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Policy communities and institution building: the role of the National Council of Health in the Brazilian Unified Health System[1]

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Abstract

The key question guiding the research that informs this article is how the strategies aiming to restructure policy areas developed by reformist policy communities have helped to establish the institutional roles of national governance fora, in Brazil. The growth of new governance instruments, especially in third wave democracies, such as the Brazilian, stimulates researchers to question about their institutional role as well as about why specific functions were assigned to them. The main theoretical assumption is that policy communities are among the most crucial collective actors for policy formation and institution building. Communities can help to explain changes in policy areas and in governance fora, as was the case in the health area in Brazil. The research is based in the analysis of legal and administrative documents and literature. In the 1990s, the reform of the Brazilian Health System advanced, the 'sanitary movement' policy community had the hegemony inside the national governance forum, social actors hold a comfortable majority of seats, but the Council grew to have a relatively non-important position within decision-making process of the area.

Keywords: Policy communities. Participation. Health policy in Brazil. Brazilian Unified Health System. Brazilian National Council of Health

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Introduction

The focus of the article is on the strategies developed by a reformist policy community, the 'sanitary movement', aiming to define the roles for the National Council of Health (Conselho Nacional de Saúde – here after CNS) within the Unified Health System (Sistema Único de Saúde - here after SUS) the community helped to create in the 1990s. The fora were placed at the highest level of a large chain of governance institutions, in which interact state actors and representatives of societal organizations established bottom-up (Côrtes & Gugliano, 2010)[2]. Besides favouring the democratization in public administration, each forum can undertake other roles in the policy area they belong to. In political systems with 'executive dominance', such as Brazil (Figueiredo & Limongi, 2009), the representatives of societal organizations are attracted to participate in governance fora placed at the national level of administration due to its proximity to federal government's decision-makers. In CNS, societal actors could influence government that, in exchange, can count on representatives of societal organizations committed to help to implement decisions there made.

The concept of actor takes into account the position the agent occupies in relation to State, society or markets. State actors are seen as individuals or groups that hold offices in government,

[2] In 2014, there were councils in all of the 5.570 Brazilian municipalities; 351 state council could be found in the 27 states and Federal District (IPEA, 2015), and there were 40 national councils and commissions (Brasil, 2016), in a variety of policy areas.

while societal actors refer both to social actors, from civil society, and market actors (Cohen, 2003). The concepts are useful to understand, for instance, the degree of openness of governance forums towards societal actors or to a particular category of societal actor. However, the construction of policies to maintain or to promote incremental changes or reforms in policies areas, the build-up of institutions – that are not immutable fixed structures since actors can unintentionally or intentionally change, destruct or construct them (Hall & Taylor, 1996; 1998; Bevir, 2003) – depends on collective actors, usually made up of a variety of members who share a set of policy beliefs, within a policy subsystem (Sabatier, 1987; Sabatier & Jenkins-Smith, 2007). This collective actor is a policy community.

The communities are made up of individuals and groups who hold positions in the state and society. They develop strategies in processes closed to other communities and to the public (Jordan & Richardson, 1979; Rhodes, 1986). They may be called iron triangles (Heclo, 1978), issue niches, policy subsystems, advocacy coalitions or issue networks, but "whatever the name one gives to these communities of specialists operating out of the political spotlight, most issues most of the time are treated within such a community of experts" (True et al., 2007). When their members become policy decision-makers, they act so that solutions given to problems that are placed in the governmental agenda agree with their values and visions on policies.

Policy communities interpret the institutional context they were placed in and act according their beliefs. In the 1980, there were in the health system in Brazil very powerful interest groups –

health professions associations, private providers, private insurance companies, pharmaceutic and medical equipment industries – who had well established channels to influence government decision-making process.

The data used in the paper was gathered in (1) previous research on the theme; (2) legal and administrative documents (ministry's relevant acts and regulations; federal laws); (3) information available in the Ministry of Health and CNS websites. Previous results of the investigation on CNS has been published (Côrtes et al., 2009; Silva et al., 2009). However, these studies focused on the participatory process, aiming to solve other research problems.

Besides the introduction, the paper has two sections. The first examines the creation of SUS, when CNS was restructured. The second presents the strategies developed by the policy community to advance its reformist objectives, and describes changes in CNS's role within the system as well as in the community, as the reformist process took pace.

The Unified Health System (SUS) and the new National Council of Health (CNS)

During the 1980s, Brazilian society underwent a process of political democratisation, after more than 15 years of military dictatorship, whose culmination was the promulgation, in 1988, of a new Constitution. It buried the concept only those who paid social security taxes were entitled to receive social services and benefits, establishing the notion of citizenship rights. The Constitution states that the social security system – encompassing national systems of social insurance, of health and of social assistance – should

have democratic and decentralized administration, which should have the participation of workers, employers, pensioners, users, beneficiaries and providers in its decision-making process (Brasil, 1988).

The Constitution set up the legal basis for the creation of the SUS. The new health system 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 that should be financed by government budget, but private financing for services was allowed. State and private sectors would provide health care. By the end of 1990, health laws (Brasil, 1990; 1990a) were passed by the Congress, to make operative constitutional principles and to establish the legal parameters that could make the SUS feasible. By 1993, the reform of the Brazilian health system took pace thanks to administrative norms issued by the Ministry of Health (Brasil, 1993). These norms enforced constitutional principles and established municipal, state and national councils would have planning and supervisory powers over health services.

In 1988, half of the Brazilian population did not have access health care. Two decades after establishing the SUS, more than 75% of the country's estimated 202 million people rely exclusively on it for their health care coverage (WHO, 2010). In 2015, although underfunded[3], it was the third among 10 social areas, re-

[3] The expansion in coverage correspond to a decrease of 6% of federal

garding federal government spending, surpassed only by social insurance and education (Silva, et al., 2017). Brazil has a universal system of care, but, in 2012, 53% of the country expenses on health were made by private individuals or organizations. In the same year, central government expenditures in the area (43% of total public-sector expenses) were higher than those made by states (27%) and municipalities (30%) (Monti, 2015).

These major changes in the health system has happened due, to a great deal, to the actions of the policy community defending health as citizen rights (Côrtes, 1995; Escorel, 1999). The community, whose central group was made up mainly of academics and health professionals, proposes the reform while took an active part in an alliance established with civil society activists (Côrtes, 1998; Côrtes et al., 2009). Most of the activists, either professionals or leaders of civil society organizations, belonged to left wing parties or to left faction of centrist ones (Côrtes, 1995; Côrtes et al., 2009). Members of the community, regardless their momentary institutional position – in government, as leaders of unions or of professional organizations, as 'specialists', or other – promoted political-institutional changes to advance the reforms they defended.

The mobilization the community promoted, aimed to advance the institutionalisation of a universal, decentralized health system, that should offer comprehensive care to all citizens. The system would be organized under the strict control of public sector, with some degree of civil society participation in the decision-

government spending on the area, as a percentage of GDP, between 1995 and 2010 (WHO, 2010; Castro et al., 2012).

making process. The reformers defended participation of users and of health professionals not only because they believed in increasing democracy, but also because civil society activists could offer political support to challenge the resistance by those against reform. The community saw governance fora, that were well established into the 2000s, as an indispensable strategic mechanism to advance the institutionalisation of the new system.

The CNS had been originally created in 1937, the CNS was set up as 'collaborative committee' to assist decision-makers in the health area at the federal level of administration (Brasil, 1937; 1953). Its size and participants varied throughout the time (Côrtes et al., 2009), but its members, governmental or societal, until the 1990s, were chosen by federal government. In accordance to principles stated in 1988 Constitution, Federal Laws established how the new national Council would be made up of and its functions (Brasil, 1990a). Three quarters of its members should come from societal organizations and only one quarter, from government (Brasil, 1990a)[4]. The CNS have plenary – the most important body –, permanent and temporary commissions, working parties, executive secretariat and a managing group (Brasil, 2006)[5]. The plenaries gathered monthly during two or three consecutive days to analyse and to discuss proposals for the area. The plenary meetings produce rulings, formally issued as Resolutions, and minor decisions, such as: who will represent the forum in a conference, who

[4] Since 2006, the CNS has 48 full members, each with one deputy member (Côrtes et al., 2009).

[5] The CNS was located in set of meeting rooms in an office building in the Annex Building of the Ministry of Health.

will inform the plenary about a given issue, who would take part in a temporary commission, etc. The CNS was functionally linked to the Ministry of Health. The President, elected by council members, was in charge of most duties related to Council management and representation. Societal representatives, and among them those coming from civil society organizations, form an expressive majority (Silva et al., 2009). Moreover, a quarter of CNS's members represented organizations of health professionals, in addition to participants from other civil society associations who were themselves health professionals (Brasil, 2016a). The presence of market representatives was insignificant (Silva et al., 2009). These features together with the institutional characteristics of the area offered a frame the community would take into account when developing strategies aiming to achieve their reformist objectives.

'Sanitary movement' strategies to establish the institutional role of CNS

At the begging of the 1990s, members of the 'sanitary movement' occupied managing positions at different federative levels of administration of the recently inaugurated SUS. They had also the hegemony inside CNS. Under their influence, the Council recommended to the Ministry of Health the creation, in 1993, of fora of federative planning and management at the federal and state levels of administration: the triparty and the biparty inter-management commissions (Comissões Intergestores Tripartite e Bipartites)[6]. According to them, without this type of forum would

[6] The triparty inter-management commissions had equal representations of

be impossible to structure and make functional an actually national system of health (Silva et al., 2009).

The institutionalisation of the inter-management commissions had an impact over the CNS. After 1993, "nearly all issues related to financing, decentralisation of management, organization and workings of the system" were discussed in the triparty and the biparty inter-management commissions (Levcovitz et al., 2001). Most of the decision-making in the area no longer took place in the CNS but in the inter-management commissions (Silva et all, 2009). Moreover, during Lula administration, which began in 2003, many members of the 'sanitary movement' were recruited to high-level executive positions in the Ministry of Health. These new health authorities had small interest in taking a more active part in the workings of CNS, since the actual decision-making in the area was not there.

The transfer of the decision-making to the inter-management commissions, were social actors do not participate, reduced the possibilities of these actors to influence policies. Market actors, even without seats in the commissions, could represent their interests through traditional 'bureaucratic links' (Cardoso, 1975) with federal health authorities. In contrast, social actors had less possibilities to influence directly government officials. CNS remained the main channel to make their demands heard.

Inside the Council, social actors, representing organizations of residents of poor urban areas, of persons with pathologies or

federal, state and municipal authorities, whereas biparty commissions, placed at the state level of administration, had equal proportion of members representing either state or municipal health authorities (Brasil, 1993).

disabilities, of ethnical groups – such as black and native people – of gender, and, of health professionals, mostly non-medical, were the most influent members (Côrtes et al., 2009; Silva et al., 2009). They conducted discussions and the decision-making in the forum. They had not only more seats in the Council, they led, spoke more at, were more assiduous to the meetings, in comparison with lesser participation of government representatives and nearly none of members from market organizations.

By the end of the first decade of 21st century, CNS was an important agency of public control of health care provision, developing intense search of information on public and private institutions in the area (Côrtes et al., 2009; Silva et al., 2009). The Council was not an arena for the construction of consensus, for eliciting conflicts or building up agreements. Instead, it discussed policies and programmes, taking positions about them. Despite disputes between original leaders of the reformist policy community and the group leading the Council, the forum was a place for intense social interactions and reformists mobilization. From there they could reach state and municipal councils, gathering forces for the defence SUS principles (Silva et al., 2009).

However, market and government actors and medical profession associations did not lose the central place they had in the decision-making process of the health area. Their position inside the Council did not reflected their place in the health field (Silva et al., 2009). Medical organizations, private providers of health services, pharmaceutical industry, and, specially, health authorities,

particularly those acting in the inter-management commissions, remain occupying the dominant positions in the area, altering or even inverting the hierarchy of positions identified in the council.

Although there were conflicts inside the community such the one between members who became health authorities and promoted the creation and have strengthened the institutional role of inter-management commissions and the societal organizations leaders who were hegemonic inside CNS, it had an important part in shaping the system of health. The place occupied and the role played by CNS in the new system was, to a great deal, defined by the actions of the community, guided as they were by the strategies they build up to advance their main objective: the institutionalisation of a universal, decentralized health system, that should offer comprehensive care to all citizens.

Final Remarks

The role assumed by the CNS in the health area, during the present century, results of an interplay between institutional characteristics of the forum and policy area, and the actions of a reformist policy community to advance its proposals. CNS has been mostly the place to mobilize supporters of SUS as a system that offered comprehensive health care to all Brazilians. The analysis focused on the strategy adopted by the 'sanitary movement', in Brazil, in the last two decades, highlighting the institutional role assumed by CNS. The objective was the constitution of a decentralized system of care that would guarantee health care as a citizen

right, in which public sector would strictly regulate a comprehensive range of services and goods offered by public and private providers. There would be societal participation in the decision-making in participatory forums located at federal, state and municipal levels of government. Regarded as the main agent behind the institution of SUS, in the 1990s, overall, the community successful achieved its main objectives.

The 'sanitary movement' helped to create inter-management commissions to improve federative organization of the system. However, the transfer of most of the decision-making to the commissions reduced the relative importance of CNS. In the 2000s, the Council was an arena for intra-reformist policy community disputes, and, more importantly, there societal and state actors defending the SUS could articulate actions at national level. The community have intensely participated in the institution of SUS. It came up with arguments, produced technical solutions to issues that came up throughout the implementation of the new health systems and designed strategies to advance the policies it defended. The reformist policy community, and the Council, as a mobilizing forum, have played a decisive role in the constitution and consolidation of the Brazilian Unified Health System, as well as in assuring the right to health care to all citizens.

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