medical profession;

(4) what was the nature of the relationship between the user representatives and both the Brazilian health system reformers and the medical profession.

I.3. Final Comments

According to Yin (1991, 95-8), a major strength of case study data collection is the opportunity to use many different sources of information. In a process of "triangulation" - that is, of the constant cross-checking of the evidence - problems related to "constructing validity" are addressed, because multiple sources of information provide multiple measures of the same phenomenon (Yin 1991, 97).

As shown above, this research dealt with a variety of sources of information and each of them alone was regarded as unreliable. The interviewees could only offer their personal views, which could be biased by their political positions, partial access to information or their relations of friendship or personal animosity with health authorities or user representatives. Moreover, as many questions referred to events that took place in the past, they could simply not have remembered precisely what had happened. The official documents - such as plans, bills, projects or programmes - present "official" views, usually promoting the policies and political positions of the authorities responsible for issuing them. The minutes of meetings present the views of the person that wrote them, since they were a summary of the meeting. Some aspects might or might not be regarded as important, depending on the writer.

Considering these types of constraints, information obtained from one source was cross-checked with others in order to confirm or deny its veracity. For instance some respondents affirmed that, during 1989, there was an overload of financial issues on the plenary

meetings' agenda. This initial information was confirmed by the agenda of the plenary meetings reconstructed through the analysis of the minutes of plenary meetings. It was also confirmed by a letter found in the commission's files, in which a local health commission co-ordinator complained about the exhaustive discussion of financial issues and administrative details in plenary meetings. When different sources presented conflicting information, an explanation for the difference was sought. This was the case for instance when user respondents affirmed that the state health authorities, during 1985 and 1986, favoured user participation while the literature, a non-user respondent and some documents indicated that they did not. Looking at the concept of participation that these users were using, looking at the idea of participation that these state authorities expressed in interviews and documents and comparing this to the notion of participation of that non-user respondent, who was a Brazilian health system reformer, it was possible to understand the difference. User respondents and state health authorities regarded as participation users being listened to directly and informally by health authorities. The non-user respondent regarded as participation user representatives having formal and actual power over overt decision-making processes in the health sector.

The use of multiple sources of evidence imposes a great burden on a case study investigator. The researcher has to carry out a variety of data collection techniques and these data need to be properly examined, categorised, tabulated, and recombined in order to address the initial questions and propositions of the study (Yin 1991, 97, 105). These difficult tasks can be summarised in the most intricate challenge of this research which is using varied data to set up a method for the assessment of participation.

The use of the two indicators of user involvement - *the number of users attending the plenary meetings* and *the types of user representatives' involvement in the decision-making process* - helped to solve the problem. On the one hand, the number of users attending plenary meetings is a very objective indicator, while the types of user representatives' involvement in the decision-making process is not. On the other hand, the attendance of users is a very limited indicator of involvement, while the types of involvement in the decision-making process can give a substantive indication of the intensity of user involvement. The classification of types of user representatives' involvement in the decision-making process could give room for different interpretations, even bearing in mind that the construction of these "types" involved the use of as many sources of information as possible.

Varied sources of information were also used to construct the categories which indicate variations in the factors used to explain the intensity of user involvement. The easiest

classification was the one concerned with changes in the institutional framework of the Brazilian health system, that took into account two major policies and a set of laws. The others were based on the literature, documents and interviews, as can be seen in chapter seven. Here again there is room for disagreement about the way the categories were set up.

Even taking into account the constant cross-checking of the information, another researcher might reach different conclusions. Nonetheless, only positivist conceptions of the research process would attempt to pose the researcher as a "neutral" agent in this process. As Bulmer (1984, 3-4) argues, sociological research involves the strategies and techniques of empirical investigation as well as theory. The researcher examining a particular social process is seeking both to understand and explain social phenomena, and is always interpreting the world through a frame of reference, not merely describing it.

Appendix II

Questionnaires

II.1. Questionnaires of Interviews

Model 1 - Main Directors of the Municipal Health Secretariat

Respondent Identification: full name
Place, date and time of interview

1. Durante o período que dirigiste a Secretaria Municipal de Saúde e Serviço Social quais eram os principais objetivos, o programa ou o projeto dessa Secretaria para a área de saúde?

(During the period when you directed the Municipal Health Secretariat which were this Secretariat's main goals, programmes or plans in the health field?)

2. Qual o significado que tu atribuirias ao termo participação comunitária/popular/do consumidor/do cidadão/do usuário **[dependendo do termo que ela/e usar anteriormente, se não mencionou participação, perguntar sobre participação do usuário]**?

(What is the meaning, for you, of the term community/popular/consumer/citizen/user participation **[depending on the expression that s/he used before, if s/he does mention participation, ask about user participation]**?

3. Durante o período de tua gestão na Secretaria Municipal de Saúde e Serviço Social, tu classificarias a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS como:

(During the period of your administration in the Municipal Health Secretariat, how would you classify user representatives' participation in the decision-making process taking place in the CIMS:)

- ☐ Inexistente (Non-existent)
- ☐ Fraca (Weak)
- ☐ Razoável (Reasonable)
- ☐ Intensa (Intense)
- ☐ Muito Intensa (Very Intense)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

4. Durante **[ano/s ela/e dirigiu a Secretaria]***, qual o entendimento que a direção da Secretaria Municipal de Saúde e Serviço Social tinha sobre o papel que deveria ser desempenhado pelos representantes dos usuários nas atividades da CIMS?

(During **[year/s s/he directed the Secretariat]***, what did the directors of the Municipal Health Secretariat think should be the role of user representatives in the activities of the CIMS?)

5. Descreva o papel que de fato desempenhavam os representantes dos usuários nas atividades da CIMS, neste período.

(Describe the actual role of user representatives in the activities of the CIMS, during this period.)

6. Durante **[ano/s ela/e dirigiu a Secretaria]***, tu dirias que a direção da Secretaria tinha:

(During **[year/s s/he directed the Secretariat]***, would you say that the directors of the Secretariat had:)

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em promover a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS

(In promoting the participation of user representatives participation in decisions taken by the CIMS)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

7. Neste mesmo período quais foram as medidas ou as ações concretas que a administração da Secretaria Municipal de Saúde e Serviço Social tomou para viabilizar esta participação?

(In this same period, which measures or concrete actions were taken by the Municipal Health Secretariat to make feasible this participation?)

8. No período em que dirigiste a Secretaria, tu dirias que as entidades que representavam os usuários - associações de moradores, centrais sindicais, etc - demonstravam:

(During the period in which you directed the Secretariat, would you say that the organisations representing users - residential associations, trade union confederations, etc. - showed:

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em participar nas decision tomadas pela CIMS?

(In participating in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

9. Neste mesmo período, como era o relacionamento entre os representantes dos usuários e a direção da Secreataria? Os representantes dos usuários encaravam de que forma a direção da Secretaria?

(In this same period, how was the relationship between user representatives and Secretariat directors? How did user representatives view these directors?)

10. Quais eram as pessoas, os profissionais ou grupo de pessoas ou professionais, com os quais tu discutias as questões referentes à política de saúde? Quais eram os autores ou grupo de autores, ou publicações ou entidades profissionais, políticas ou acadêmicas que mais influenciaram na definição da política de saúde que tua administração implementou no município?

(With whom - people, professionals or group of people or professionals - did you discuss health policies? Which were the authors or author groups, publications or professional, political or academic organisations, which most influenced the definition of the health policies promoted by your administration?)

11. Durante **[ano/s ela/e dirigiu a Secretaria]***, os funcionários da Secretaria eram:

(During **[year/s s/he directed the Secretariat]***, the Secretariat civil servants had:)

- ☐ Favoráveis (Favoured)
- ☐ Indiferentes (Been indifferent to)
- ☐ Resitentes (Resisted)
- ☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

12. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

13. Durante [**ano/s ela/e dirigiu a Secretaria**]*, a área de saúde do governo federal era:

(During [**year/s s/he directed the Secretariat**]*, the federal health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

14. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

15. Durante [**ano/s ela/e dirigiu a Secretaria**]*, a área de saúde do governo estadual era:

(During years [**year/s s/he directed the Secretariat**]*, the state health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

16. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

17 . Durante [**ano/s ela/e dirigiu a Secretaria**]*, alguma central sindical participou das atividades da CIMS? [**Se sim**] Qual/s?

(During [**year/s s/he directed the Secretariat**]*, was there any trade union confederation participating in the CIMS? [**If yes**] Which one/s?)

18. Durante [**ano/s ela/e dirigiu a Secretaria**]* , a/s central/s sindical/s era/m:

(During [**year/s s/he directed the Secretariat**]*, trade union confederation/s had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

19. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

20. Que tu saibas, houve ao longo do período de existência da CIMS, algum momento em que as entidades que representavam os usuários decidiram priorizar a participação na CIMS?

(Do you know, whether, since the CIMS was created, there was a period when user organisations decided to prioritise their participation in the CIMS?)

Próximas questões aplicáveis para os que participaram entre 1987 e 1991

(The following questions are applicable to those participating between 1987 and 1991)

Observando o gráfico (Graph II.1), como tu explicarias:

(Observing the graph (Graph II.1), how would you explain:)

21. O aumento da presença dos usuários nas reuniões plenárias em 1987 e 1988?

(The increased user attendance at plenary meetings in 1987 and 1988?)

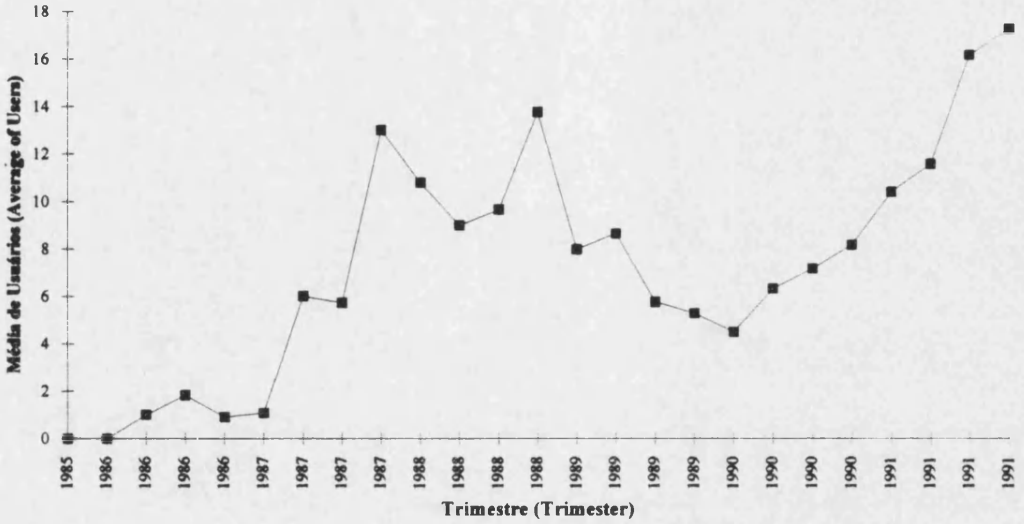
22. A queda na presença dos usuários nas reuniões plenárias em 1989 e 1990?

(The drop in user attendance at plenary meetings during 1989 and 1990?)

23. O aumento da presença dos usuários nas reuniões plenárias em 1991?

(The increased user attendance at plenary meetings in 1991?)

Graph II.1 - Average of Users Present at Plenary Meetings at Three Monthly Intervals - Porto Alegre - CIMS - 1985/ 1991



SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias - Listas de Presença" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

***When respondent had participated in more than a year or more than an administrative period of that type of health authority, the whole question was asked again**

Model 2 - Users

Respondent Identification: full name
Place, date and time of interview

1. Durante [**ano/s ela/e participou na CIMS**]* a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS poderia ser classificada como:

(During [**year/s s/he participated in the CIMS**]* the participation of user representatives in decisions taken by CIMS could be classified as:)

☐ Inexistente (Non-existent)
☐ Fraca (Weak)
☐ Razoável (Reasonable)
☐ Intensa (Intense)
☐ Muito Intensa (Very Intense)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

2. Como tu descreverias o papel que de fato desempenhavam os representantes dos usuários nas atividades da CIMS em [**ano/s ela/e participou na CIMS**]*?

(How would you describe the actual role of user representatives in the CIMS activities, in [**year/s s/he participated in the CIMS**]*?)

3. Durante [**período/s ela/e participou na CIMS**]*, tu dirias que a direção da Secretaria Municipal de Saúde e Serviço Social tinha:

(During [**period/s s/he participated in the CIMS**]*, would you say that the directors of the Municipal Secretariat Health Secretariat had:)

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em promover a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS

(In promoting the participation of user representatives participation in decisions taken by the CIMS)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

4. Que tu saibas, houve ao longo do período de existência da CIMS, algum momento em que as entidades que representavam os usuários decidiram priorizar a participação na CIMS?

(Do you know, whether, since the CIMS was created, there was a period when user organisations decided to prioritise their participation in the CIMS?)

5. Durante **[ano/s ela/e participou na CIMS]***, tu dirias que as entidades que representavam os usuários - associações de moradores, centrais sindicais, etc - demonstravam:

(During **[year/s s/he participated in the CIMS]***, would you say that the organisations representing users - residential associations, trade union confederations, etc. - showed:

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em participar nas decision tomadas pela CIMS?

(In participating in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

6. Durante **[período/s ela/e participou na CIMS]***, como era o relacionamento entre os representantes dos usuários e a direção da Secreataria? Os representantes dos usuários encaravam de que forma a direção da Secretaria?

(During **[period/s s/he participated in the CIMS]***, how was the relationship between user representatives and Secretariat directors? How did user representatives view these directors?)

7. Quais são as pessoas - profissionais, líderes sindicais ou líderes dos movimentos populares, etc - que tu mais confias?

(Whom, among professionals, trade union or popular movements' leaders, etc., do you most regard as reliable?)

8. Quais são as pessoas, professionais ou grupo de pessoas e professionais, com quem tu discutes questões relacionadas à política de saúde?

(With whom - people, professionals or group of people and professionals - do you discuss issues concerning health policies?)

9. Durante **[período/s ela/e participou na CIMS]***, os funcionários da Secretaria Municipal de Saúde e Serviço Social eram:

(During **[period/s s/he participated in the CIMS]***, the Municipal Health Secretariat civil servants had:)

☐ Favoráveis (Favoured)
☐ Indiferentes (Been indifferent to)
☐ Resitentes (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

10. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

11. Durante **[período/s ela/e participou na CIMS]***, a área de saúde do governo federal era:

(During **[period/s s/he participated in the CIMS]***, the federal health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

12. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

13. Durante **[período/s ela/e participou na CIMS]***, a área de saúde do governo estadual era:

(During **[period/s s/he participated in the CIMS]***, the state health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

14. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

15. Durante [**período/s ela/e participou na CIMS**]*, alguma central sindical participou das atividades da CIMS? [**Se sim**] Qual/s?

(During [**period/s s/he participated in the CIMS**]*, was there any trade union confederation participating in the CIMS? [**If yes**] Which one/s?)

16. Durante [**year/s ela/e participou na CIMS**]* , a/s centrais sindical/s era/m:

(During [**year/s s/he participated in the CIMS**]*, trade union confederation/s had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

17. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

Próximas questões aplicáveis para os que participaram entre 1987 e 1991
(The following questions are applicable to those participating between 1987 and 1991)

Observando o gráfico (Graph II.1), como tu explicarias:

(Observing the graph (Graph II.1), how would you explain:)

18. O aumento da presença dos usuários nas reuniões plenárias em 1987 e 1988?

(The increased user attendance at plenary meetings in 1987 and 1988?)

19. A queda na presença dos usuários nas reuniões plenárias em 1989 e 1990?

(The drop in user attendance at plenary meetings during 1989 and 1990?)

20. O aumento da presença dos usuários nas reuniões plenárias em 1991?

(The increased user attendance at plenary meetings in 1991?)

***When respondent had participated in more than a year or more than an administrative period of that type of health authority, the whole question was asked again**

Model 3 - Other Participants in the Commission

Respondent Identification: full name

Place, date and time of interview

1. Durante [**ano/s ela/e participou na CIMS**]* a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS poderia ser classificada como:

(During [**year/s s/he participated in the CIMS**]* the participation of user representatives in decisions taken by the CIMS could be classified as:)

☐ Inexistente (Non-existent)
☐ Fraca (Weak)
☐ Razoável (Reasonable)
☐ Intensa (Intense)
☐ Muito Intensa (Very Intense)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

2. Como tu descreverias o papel que de fato desempenhavam os representantes dos usuários nas atividades da CIMS em [**ano/s ela/e participou na CIMS**]*?

(How would you describe the actual role of user representatives in the CIMS activities, in [**year/s s/he participated in the CIMS**]*?)

3. Durante [**período/s ela/e participou na CIMS**]*, tu dirias que a direção da Secretaria Municipal de Saúde e Serviço Social tinha:

(During [**period/s s/he participated in the CIMS**]*, would you say that the directors of the Municipal Secretariat Health Secretariat had:)

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em promover a participação dos representantes dos usuários nas decisões que eram tomadas pela CIMS

(In promoting the participation of user representatives participation in decisions taken by the CIMS)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

4. Que tu saibas, houve ao longo do período de existência da CIMS, algum momento em que as entidades que representavam os usuários decidiram priorizar a participação na CIMS?

(Do you know, whether, since the CIMS was created, there was a period when user organisations decided to prioritise their participation in the CIMS?)

5. Durante [**ano/s ela/e participou na CIMS**]*, tu dirias que as entidades que representavam os usuários - associações de moradores, centrais sindicais, etc - demonstravam:

(During [**year/s s/he participated in the CIMS**]*, would you say that the organisations representing users - residential associations, trade union confederations, etc. - showed:

☐ Nenhum interesse (No interest)
☐ Algum interesse (Some interest)
☐ Razoável interesse (Reasonable interest)
☐ Forte interesse (Strong interest)
☐ Muito forte interesse (Very strong interest)

Em participar nas decision tomadas pela CIMS?

(In participating in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

6. Durante [**período-s ela/e participou na CIMS**]*, como era o relacionamento entre os representantes dos usuários e a direção da Secreataria? Os representantes dos usuários encaravam de que forma a direção da Secretaria?

(During [**period/s s/he participated in the CIMS**]*, how was the relationship between user representatives and Secretariat directors? How did user representatives view these directors?)

7. Durante [**período/s ela/e participou na CIMS**]*, os funcionários da Secretaria Municipal de Saúde e Serviço Social eram:

(During [**period/s s/he participated in CIMS**]*, the Municipal Health Secretariat civil servants had:)

☐ Favoráveis (Favoured)
☐ Indiferentes (Been indifferent to)
☐ Resitentes (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

8. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

9. Durante **[período/s ela/e participou na CIMS]***, a área de saúde do governo federal era:

(During **[period/s s/he participated in the CIMS]***, the federal health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

10. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

11. Durante **[período/s ela/e participou na CIMS]***, a área de saúde do governo estadual era:

(During **[period/s s/he participated in the CIMS]***, the state health authorities had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

12. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

13. Durante [**período/s ela/e participou na CIMS**]*, alguma central sindical participou das atividades da CIMS? [**Se sim**] Qual/s?

(During [**period/s s/he participated in the CIMS**]*, was there any trade union confederation participating in the CIMS? [**If yes**] Which one/s?)

14. Durante [**year/s ela/e participou na CIMS**]* , a/s centrais sindical/s era/m:

(During [**year/s s/he participated in the CIMS**]*, trade union confederation/s had:)

☐ Favorável (Favoured)
☐ Indiferente (Been indifferent to)
☐ Resitente (Resisted)
☐ Outro (Other)_____

À participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(The participation of user representatives in decisions taken by the CIMS?)

Tu poderias explicar tua resposta?

(Could you explain your answer?)

15. Tu achas que tal atitude teria tido influência sobre o grau de participação dos representantes dos usuários nas decisões tomadas pela CIMS?

(Do you believe that such attitudes, influenced the degree of participation of user representatives in decision taken by the CIMS?)

Próximas questões aplicáveis para os que participaram entre 1987 e 1991
(The following questions are applicable to those participating between 1987 and 1991)

Observando o gráfico (Graph II.1), como tu explicarias:

(Observing the graph (Graph II.1), how would you explain:)

16. O aumento da presença dos usuários nas reuniões plenárias em 1987 e 1988?

(The increased user attendance at plenary meetings in 1987 and 1988?)

17. A queda na presença dos usuários nas reuniões plenárias em 1989 e 1990?

(The drop in user attendance at plenary meetings during 1989 and 1990?)

18. O aumento da presença dos usuários nas reuniões plenárias em 1991?

(The increased user attendance at plenary meetings in 1991?)

***When respondent had participated in more than an year or more than a administrative period of that type of health authority, the whole question was asked again**

Model 4 - Respondents Representing Brazilian Health System Reformers and the Medical Profession

Respondent Identification: full name
Place, date and time of interview

1. Tu tens tido uma atuação muito intensa na área de saude, discutindo principalmente questões relacionadas à política de saúde. Qual é o projeto que tu e o grupo político que tu integras defendem para o setor saúde no país?

(You have been intensely involved in the health area, mainly discussing issues related to health policies. What are the plans that you and the political group in which you take part support for the health sector in the country?)

2. Qual o papel que tu atribuirias aos usuários dos serviços de saúde neste projeto?

(What would be the role of health service users in these plans?)

Se importante, se teriam papel deliberativo, perguntar a próxima questão

(If important, if they would participate in the decision-making process, ask the following question)

3. Porque os usuários teriam importância tão decisiva?

(Why would users be so important?)

4. Tu achas que existem diferenças de entendimento quanto a questão saúde entre o executivo central de governo (Presidência, Governadores, Prefeitos) e os setores de saúde destes governos (Menistério da Saúde, INAMPS, secretarias de Saúde)? [**Se existem**] Que diferenças são estas?

(Do you think there are differences in the understanding of health issues between the government's central executive (Presidency, Governors, Mayors) and the government's health areas (Ministry of Health, INAMPS, health secretariats)? [**If there is**] What are the differences?

5. Tendo em conta os seguintes atores políticos:
(1) Prefeitos,
(2) Secretários Municipais de Saúde,
(3) Representantes dos usuários de serviços de saúde,
(4) Representantes dos prestadores privados de serviços de saúde e
(5) Organisações que representam profissionais e trabalhadores dos serviços de saúde
Como estão se articulando estes atores nos últimos anos na área de saúde em Porto Alegre?

(Taking into account the following political actors:
(1) Mayors,
(2) Municipal Secretaries of Health,
(3) User representatives,
(4) Private providers' representatives and
(5) Health professionals and health workers representatives
How have their relationships been in recent years in Porto Alegre?

6. Qual seria a forma desejável de articulação entre estes atores, tendo em vista a proposta de política de saúde que tu defendes?

(What would be the ideal relationship between these actors, taking into account the plans for the health sector that you support?)

7. Como que tu caracterizarias as relações entre o grupo de pessoas que como tu defendem este projeto e os representantes dos usuários de serviços de saúde?

(How would you characterise the relationship between people who like you support these plans for the health sector and the representatives of health service users?)

8. Quais eram as pessoas, os profissionais ou grupo de pessoas ou professionais, com os quais tu discutias as questões referentes à política de saúde? Quais eram os autores ou grupo de autores, ou publicações ou entidades profissionais, políticas ou acadêmicas que mais influenciaram na definição da política de saúde que tua administração implementou no município?

(With whom - people, professionals or groups of people or professionals - did you discuss health policies? Which were the authors or author groups, publications or professional, political or academic organisations, which most influenced the definition of the health policies promoted by your administration?)

Model 5 - Participants in the Commission Informing about Local Health Commissions

Respondent Identification: full name
Place, date and time of interview

1. Durante [**anos 1985 a 1991**]*, havia comissões locais de saúde atuantes?

(During [**years 1985 to 1991**]*, were there active local health commissions?)

2. Durante [**anos 1985 a 1991**]*, a participação dos usuários nas comissões locais de saúde diminuiu, se manteve estável ou aumentou?

(During [**years 1985 to 1991**]*, did user participation in local health commissions decreased, remain stable or increased?)

Se houve aumento
3. Em quais delas houve aumento? Porque?

(If increased
In which of them did it increase? Why?)

Se diminuiu
4. Em quais delas diminuiu? Porque?

(If decreased
In which of them did it decrease? Why?)

5. Isto influiu no nível de participação dos usuários na comissão municipal de saúde? Porque?

(Did this influence the degree of user participation in the municipal health commissions? Why?)

6. Tu poderias fazer um breve histórico e caracterização de cada uma das comissões locais de saúde?

(Could you briefly tell me about the evolution and main characteristics of each local health commission?)

CLIS 1

CLIS 2

[CLIS 3 to CLIS 10]

CLIS 11

***For each year the whole question was asked again**

Model 6- Respondent Representing CONASEMS

Respondent Identification: full name
Place, date and time of interview

1. Qual tem sido o papel do CONASEMS no contexto das mudanças que vem ocorrendo no sistema de saúde Brasileiro?

(What has been the role of CONASEMS in the changes taking place in the Brazilian health system?)

2. Desde a criação das primeiras comissões locais de saúde houve mudanças nestes fóruns? Gostaria que tu salientasses o caráter e a intensidade da participação dos usuários nestes fóruns?

(Since the first commissions were created, were there changes in these fora? I would like you to highlight the nature and intensity of user participation in these fora?)

3. Qual é a proporção de municípios no país que tem comissão ou conselho municipal de saúde?

(What is the proportion of municipalities in the country with municipal health commissions or councils?)

4. Tu achas que esta proporpoção varia de região para região? Tentando uma comparação qual seria a proporção de cidades com fórum municipal de saúde em cada região do país?

(Do you think that this proportion varies among the regions? Trying to compare, what would be the proportion of cities with municipal health fora in each region of the country?)

5. Existem diferenças inter-regionais em termos da intensidade, autenticidade ou autonomia da participação dos usuários nestes foruns?

(Were there inter-regional differences in terms of intensity, authenticity or autonomy of user participation in these fora?)

6. As capitais dos estados se diferenciam em termos da intensidade e do efetivo poder de decisão dos representantes dos usuários nestes fóruns, se comparadas as demais cidades do país? **[Se se diferenciam]** Em que termos?

(Are state capitals different in terms of the intensity of involvement and effective decision-making power of user representatives in these fora when compared to other cities in the country? **[If so]** In what ways are they different?)

7. Os fóruns das cidades maiores também se differenciam dos das cidades menores?

(Are the fora of large cities different from those of small cities?)

8. Como tu situarias o Conselho Municipal de Saúde de Porto Alegre neste contexto?
(How would you place Porto Alegre's Municipal Health Council in this context?)

II.2. Questionnaires Sent to Local Health Commissions

Model 7- Questionnaire Sent to Co-ordinators of Local Health Commissions

Respondent Identification: full name
Place, date

1. **Sublinhe as respostas corretas**

(Underline the right answers)

A Comissão Local de Saúde se reunia periodicamente em:

(Did the Local Health Commission meet regularly in:)

[anos 1985 a 1991]*	Sim	Não
[years 1985 to 1991]*	(Yes)	(No)

Se sim

(If yes)

periodicidade:	mensal	quinzenal	semanal	outra_____
(frequency)	(monthly)	(fortnightly)	(weekly)	(other)

2. Tu poderias caracterizar as atividades da Commissão Local de Saúde durante:

(Could you characterise the activities of the Local Health Commission during:)

1985

1986

[years 1987 to 1990]

1991

3. Como era a participação dos usuários do distrito nas atividades da Commissão Local e Municipal durante:

(How did users of the district participate in the activities of the Local and Municipal Commissions' during:)

1985

CLIS:

CIMS:

[years 1986 to 1990]

1991

CLIS:

CIMS:

***For each year the whole question was asked again**

Appendix III

Data of Graphs, Tables and Statistics

Table III.1 - Base for Graph 5.1 - Percentage of Deliberative Municipal Health Councils with Parity of User Representation, by Brazilian Region - 1991

Regions	Municipal Councils 1 *	Deliberative Councils 2	Deliberative Councils with Half Representatives Being Users 3	% 2/1	% 3/2
Brazil	348	287	144	**82**	**50**
South	130	114	67	**88**	**59**
Southeast	154	126	62	**82**	**49**
Northeast	38	30	11	**79**	**37**
Central-west	22	15	4	**68**	**27**
North	4	2	0	**50**	**0**

* Research surveyed 11per cent of the Brazilian cities (Instituto Brasileiro de Administração Municipal and others 1991, 1).

SOURCE: Instituto Brasileiro de Administração Municipal and others, "Perfil dos Municípios na Área de Saúde - Síntese" (Ministério da Saúde, Fundação Nacional de Saúde, IBAM, 1991), 25, photocopied.

Table III.2 - Base for Graph 5.2 - Percentage of Porto Alegre Population Living in Illegally Occupied Areas - 1981/1991

Years	Total Population	Population in Irregular Areas	%
1981	1114867	182480	16
1991	1263239	391501	31

SOURCES: Giacomoni, James, *A Comunidade como Instância Executora do Planejamento: o Caso do "Orçamento Participativo" de Porto Alegre* (PPGA - Departamento de Ciências Administrativas da Faculdade de Ciências Econômicas - UFRGS, Porto Alegre, 1993), 107, photocopied.

Fundação Instituto Brasileiro de Geografia e Estatística, *Anuário Estatístico do Brasil* (Rio de Janeiro, IBGE, 1993), 208.

Table III.3 - Base for Graphs 6.1, 6.2, 6.3 and Table 6.2 - Attendance at Plenary Meetings by Type of Participant - Porto Alegre - CIMS - 1985/1991

1st

Meeting	Date	Providers	Health Workers/ Professionals	Users	Others	Non Identified	Total
1	02/09/85	7	0	0	0	0	7
2	09/09/85	13	0	0	1	0	14
3	16/09/85	10	0	0	2	2	14
4	24/09/85	10	0	0	3	0	13
5	30/09/85	46	0	0	2	0	48
6	08/10/85	15	0	0	8	0	23
7	15/10/85	6	0	0	5	0	11
8	22/10/85	11	0	0	2	0	13
9	29/10/85	9	0	0	3	0	12
10	06/11/85	4	0	0	4	0	8
11	13/11/85	7	0	0	1	0	8
12	20/11/85	5	0	0	1	0	6
13	27/11/85	5	0	0	1	0	6
14	11/12/85	7	0	0	1	0	8
15	17/12/85	4	0	0	3	0	7
16	23/12/85	9	0	0	5	0	14
17	07/01/86	5	0	0	1	0	6
18	14/01/86	2	0	0	1	0	3
19	21/01/86	5	0	0	4	0	9
20	28/01/86	6	0	0	2	0	8
21	04/02/86	6	0	0	1	0	7
22	06/02/86	7	0	0	1	0	8
23	18/02/86	7	0	0	1	0	8
24	25/02/86	6	0	0	1	0	7
25	04/03/86	6	0	0	2	0	8
26	11/03/86	4	0	0	2	0	6
27	18/03/86	6	0	0	1	0	7
28	25/03/86	4	0	0	1	0	5
29	01/04/86	8	0	0	3	0	11
30	08/04/86	5	0	0	2	0	7
31	15/04/86	5	0	0	1	0	6
32	22/04/86	5	0	0	2	0	7
33	29/04/86	6	0	0	2	0	8
34	06/05/86	9	0	0	1	0	10
35	13/05/86	37	0	8	2	0	47
36	20/05/86	3	0	4	4	0	11
37	27/05/86	13	0	1	2	0	16
38	03/06/86	24	0	0	1	0	25
39	10/06/86	9	0	0	2	0	11
40	17/06/86	8	0	0	2	0	10
41	24/06/86	16	0	0	2	0	18
42	01/07/86	13	0	0	2	0	15
43	10/07/86	4	0	0	1	0	5
44	29/07/86	13	0	0	2	0	15
45	05/07/86	22	0	1	1	0	24
46	19/08/86	10	0	0	0	0	10
47	26/08/86	21	0	1	1	0	23
48	02/09/86	22	1	3	13	0	39
49	04/09/86						0
50	09/09/86	14	0	4	2	0	20
51	09/09/86	6	0	0	9	0	15
52	16/09/86	8	0	5	3	0	16
53	23/09/86	22	0	4	3	0	29
54	30/09/86	13	1	4	3	0	21
55	07/10/86	12	0	1	2	0	15
56	14/10/86	10	0	3	2	0	15
57	21/10/86	13	0	1	1	0	15
58	28/10/86	12	0	0	1	0	13
59	11/11/86	10	0	3	4	0	17
60	18/11/86	17	0	3	2	2	24
61	25/11/86	23	0	0	3	0	26
62	02/12/86	15	1	0	1	0	17
63	09/12/86	13	0	0	1	1	15
64	16/12/86	16	0	0	0	0	16
65	23/12/86	3	0	0	0	0	3

2nd

Meeting	Date	Providers	Health Workers/ Professionals	Users	Others	Non Identified	Total
66	30/12/86	5	0	0	1	0	6
67	06/01/87	7	0	0	1	0	8
68	13/01/87	18	0	0	1	0	19
69	20/01/87	6	0	0	1	0	7
70	27/01/87	7	0	0	1	0	8
71	03/02/87	5	0	0	1	0	6
72	10/02/87	5	0	0	2	0	7
73	17/02/87	7	0	0	3	0	10
74	24/02/87	8	0	0	2	0	10
75	10/03/87	28	3	0	0	0	31
76	17/03/87	26	2	2	2	0	32
77	24/03/87	21	2	7	0	0	30
78	31/03/87	13	2	4	0	0	19
79	07/04/87	14	2	2	0	0	18
80	14/04/87	24	1	2	1	0	28
81	28/04/87	16	2	7	3	0	28
82	05/05/87	27	0	10	5	0	42
83	12/05/87	19	2	11	8	0	40
84	19/05/87	13	1	5	0	0	19
85	26/05/87	21	1	5	0	0	27
86	02/06/87	18	2	12	0	0	32
87	09/06/87	17	2	4	0	0	23
88	16/06/87	17	2	2	0	0	21
89	07/07/87	20	2	6	2	0	30
90	14/07/87	16	2	3	0	0	21
91	21/07/87	16	2	4	0	0	22
92	28/07/87	19	2	5	3	2	31
93	04/08/87	18	0	8	0	0	26
94	11/08/87	17	3	5	5	1	31
95	18/08/87	21	2	9	1	0	33
96	25/08/87	17	2	6	0	2	27
97	01/09/87	18	1	5	1	1	26
98	03/09/87	12	11	5	1	1	30
99	22/09/87	9	8	7	0	0	24
100	01/10/87	24	12	22	1	3	62
101	27/10/87	24	0	0	8	0	32
102	05/11/87	25	9	22	1	1	58
103	12/11/87	11	5	13	0	2	31
104	19/11/87	15	0	9	1	1	26
105	03/12/87	27	9	15	0	0	51
106	10/12/87	13	6	10	1	4	34
107	07/01/88	12	5	12	1	1	31
108	04/02/88	23	6	8	3	0	40
109	11/02/88	9	6	8	0	1	24
110	10/03/88	17	7	11	4	4	43
111	17/03/88	11	6	15	4	1	37
112	05/05/88	21	10	11	1	4	47
113	19/05/88	21	9	8	3	4	45
114	09/06/88	23	8	8	3	1	43
115	07/07/88	18	8	6	2	0	34
116	21/07/88	16	2	7	1	0	26
117	04/08/88	25	10	9	1	1	46
118	18/08/88	27	7	13	1	1	49
119	01/09/88	22	10	11	6	5	54
120	15/09/88	19	10	12	2	12	55
121	13/10/88	19	5	24	182	8	238
122	20/10/88	19	6	15	4	3	47
123	27/10/88	13	9	10	0	0	32
124	03/11/88	18	3	23	0	35	79
125	17/11/88	14	5	9	1	3	32
126	01/12/88	13	6	7	2	0	28
127	08/12/88	16	6	7	1	2	32
128	15/12/88	13	9	15	2	1	40
129	05/01/89	28	10	9	3	2	52
130	19/01/89	28	6	8	0	0	42
131	26/01/89	58	8	14	0	1	81
132	16/02/89	14	7	6	3	0	30
133	02/03/89	14	2	3	1	0	20
134	16/03/89	12	4	8	2	1	27
135	29/03/89	6	4	8	2	0	20
136	06/04/89	23	6	11	2	2	44
137	13/04/89	9	4	5	0	0	18
138	27/04/89						0

3rd

Meeting	Date	Providers	Health Workers/ Professionals	Users	Others	Non Identified	Total
139	04/05/89	22	3	7	5	0	37
140	18/05/89	36	8	10	6	3	63
141	01/06/89	18	6	9	1	0	34
142	15/06/89	19	2	10	1	3	35
143	06/07/89	12	3	4	1	4	24
144	13/07/89	16	6	10	4	4	40
145	20/07/89	13	1	7	1	4	26
146	03/08/89	43	6	5	5	2	61
147	17/08/89	13	3	5	2	1	24
148	24/08/89	8	4	5	2	0	19
149	31/08/89	14	7	5	1	0	27
150	21/09/89	17	2	2	4	1	26
151	28/09/89	12	5	9	1	3	30
152	05/10/89	17	3	2	0	1	23
153	19/10/89	18	7	13	2	7	47
154	09/11/89	9	3	5	0	2	19
155	23/11/89	15	7	6	6	1	35
156	30/11/89	18	2	5	5	5	35
157	07/12/89	16	2	4	2	0	24
158	21/12/89	18	2	2	0	0	22
159	18/01/90	16	3	5	5	2	31
160	08/02/90	14	3	3	2	0	22
161	08/03/90	18	8	8	4	2	40
162	15/03/90	7	2	2	0	0	11
163	05/04/90	11	4	3	12	0	30
164	19/04/90	18	3	0	4	1	26
165	03/05/90	16	3	9	3	2	33
166	17/05/90	18	4	7	6	1	36
167	07/06/90	23	10	12	2	4	51
168	21/06/90	43	10	7	2	1	63
169	05/07/90	18	8	6	3	3	38
170	19/07/90	30	5	5	8	1	49
171	02/08/90	16	9	4	3	3	35
172	16/08/90	22	10	20	2	4	58
173	13/09/90	29	10	3	2	5	49
174	27/09/90	17	4	5	5	1	32
175	04/10/90	13	5	3	1	3	25
176	25/10/90	21	10	3	3	0	37
177	08/11/90	21	10	4	6	0	41
178	22/11/90	24	10	24	5	8	71
179	06/12/90	20	10	9	0	2	41
180	20/12/90	16	7	6	2	0	31
181	17/01/91	21	7	13	2	1	44
182	24/01/91	21	6	15	0	2	44
183	21/02/91	9	3	10	0	2	24
184	07/03/91	29	5	9	2	3	48
185	21/03/91	25	7	5	2	6	45
186	04/04/91	24	7	16	4	5	56
187	18/04/91	35	5	9	3	4	56
188	02/05/91	30	7	14	4	4	59
189	16/05/91	16	7	11	7	0	41
190	06/06/91	27	6	8	4	5	50
191	13/06/91	23	3	9	8	1	44
192	20/06/91	37	8	14	2	4	65
193	04/07/91	45	11	27	7	13	103
194	18/07/91	19	3	9	1	2	34
195	01/08/91	42	12	27	6	3	90
196	08/08/91	21	5	13	5	3	47
197	15/08/91	42	10	9	6	1	68
198	29/08/91	24	8	13	3	4	52
199	05/09/91	30	5	15	7	1	58
200	10/10/91	27	10	14	2	2	55
201	17/10/91	27	6	17	3	16	69
202	31/10/91	15	14	25	16	4	74
203	07/11/91	44	1	9	2	4	60
204	21/11/91	30	7	22	1	6	66
205	05/12/91	83	8	19	1	5	116
206	12/12/91	22	0	10	3	3	38
207	19/12/91	52	4	22	3	4	85

SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 12 May 1987 to December 1988), attendance lists, typewritten.

Table III.4 - Base for Graphs 6.4 and 6.5 - Attendance of Users at Plenary Meetings by Type of Organisation or Region They Came from - Porto Alegre - CIMS - 1985/1991

1st

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
1	02/09/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	09/09/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3	16/09/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	24/09/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	30/09/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	08/10/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	15/10/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	22/10/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
9	29/10/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10	06/11/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
11	13/11/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
12	20/11/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	27/11/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
14	11/12/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	17/12/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	23/12/85	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17	07/01/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18	14/01/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
19	21/01/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20	28/01/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
21	04/02/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	06/02/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
23	18/02/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
24	25/02/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	04/03/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	11/03/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
27	18/03/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
28	25/03/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
29	01/04/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30	08/04/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

2nd

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
31	15/04/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
32	22/04/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
33	29/04/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
34	06/05/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35	13/05/86	0	0	0	0	0	0	0	0	0	0	0	0	0	8	0	0	0	0	8
36	20/05/86	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	4
37	27/05/86	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
38	03/06/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
39	10/06/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40	17/06/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
41	24/06/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
42	01/07/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
43	10/07/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
44	29/07/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45	05/07/86	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
46	19/08/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
47	26/08/86	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
48	02/09/86	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
49	04/09/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
50	09/09/86	1	0	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	4
51	09/09/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52	16/09/86	2	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5
53	23/09/86	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
54	30/09/86	2	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	4
55	07/10/86	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
56	14/10/86	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
57	21/10/86	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
58	28/10/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
59	11/11/86	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3

3rd

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
60	18/11/86	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	3
61	25/11/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
62	02/12/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
63	09/12/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
64	16/12/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65	23/12/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
66	30/12/86	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
67	06/01/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
68	13/01/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
69	20/01/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70	27/01/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
71	03/02/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
72	10/02/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
73	17/02/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
74	24/02/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
75	10/03/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
76	17/03/87	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
77	24/03/87	1	0	0	0	0	0	1	0	1	0	0	0	0	3	0	0	0	1	7
78	31/03/87	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	1	4
79	07/04/87	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	2
80	14/04/87	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
81	28/04/87	3	0	0	0	0	0	0	0	2	0	0	1	0	1	0	0	0	0	7
82	05/05/87	2	0	0	0	0	0	0	0	4	0	0	1	0	0	0	0	0	3	10
83	12/05/87	3	1	1	1	0	0	0	0	2	0	0	1	0	0	0	0	2	0	11
84	19/05/87	2	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	5
85	26/05/87	1	1	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	5
86	02/06/87	2	1	0	0	0	0	0	0	7	0	0	0	0	0	0	0	0	2	12
87	09/06/87	1	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	4
88	16/06/87	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
89	07/07/87	1	1	0	0	0	0	0	0	0	1	0	0	0	3	0	0	0	0	6

4th

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
90	14/07/87	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	3
91	21/07/87	0	1	0	1	0	0	0	0	1	1	0	0	0	0	0	0	0	0	4
92	28/07/87	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5
93	04/08/87	1	1	0	1	0	0	2	0	0	2	0	0	0	1	0	0	0	0	8
94	11/08/87	0	1	0	1	0	0	1	0	0	2	0	0	0	0	0	0	0	0	5
95	18/08/87	1	1	1	1	2	0	1	0	0	2	0	0	0	0	0	0	0	0	9
96	25/08/87	2	0	0	1	0	0	3	0	0	0	0	0	0	0	0	0	0	0	6
97	01/09/87	1	1	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	5
98	03/09/87	0	0	1	1	1	0	0	0	0	1	0	0	0	0	0	0	0	1	5
99	22/09/87	0	2	0	1	1	0	0	0	0	2	0	0	0	0	0	0	1	0	7
100	01/10/87	1	1	1	1	0	0	3	1	2	7	2	0	0	1	0	0	1	1	22
101	27/10/87	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
102	05/11/87	1	0	1	1	1	0	0	0	3	6	1	1	0	0	4	0	1	2	22
103	12/11/87	1	0	0	1	1	0	2	0	2	1	0	0	0	4	0	0	1	0	13
104	19/11/87	1	1	0	1	0	0	1	0	0	1	0	0	0	1	2	0	1	0	9
105	03/12/87	1	1	1	0	0	0	1	0	2	2	2	0	1	0	2	0	1	1	15
106	10/12/87	1	0	0	1	1	0	1	0	2	0	0	0	0	1	3	0	0	0	10
107	07/01/88	1	0	0	1	1	0	1	0	1	1	0	0	0	0	5	0	1	0	12
108	04/02/88	1	1	1	0	0	0	1	0	0	0	0	0	0	1	2	0	1	0	8
109	11/02/88	1	1	1	1	2	0	1	0	0	0	0	0	0	0	0	0	1	0	8
110	10/03/88	1	1	0	1	1	1	1	0	1	1	0	0	0	0	3	0	0	0	11
111	17/03/88	3	1	0	1	1	0	2	0	3	1	0	0	0	0	3	0	0	0	15
112	05/05/88	1	1	0	1	0	1	1	0	1	1	0	0	0	0	3	0	1	0	11
113	19/05/88	1	1	0	1	0	1	1	0	0	1	0	0	0	0	2	0	0	0	8
114	09/06/88	1	1	0	1	0	0	1	0	0	2	1	0	0	0	0	0	1	0	8
115	07/07/88	0	1	0	0	0	0	1	0	0	2	0	0	0	0	1	0	1	0	6
116	21/07/88	0	2	0	1	0	0	1	0	1	1	0	0	0	0	0	0	1	0	7
117	04/08/88	0	1	0	0	0	0	1	0	2	2	0	0	0	0	1	0	1	1	9
118	18/08/88	1	1	0	1	0	0	1	1	2	2	1	0	0	0	0	0	1	2	13
119	01/09/88	2	0	0	0	0	1	4	0	0	1	0	1	0	0	1	0	1	0	11

5th

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
120	15/09/88	1	0	0	0	0	2	0	0	0	2	1	0	0	0	4	0	1	1	12
121	13/10/88	1	1	0	0	1	2	9	0	4	2	1	1	0	0	1	0	1	0	24
122	20/10/88	0	1	0	0	1	0	6	0	2	2	0	1	0	0	1	0	1	0	15
123	27/10/88	0	0	0	0	0	2	1	0	1	2	0	1	0	0	1	0	1	1	10
124	03/11/88	0	0	0	0	0	0	16	0	0	1	0	1	0	4	1	0	0	0	23
125	17/11/88	0	1	0	0	0	0	2	0	0	1	0	0	0	3	1	0	1	0	9
126	01/12/88	0	1	0	0	0	0	1	0	1	0	0	1	0	2	1	0	0	0	7
127	08/12/88	1	0	0	0	0	0	1	0	2	1	0	0	0	1	0	0	1	0	7
128	15/12/88	0	1	0	0	0	0	1	0	2	2	9	0	0	0	0	0	0	0	15
129	05/01/89	0	0	0	0	0	0	0	0	2	2	1	1	0	0	1	0	1	1	9
130	19/01/89	1	0	0	0	0	0	1	0	3	1	0	0	0	0	1	0	1	0	8
131	26/01/89	3	0	0	0	0	1	1	1	4	1	0	1	0	0	1	0	1	0	14
132	16/02/89	0	0	0	0	0	0	1	0	1	1	2	0	0	0	0	0	1	0	6
133	02/03/89	0	0	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	0	3
134	16/03/89	1	0	0	0	0	0	3	0	1	1	0	0	0	0	1	0	1	0	8
135	29/03/89	1	1	0	1	1	0	0	0	0	1	0	1	0	0	0	0	1	1	8
136	06/04/89	1	0	0	0	0	2	1	0	1	2	0	1	0	3	0	0	0	0	11
137	13/04/89	1	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	1	0	5
138	27/04/89																			
139	04/05/89	0	0	0	0	0	0	1	0	1	2	0	1	0	2	0	0	0	0	7
140	18/05/89	1	0	0	0	1	0	1	0	1	1	0	1	0	2	0	0	1	1	10
141	01/06/89	0	0	0	0	0	0	1	0	2	2	0	1	0	2	0	0	1	0	9
142	15/06/89	0	0	0	0	0	0	4	0	1	1	0	1	0	1	2	0	0	0	10
143	06/07/89	0	0	0	0	0	0	1	0	0	1	0	1	0	1	0	0	0	0	4
144	13/07/89	0	0	0	0	0	1	3	0	2	1	1	1	0	0	0	0	0	1	10
145	20/07/89	0	0	0	0	0	0	0	0	1	1	1	1	0	3	0	0	0	0	7
146	03/08/89	0	0	0	0	0	0	1	0	1	2	0	0	0	1	0	0	0	0	5
147	17/08/89	0	0	0	0	0	0	0	0	2	1	0	1	0	1	0	0	0	0	5
148	24/08/89	0	0	0	0	0	0	2	0	1	0	0	1	0	0	0	0	1	0	5
149	31/08/89	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	1	1	5

6th

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
150	21/09/89	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	2
151	28/09/89	1	0	0	0	0	0	1	0	2	1	1	0	0	2	1	0	0	0	9
152	05/10/89	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
153	19/10/89	0	0	0	0	0	0	1	1	4	3	1	0	0	1	0	0	0	2	13
154	09/11/89	0	0	0	0	0	0	0	0	4	0	0	0	0	1	0	0	0	0	5
155	23/11/89	0	0	0	0	0	0	1	0	2	1	0	0	0	1	0	0	0	1	6
156	30/11/89	0	0	0	0	0	0	0	1	1	1	0	0	0	1	0	0	1	0	5
157	07/12/89	0	0	0	0	0	0	0	1	0	1	1	0	0	1	0	0	0	0	4
158	21/12/89	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	2
159	18/01/90	0	0	0	0	0	0	0	1	4	0	0	0	0	0	0	0	0	0	5
160	08/02/90	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	1	0	3
161	08/03/90	0	0	0	0	0	0	1	2	4	0	0	0	0	0	1	0	0	0	8
162	15/03/90	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	2
163	05/04/90	0	0	0	0	0	0	0	1	2	0	0	0	0	0	0	0	0	0	3
164	19/04/90	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
165	03/05/90	2	0	0	0	0	0	1	1	1	2	0	0	0	1	0	0	1	0	9
166	17/05/90	0	0	0	0	0	0	2	1	1	2	0	0	0	0	0	0	1	0	7
167	07/06/90	0	0	0	0	0	0	2	2	4	1	0	0	0	2	0	0	1	0	12
168	21/06/90	0	0	0	0	0	0	0	3	0	1	2	0	0	1	0	0	0	0	7
169	05/07/90	0	0	0	0	0	0	2	0	1	1	0	0	0	1	0	0	1	0	6
170	19/07/90	0	0	0	0	0	0	0	1	1	0	1	0	0	1	0	0	1	0	5
171	02/08/90	0	0	0	0	0	0	1	0	3	0	0	0	0	0	0	0	0	0	4
172	16/08/90	0	0	0	0	0	0	1	0	1	0	1	0	0	16	0	0	1	0	20
173	13/09/90	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	1	0	3
174	27/09/90	0	0	0	0	0	0	0	1	2	1	0	0	0	1	0	0	0	0	5
175	04/10/90	0	0	0	0	0	0	0	1	0	0	1	0	0	1	0	0	0	0	3
176	25/10/90	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0	3
177	08/11/90	0	0	0	0	0	0	0	1	2	0	0	0	0	1	0	0	0	0	4
178	22/11/90	0	0	0	0	0	0	0	2	2	1	1	0	0	1	11	0	0	6	24
179	06/12/90	0	0	0	0	0	0	2	0	2	1	1	0	0	1	2	0	0	0	9
180	20/12/90	0	0	0	0	0	0	2	1	1	1	0	0	0	1	0	0	0	0	6
181	17/01/91	0	0	0	0	0	0	1	0	6	0	1	0	0	1	3	0	1	0	13
182	24/01/91	0	0	0	0	0	0	1	2	5	0	3	0	0	1	2	0	1	0	15
183	21/02/91	0	0	0	0	0	0	0	2	1	0	0	0	0	1	6	0	0	0	10
184	07/03/91	0	0	0	0	0	0	2	2	1	0	0	1	0	1	0	0	1	1	9

7th

Meeting	Date	UAMPA	CUT	CGT	FRACAB	FETAG	Dist 1	Dist 2	Dist 3	Dist 4	Dist 5	Dist 6	Dist 7	Dist 8	Dist 9	Dist 10	Dist 11	Trade Unions	Others	Total
185	21/03/91	0	0	0	0	0	0	2	0	1	0	0	0	0	1	0	0	1	0	5
186	04/04/91	1	0	0	0	0	0	2	1	4	1	0	0	0	6	1	0	0	0	16
187	18/04/91	0	0	0	0	0	0	1	1	1	2	1	0	0	1	1	0	1	0	9
188	02/05/91	0	0	0	0	0	0	2	1	1	2	0	3	2	2	0	0	0	1	14
189	16/05/91	1	0	0	0	0	0	0	2	0	1	1	0	3	1	1	0	1	0	11
190	06/06/91	0	0	0	0	0	0	2	1	1	0	0	1	2	1	0	0	0	0	8
191	13/06/91	0	0	0	0	0	0	3	0	1	1	0	1	2	0	1	0	0	0	9
192	20/06/91	0	0	0	0	0	0	1	3	1	0	1	1	1	2	4	0	0	0	14
193	04/07/91	0	0	0	0	0	0	2	0	4	2	3	3	1	2	9	0	0	1	27
194	18/07/91	1	0	0	0	0	0	1	1	0	0	2	3	0	1	0	0	0	0	9
195	01/08/91	1	0	0	0	0	0	1	0	3	3	5	2	1	2	6	1	2	0	27
196	08/08/91	0	0	0	0	0	0	1	3	1	1	1	0	1	1	1	0	0	3	13
197	15/08/91	0	0	0	0	0	0	0	2	1	1	1	1	1	0	1	0	0	1	9
198	29/08/91	1	0	0	0	0	0	0	2	1	2	1	1	2	1	1	0	0	1	13
199	05/09/91	0	0	0	0	0	0	0	2	1	1	1	2	2	4	0	0	0	2	15
200	10/10/91	1	0	0	0	0	0	0	3	2	0	1	1	1	2	1	1	1	0	14
201	17/10/91	1	0	0	0	0	0	5	2	1	1	1	1	1	2	1	0	1	0	17
202	31/10/91	0	0	0	0	0	0	0	1	12	0	2	2	1	1	0	0	0	6	25
203	07/11/91	0	0	0	0	0	0	2	0	0	0	0	3	1	1	1	1	0	0	9
204	21/11/91	0	0	0	0	0	2	2	1	2	4	1	3	1	1	0	1	0	4	22
205	05/12/91	0	0	0	0	0	0	2	3	3	1	2	1	1	2	2	1	1	0	19
206	12/12/91	0	0	0	0	0	1	1	1	0	2	1	2	1	1	0	0	0	0	10
207	19/12/91	0	0	0	0	0	2	0	2	1	3	6	2	0	2	1	2	0	1	22
Total		81	39	11	36	16	19	150	64	188	136	68	59	27	136	106	7	56	52	1251

SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 12 May 1987 to December 1988), attendance lists, typewritten.

Table III.5 - Base for Graphs 7.1 and 7.2 - Opinion of Participants in the Municipal Health Commission about the Position of Federal Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991

Type of Answer	1985/1988		1988/1989		1990/1991	
	Non-User	User	Non-User	User	Non- User	User
Resistant	6	2	4	1	3	1
Indifferent	4	1	5	3	5	4
In Favour	4	5	0	1	0	0
Missing	1	2	2	4	2	3

SOURCE: Interviews with Participants of Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December 1992, transcript, Interviewer Files, London.

Table III.6 - Base for Graphs 7.3 and 7.4 - Opinion of Participants in the Municipal Health Commission about the Position of State Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991

Type of Answer	1985/1986		1987/1990		1991	
	Non- Users	Users	Non- Users	Users	Non- Users	Users
Resistant	1	0	6	2	3	5
Indifferent	4	0	4	4	1	1
In Favour	2	2	5	4	3	2
Missing	0	0	0	0	0	0

SOURCE: Interviews with Participants of Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December 1992, transcript, Interviewer Files, London.

Table III.7 - Base for Graphs 7.5 and 7.6 - Opinion of Participants in the Municipal Health Commission about the Position of Municipal Health Authorities on User Participation: Number of Answers by Period - Porto Alegre - CIMS - 1985/1991

Type of Answer	1985		1986		1987/1988		1989/1991	
	Non-Users	Users	Non-Users	Users	Non-Users	Users	Non-Users	Users
No/Some Interest	4	0	3	0	6	5	0	0
Reasonable Interest	1	0	1	1	3	2	1	0
Strong/Very Strong Interest	0	0	2	1	4	3	11	9
Missing	0	0	0	0	0	0	0	0

SOURCE: Interviews with Participants of Porto Alegre's CIMS. Interviewed by Soraya M. V. Cortes, September to December 1992, transcript, Interviewer Files, London.

Table III.8 - Base for Graph 7.7 - Issues Discussed in Plenary Meetings: Per cent of Meetings, During Each Six Month Period, by Different Types of Issues - Porto Alegre - CIMS - 1985 and 1991

1st

Meetings	Date	Themes						
		Minor	Financial	Labour	Local	CIMS' Regulations	Nat Health Policies	Org of Health Serv in P Alegre
1	02/09/85	0[1]	0	0	0	1[2]	0	1
2	09/09/85	0	0	0	0	1	0	1
3	16/09/85	1	1	0	0	1	0	0
4	24/09/85	1	1	0	0	1	0	0
5	30/09/85	1	0	1	0	0	0	1
6	08/10/85	0	0	1	0	0	0	0
7	15/10/85	0	1	0	0	0	0	0
8	22/10/85	1	1	0	0	1	0	0
9	29/10/85	1	0	0	0	1	0	0
10	06/11/85	0	1	1	0	0	0	0
11	13/11/85	0	1	1	0	1	0	0
12	20/11/85	1	1	0	0	1	0	0
13	27/11/85	1	0	1	0	0	0	0
14	11/12/85	1	1	1	0	1	0	0
15	17/12/85	1	1	1	0	1	0	0
16	23/12/85	0	0	0	0	0	0	1
17	07/01/86	1	0	0	0	1	0	1
18	14/01/86	0	0	0	0	0	0	0
19	21/01/86	0	1	0	0	1	0	1
20	28/01/86	0	1	0	0	1	0	0
21	04/02/86	1	1	0	0	0	0	0
22	06/02/86	0	1	0	0	0	0	0
23	18/02/86	0	1	0	0	1	0	0
24	25/02/86	0	1	0	0	1	0	0
25	04/03/86	0	1	0	0	1	0	0
26	11/03/86	0	1	0	0	0	0	1
27	18/03/86	0	1	0	0	0	0	0
28	25/03/86	0	1	0	0	0	0	1
29	01/04/86	0	1	0	0	1	0	1
30	08/04/86	1	1	0	0	0	0	1
31	15/04/86	1	0	0	0	0	0	1
32	22/04/86	1	0	0	0	0	0	1
33	29/04/86	1	0	0	0	0	0	0
34	06/05/86	0	1	0	0	0	0	1
35	13/05/86	1	0	0	0	0	0	1
36	20/05/86	0	0	0	0	0	0	1
37	27/05/86	1	0	0	0	0	0	1
38	03/06/86	1	0	0	0	0	0	1
39	10/06/86	1	1	0	0	1	0	0
40	17/06/86	1	0	0	0	0	0	1
41	24/06/86	0	0	0	0	1	0	1
42	01/07/86	1	0	0	0	1	0	1
43	10/07/86	0	0	0	0	0	0	0

2nd

Meetings	Date	Themes						
		Minor	Financial	Labour	Local	CIMS' Regulations	Nat Health Policies	Org of Health Serv in P Alegre
44	29/07/86	0	0	0	0	1	0	1
45	05/07/86	0	0	1	1	0	0	1
46	19/08/86	1	1	0	0	0	0	1
47	26/08/86	0	0	0	0	0	0	1
48	02/09/86	0	1	1	0	0	0	1
49	04/09/86	0	0	1	0	0	0	0
50	09/09/86	1	1	0	0	0	0	0
51	09/09/86	0	0	1	0	0	0	0
52	16/09/86	1	0	0	0	1	0	1
53	23/09/86	1	0	1	1	0	0	1
54	30/09/86	1	0	1	1	1	0	1
55	07/10/86	1	1	1	0	1	0	1
56	14/10/86	0	0	0	1	0	0	1
57	21/10/86	1	0	0	0	0	0	1
58	28/10/86	1	0	0	0	0	0	1
59	11/11/86	1	1	0	1	0	0	1
60	18/11/86	1	1	0	1	0	0	1
61	25/11/86	1	0	0	0	0	0	1
62	02/12/86	1	0	1	1	0	0	1
63	09/12/86	0	1	0	0	0	0	1
64	16/12/86	0	0	0	1	0	0	1
65	23/12/86	0	0	0	0	0	0	0
66	30/12/86	0	0	0	1	0	0	1
67	06/01/87	1	0	1	0	0	0	1
68	13/01/87	1	1	0	1	0	0	1
69	20/01/87	0	0	0	0	0	0	0
70	27/01/87	1	1	0	0	1	0	1
71	03/02/87	0	1	0	0	1	0	0
72	10/02/87	0	0	0	0	1	0	0
73	17/02/87	1	1	0	0	1	0	0
74	24/02/87	0	0	0	0	0	0	1
75	10/03/87	0	0	0	0	0	0	1
76	17/03/87	0	0	0	0	0	0	1
77	24/03/87	1	0	0	1	1	0	1
78	31/03/87	0	0	0	1	1	0	1
79	07/04/87	0	0	0	1	0	0	1
80	14/04/87	0	0	0	0	0	0	1
81	28/04/87	0	0	1	1	0	0	1
82	05/05/87	0	0	1	1	1	0	1
83	12/05/87	0	0	0	0	1	0	1
84	19/05/87	0	0	0	0	1	0	1
85	26/05/87	1	1	0	0	1	0	1
86	02/06/87	0	0	0	1	1	0	1
87	09/06/87	0	0	0	1	1	0	1
88	16/06/87	0	0	1	1	0	0	1
89	07/07/87	0	0	0	0	1	0	1

3rd

Meetings	Date	Themes						
		Minor	Financial	Labour	Local	CIMS' Regulations	Nat Health Policies	Org of Health Serv in P Alegre
90	14/07/87	0	0	0	0	1	0	0
91	21/07/87	0	0	0	0	1	0	0
92	28/07/87	0	0	0	0	1	0	0
93	04/08/87	0	0	0	0	1	0	0
94	11/08/87	1	1	0	0	0	1	0
95	18/08/87	1	0	0	0	1	1	1
96	25/08/87	0	0	0	0	1	0	1
97	01/09/87	0	0	0	1	1	1	1
98	03/09/87	0	0	0	0	1	0	0
99	22/09/87	0	0	1	0	0	0	1
100	01/10/87	0	0	0	0	1	0	0
101	27/10/87	0	0	0	0	0	1	0
102	05/11/87	0	0	0	0	1	0	1
103	12/11/87	0	0	0	0	0	0	1
104	19/11/87	0	0	0	0	0	0	1
105	03/12/87	0	0	0	1	1	0	1
106	10/12/87	0	0	0	0	0	0	1
107	07/01/88	0	0	0	0	1	0	1
108	04/02/88	0	0	1	0	0	0	1
109	11/02/88	0	0	1	0	0	0	0
110	10/03/88	1	0	0	0	0	0	1
111	17/03/88	0	0	0	0	0	0	1
112	05/05/88	0	0	0	0	0	0	1
113	19/05/88	0	0	1	0	1	0	1
114	09/06/88	0	0	0	1	1	0	1
115	07/07/88	0	0	0	0	1	1	1
116	21/07/88	0	1	0	0	1	0	1
117	04/08/88	0	1	0	0	0	0	1
118	18/08/88	1	1	0	0	1	0	1
119	01/09/88	1	0	0	0	1	0	1
120	15/09/88	0	1	1	1	1	1	1
121	13/10/88	0	0	1	1	1	0	0
122	20/10/88	0	1	1	1	0	0	1
123	27/10/88	0	0	0	0	0	0	1
124	03/11/88	0	0	0	1	0	0	1
125	17/11/88	0	1	0	1	0	0	1
126	01/12/88	0	1	0	0	0	0	1
127	08/12/88	0	1	0	0	0	0	0
128	15/12/88	0	0	0	0	0	0	1
129	05/01/89	1	0	0	0	1	1	1
130	19/01/89	0	0	0	0	0	0	0
131	26/01/89	0	1	0	0	0	0	1
132	16/02/89	1	1	0	1	0	1	1
133	02/03/89	0	0	0	1	0	0	1
134	16/03/89	0	1	0	0	0	0	1
135	29/03/89	0	1	0	0	0	0	0

4th

Meetings	Date	Themes						
		Minor	Financial	Labour	Local	CIMS' Regulations	Nat Health Policies	Org of Health Serv in P Alegre
136	06/04/89	1	0	0	1	0	0	1
137	13/04/89	0	1	0	0	0	0	0
138	27/04/89	0	1	0	1	0	0	1
139	04/05/89	1	1	0	0	0	0	1
140	18/05/89	1	0	0	0	0	1	1
141	01/06/89	0	1	1	1	1	1	1
142	15/06/89	0	1	0	0	0	0	1
143	06/07/89	0	1	1	1	0	0	1
144	13/07/89	0	1	0	0	0	0	1
145	20/07/89	0	0	0	0	0	0	1
146	03/08/89	0	1	0	0	0	0	1
147	17/08/89	0	1	1	1	0	0	0
148	24/08/89	0	1	0	0	0	0	0
149	31/08/89	0	1	0	0	1	0	0
150	21/09/89	0	1	0	0	0	0	1
151	28/09/89	1	1	0	1	1	0	0
152	05/10/89	0	1	0	1	1	0	1
153	19/10/89	0	1	0	1	1	0	1
154	09/11/89	0	1	0	1	0	0	0
155	23/11/89	0	0	0	0	0	0	1
156	30/11/89	0	0	0	0	0	0	1
157	07/12/89	0	1	0	0	1	0	0
158	21/12/89	0	0	0	0	1	0	1
159	18/01/90	0	1	0	1	0	0	1
160	08/02/90	0	1	0	0	0	1	0
161	08/03/90	0	1	0	1	1	0	0
162	15/03/90	0	0	1	1	0	1	0
163	05/04/90	0	0	1	0	0	0	1
164	19/04/90	0	1	1	0	1	0	1
165	03/05/90	0	0	0	1	1	0	0
166	17/05/90	0	1	0	0	0	0	1
167	07/06/90	1	1	0	1	1	1	1
168	21/06/90	0	0	0	0	1	0	1
169	05/07/90	0	1	0	1	0	0	1
170	19/07/90	0	1	0	1	0	0	1
171	02/08/90	1	0	0	1	0	0	1
172	16/08/90	0	1	0	0	0	0	1
173	13/09/90	0	1	0	0	0	0	1
174	27/09/90	0	1	0	1	0	0	1
175	04/10/90	1	0	0	0	0	0	0
176	25/10/90	1	1	0	0	1	0	0
177	08/11/90	0	0	0	1	1	0	1
178	22/11/90	0	0	0	0	0	0	1
179	06/12/90	0	1	0	0	1	0	0
180	20/12/90	0	1	0	1	1	0	1
181	17/01/91	1	1	0	0	0	0	1

5th

Meetings	Date	Themes						
		Minor	Financial	Labour	Local	CIMS' Regulations	Nat Health Policies	Org of Health Serv in P Alegre
182	24/01/91	0	1	0	1	0	0	1
183	21/02/91	0	1	1	1	1	0	1
184	07/03/91	0	1	0	0	0	1	0
185	21/03/91	1	1	0	1	0	0	0
186	04/04/91	1	1	1	1	0	0	1
187	18/04/91	1	1	0	0	0	0	1
188	02/05/91	0	0	0	0	1	0	1
189	16/05/91	1	1	0	0	1	0	0
190	06/06/91	0	1	0	0	1	0	1
191	13/06/91	0	0	0	0	0	1	1
192	20/06/91	0	1	0	1	0	0	1
193	04/07/91	0	1	0	1	0	0	1
194	18/07/91	0	1	0	0	0	0	1
195	01/08/91	0	1	0	1	0	0	1
196	08/08/91	1	0	0	0	0	0	1
197	15/08/91	0	1	0	0	0	0	1
198	29/08/91	0	0	0	0	0	0	1
199	05/09/91	0	0	0	1	0	0	1
200	10/10/91	1	1	0	0	0	1	1
201	17/10/91	1	1	0	1	0	1	1
202	31/10/91	0	0	0	0	0	1	1
203	07/11/91	0	1	0	0	1	0	1
204	21/11/91	0	0	0	1	1	0	1
205	05/12/91	0	0	1	0	0	0	0
206	12/12/91	0	0	0	1	1	0	1
207	19/12/91	0	0	1	1	1	0	0

0[1] - The issue was not present on the agenda of the meeting
1[2] - The issue was present on the agenda of the meeting

SOURCE: Comissão Interinstitucional Municipal de Saúde de Porto Alegre, "Atas de Reuniões Plenárias" (Porto Alegre, Secretaria Municipal de Saúde e Serviço Social, CIMS, 1985/1991), typewritten.

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