

Decentralization, Participation and Power. Ambiguity on the Policy Design of the Local Health Councils in Brazil

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Abstract

The Local Health Councils (LHC) in Brazil are one of the most interesting policy innovations of contemporary Brazilian health reform. Due to the scale with which it must deliver services, the complex design and the relative youth of Brazilian democracy, the LHC offers an excellent opportunity to study policy design through investigation and theoretical reflection. Formulated in a moment of intense social and institutional change, this policy is marked by extreme conditions of ambiguity, in which complex issues like decentralization, popular participation, social control and power may reveal conflict over policy goals. Thus, an examination of Brazilian Local Health Councils policy design provides a complex and important subject area to study policy design.

Keywords: Local Health Councils, Brazilian health system, SUS, Policy design, Policy formulation

Resumo

Os Conselhos Municipais de Saúde (CMS) são uma das inovações políticas mais interessantes oriundas da contemporânea reforma do sistema de saúde brasileiro. Devido à amplitude da prestação de serviços, o complexo design e a relativa juventude do sistema democrático brasileiro no momento de sua criação, os CMS são uma excelente oportunidade para estudar a formulação de políticas por meio da investigação prática e reflexão teórica. Formulado em um momento de intensa mudança social e institucional, a formulação dessa política foi marcada por condições de extrema ambiguidade em que questões complexas, como a descentralização, participação, controle social, e poder, podem revelar importantes conflitos sobre os objetivos desta políticas. Assim, o exame da formulação dos Conselhos Locais de Saúde do Brasil, seu design e ferramentas, proporcionam um complexo e importante objeto de análise para os estudos de formulação de políticas, o principal objetivo deste trabalho.

Palavras-chave: Conselhos Municipais de Saúde, Sistema de saúde brasileiro, SUS, Design de política, Formulação de política

Introduction

The Local Health Councils (LHC) in Brazil are one of the most interesting policy' innovations of contemporary Brazilian health reform. The LHC, as it is understood today, structured by a unique design and directly linked to current legislation, is a policy created by the Unified Health System (SUS), considered one of the largest public health systems in the world. Due to the scale on which it must deliver services, the complex design of the delivery and the relative youth of the Brazilian Democracy, the LHC offers an excellent opportunity to study policy design through investigation and theoretical reflection.

The LHC is responsible not only for implementing health programs, but also for taking suggestions from the users, market and interested groups to the various levels of government: municipal (local), state and federal. They make decisions, act as consulting bodies and exercise oversight. They also approve annual plans and health budgets and assist municipal health departments with planning, establishing priorities and auditing accounts. For that reason, this policy has increasingly become the object of investigation and theoretical reflection by researchers (Gohn, 2003; Cortes, 2002; Coelho, 2004; Moreira, Escorel, 2009; Brasil, 2013).

Sociology studies linked the origins of the health councils, among other factors, to the actions of an organized society in the period of 1970-1990, emphasizing the struggle against the military dictatorship. Economists and political scientists updated this reflection in the second half of the 1990s and 2000s, focusing on the transformations of the role of the

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State after the Political Reform in the policy making process. According to the mainstream focus on sociology and political science studies in Brazil, the action of an organized society and the radicalization of political opposition to the military dictatorship created, even in the 1980s, new directions for popular participation. In the Health issues, the movement for Sanitary Reform, inseparable from struggles against dictatorship, was in favor of re-democratization and the guaranteeing of health as a citizen's right and a duty of the state. Thus, the movement for health reform in Brazil was incorporated into popular actions and acted through the democratization movement.

Because of concerns about the re-democratization process, most of the studies on Health councils in Brazil focus on issues related to citizenry, popular inclusion in policy development, the limits and capacities of promoting a vigorous increase in participation, the legitimation and consolidation of institutions responsible for making effective participation, the power of new actors, evaluating under study-cases, etc. (Brasil, 2013). There are several authors, Brazilian and foreign, who are dedicated to participatory policy studies such as Councils, whether concerned about health, education, child services or other subjects. Among the dozens of authors, we can highlight the works of Luciana Tatagiba (2002, 2004, 2005) on the classification of types of councils and their institutional ties; Wagner Romão (2010, 2011, 2015) and the potential and the limits of popular participation in local policies; Maria Eliana Labra (2005) and her meticulous historical and analytical work on the formation, dilemmas, advances and limits of health councils in Brazil; Sarah Escorel and Renata Arruda Bloch (2005) on the construction of SUS, the National Health Conferences in Brazil and national consequences after the implementation of local councils. Under other analytical and methodological lenses, different from those proposed by this paper, which uses a formal approach about the process of formulation and design of the LHC, these authors demonstrate important aspects related to the ambiguity of participatory politics in Brazil. They also discuss limits and potential future projects for improvement.

In the opposite direction of these perspectives, the novelty that this paper intends to bring into the literature on participatory policies, more specifically into the studies about the Local Health Councils, is not to focus on the history of the social movements as an isolated dimension, or on evaluating their efficiency or even the limits of institutionalized participation. Policy formulation clearly is a critical phase of the policy process – it is also an explicit subject of policy design - which includes the goals and priorities and options definitions, costs and benefits of each options and means as well as involves identifying a set of policy alternatives and policy tools. Ambiguity of policy goals, means and the choice of instrument types is marked by the entrance of new ideas into policy deliberation, - problem identification and alternatives selection. From these perspectives, the uncertainty (bounded rationality), the role of ideas, the concepts of ambiguity of goals and means, helps us to analyze the design of Local Health Councils in a context of significant social and institutional change.

Focused in the pre-decisional moment of the policy process, this study aims to analyze the process that resulted in the formulation and implementation of the Local Health Councils, its design and the binding character to the budgeting transfer. As a secondary objective, this paper seeks to expand and consolidate the policy process studies in Brazil. Beyond the comprehension of the theoretical approaches, the use of the most recent perspectives or frameworks to analyze Brazilian policies is important to overcome a gap in our literature.

Methodology is based on NATO typology (Hood, 1986). Revisited by Howlett, Ramesh and Perl (2009), this typology can classify tools according to 4 main types: nodality, authority, resources and organization. Analyzing the Local Health Councils' design, their structure and objectives, this proposal intends to identify the mix of tools used on LHC and how that mixture is interrelated with the Brazilian Health System Reform goals.

Composed of three sections, the first part of this paper seeks to contextualize the creation and operation of Local Health Councils in Brazil. Inserted in the Brazilian health Reform under creation of the Unified Health System (SUS), the LHC can be understood as a tool and also be analyzed as an innovative policy with singular and complex dynamics. The second part presents theoretical and methodological aspects important for studies of policy design and policy tools. Finally, the third part aims to identify and analyze the tools which constitute the design of the LHC. As a conclusion, the relationship between the instruments chosen with the objectives of participation, decentralization and democratization proposed by the reform of the health system in Brazil is highlighted.

The Local Health Councils

In the mid-1980s, a series of social and political movements across Brazil opposed the dictatorial regime, aiming to increase public participation in government and make public policy more effective through an open and democratic regime. These demands, previously repressed by the military government, gave rise to participatory management policies in Brazil when the dictatorship was deposed in 1985. This process introduced the concept of "social control" on social policies in Brazil.

Drafted during the re-democratization process, the 1988 Constitution attempted to solve national problems through a combination of universal social policies, decentralization, and popular participation with an innovative policy design to guarantee participation employing new social policies. Specifically regarding health care, the new constitution established health as the right of all, defined its provision as the duty of the state, and guaranteed the right to popular participation in local public health management (Gohn, 2003; Cortes, 2002; Coelho, 2004). It is important to mention that the democratization process in Brazil was accompanied, reported and, somehow, supervised by various institutions

and international organizations. In the case of health, the WHO - World Health Organization and PAHO, Pan American Health Organization, encouraged several initiatives such as the democratic opening, popular participation in the policy making process, among others.

Consequently, merely four years after the promulgation of the new democratic constitution in Brazil, the Ninth National Health Conference (1992) legitimized the creation of a new health system in Brazil. The Health and Sanitary Movement claimed and pressed for conducting the IX National Health Conference - the time of its completion was already delayed by two years. Even with the central level of the strength of the government - weakened politically - and with the support of the Ministry of Health and the National Health Council (NHC), it was held in the period 9 to 14 August 1992 and had as its central theme "Health: Municipalization is the Way", which explains the size and power of articulation accumulated by supporters of SUS and its decentralization process in the management of health services and actions. The Conference, organized with intense social participation was held on the eve of the "impeachment" of the government. Thus, the literature links the participatory achievements to the realization of the IX National Conference, since it was an important political act to support the political movement to replace the government (Letter of IX National Health Conference the Brazilian Society) and to reassure and strengthen the protection of advances and legal achievements, practices of health reform and the implementation of SUS. The SUS is a universal, publicly funded, rights-based health system which guarantees community participation in government decision-making, reflecting the belief that decentralization and municipal control are the best approach to integrated health care (Brasil, 1988, 1992).

In the face of a regime legitimacy crisis and as a means to represent interests, several gaps in health care access and provision were present across the country. After twenty-one years of military legacy (1964-1985), the progress in health policy resulted in disproportionate improvements and was limited to urban areas as a consequence of a centralized, selective, and market-oriented public health system (Cortes, 2002; Santos, 2013). As a result, in the 1990s there was an intense debate concerning the weaknesses of the welfare state and a growing emphasis on market-based solutions. Based on that, the next years ushered in a new political-institutional moment in Brazil to reaffirm the democratic state and set a comprehensive social protection policy, including health as a social right. At that point, Brazil witnessed a reaffirmation of the central role of the state (Gohn, 2003). Since its enactment, a great number of laws, ministerial decrees and administrative actions have sought to enable the political project outlined in the Constitution. On the other hand, in the same period, a growing number of demands for the right to health increased in Brazil showing several ambiguities between formal and real situation on health policies.

The Brazilian Health movement established four propositions with the creation of the SUS. The first proposition established health as a right of every citizen, regardless of monetary contribution or employment. Contrary to the previous model, the proposal did not deny any Brazilian citizen access to the public health system. The second proposal stipulated health actions should ensure the population's access to preventive medicine and should be integrated into a unique system. The third proposal dealt with the decentralization of management, both administrative and financial, while the fourth proposal emphasized the social control of health actions. Since the establishment of the SUS, health care policy and the provision of services have become more responsive and universal to attend the needs of all Brazilians.

Different actors and institutions, with various perspectives and interests, participated in this new project democratizing the health care system in Brazil. Among the actors involved, we can highlight the veterans of the health movement: the sanitary reform activists; actors who have their origins as activists in movements from Catholic-based communities; labor unions; political parties and emerging actors within government who invested in social movements as an important democratic political strategy.

With the recognition of a universal right to health care and based on public participation in health care management, the social contract between citizens and the government appears to have been strengthened with respect to health care. The SUS laid the groundwork for the establishment of institutionalized mechanisms for citizen engagement at all Brazilian federal levels (municipal, state and national). One of the most important instruments for improving citizen participation, decentralization of social policies and universal access, the SUS created the local health councils and conferences. Designed as an overall strategy for decentralizing and increasing the quality of health services, this study focuses upon Local Health Councils (LHC) in Brazil.

Following the creation of SUS, a national policy guideline for public health, state and municipal laws gave rise to local health councils. It is important to note that national health conferences were created by "Capanema Reform" during the Vargas government. Gustavo Capanema, Minister of Education and Health, presented to President Vargas reasons for the first conference on health and education, that is, that there would be "agencies to promote the continued understanding of this Ministry with the state governments, in the business management field his competence". Under a political and social context very different from that which created the Local Health Councils, the first three national conferences that took place in the period 1941-1963 favored discussions on health organization, municipalization and decentralization of services without significantly considering public participation in decision making. With the establishment of the military dictatorship, the conferences began to have a technical character.

Under a new perspective designed according to the decentralization principle, these laws determined there would be

participatory institutions in all levels of the Brazilian Federal System (federal, state and city governments). Local health councils became a permanent and deliberate method of controlling public health care implementation (Brasil, 1990). Two laws are important in understanding the creation and rules of the Health councils in Brazil: The Organic Health Law (8080/90) and Law 8142/90. Law nº 8080/90 was approved with partial presidential veto to articles related to popular participation and financing system. Although the National Congress has kept the presidential veto, this fact has generated a political impasse between the executive and Congress. In order to enable the implementation of SUS in a scenario divided on issues concerning public participation and financing system, new institutional arrangements were created. The most importance of these arrangements was the approval of Complementary Law nº 8.142/90, which provides for the conditions and forms of resource transfers and community participation in the management of SUS. (Rodrigues, 1999).

The OHL (8080/90) determines the management, actions, and services of the SUS which must follow certain structural principles and coincide with the directives established by the Federal Constitution for health policy. Another Health regulation, the Law 8142/90 defines health councils and conferences as mandatory events, on national, state and municipal levels, institutionalizing spaces for the participation of the public. In the health sector, therefore, in both cases, societal participation represents a central means for democratization and decentralization, incorporated to the rule that makes the participative decision-making an official process.

The Local Health Councils are responsible not only for taking government projects to the population, but also for taking suggestions from the population to the various levels of government: municipal, state and federal. The LHC make decisions, act as deliberative bodies, and exercise oversight. They inspect public health accounts, demand accountability in service-delivery and budgeting, and exert influence over how public health resources are spent. Additionally, they assist municipal health departments with planning, establishing priorities and auditing accounts.

In Brazilian Federalism, a major portion of local budget is provided by funds transferred by the Federal Government to municipalities. These transfers are Constitutional rules and the most important source of municipal revenues in Brazil (especially for the small municipalities). As the capacity of local governments to provide services in Brazil is highly dependent on federal resources, the Local Health Councils are one of the most important policy tools for providing resources for local health systems (Cortes, 2002; Gohn, 2003). According the SUS rules, Federal transfers became contingent upon the existence of the LHCs. The councils must verify accounts and notify authorities of any irregularities. If a local council does not exist, or if the plan is rejected, the city does not receive health funding from the Federal Health Ministry.

Following that rule, the local health councils are operated at all levels of Brazilian Federative. However, considering the high number of local level governments in Brazil (municipalities), the local (or municipal) health councils are more widespread and more studied than state councils.

According to Moreira and Escorel (Fig 1), from the 5,463 LHC's created by 2007, the period from 1991 to 1997 saw the greatest number of councils created (76.7%). These years were marked by the initial impact of the rules making the LHC required by Federal Law. An updated database of the Brazilian National Record of Health Councils shows that 5,564 Brazilian cities had a local health council implemented as of 2010, or 98% of all cities.

Ordinary Brazilian citizens, health managers, health workers, and interest groups compose municipal health councils. The main objective is sharing perspectives and ideas regarding problems and solutions relating to the health issues of their local communities (Moreira, Escorel, 2009). Through a process of debate, problem identification, selection of alternatives, contagiousness of conflict (Schattschneider), formulations and reformulations, Brazilian citizens, health workers and government staff try to gain each other's attention about their own ideas. This process, marked by ambiguous ideas and conflicting interests, can create images about the problems and alternatives good enough to garner attention and become policy. And when they do not, these actors often continue to fight for their interests in other areas and at others meeting of these Councils (Gerschman, 2004; Cortes, 2002).

Thus, the Local Health Council is not a policy for health care, exclusively. The policy process and its design, formulated

Figure 1: LHC's Creation per period.

Years/Periods	LHC created	
	N	%
Before 1991	312	5,7
1991	1351	24,7
1992	281	5,1
1993	758	13,9
1994	477	8,7
1995	176	3,2
1996	145	2,7
1997	1.003	18,4
1998	196	3,6
1999	98	1,8
2000	50	0,9
2001	233	4,3
2002	38	0,7
2003	31	0,6
2004	27	0,5
2005	98	1,8
2006	18	0,3
2007	13	0,2
Non-informed	158	2,9
Total	5.463	100

Fonte: ParticipaNetSus – 2008 (www.ensp.fiocruz.br/participanetsus). Moreira e Escorel

under specific political and social conditions in Brazil, is recognized for its democratic, inclusive nature. Since the promulgation of the Constitution in 1988 to the creation of Organic Health Laws in 1990, which defines health councils and conferences as mandatory events, an uninvestigated process has existed.

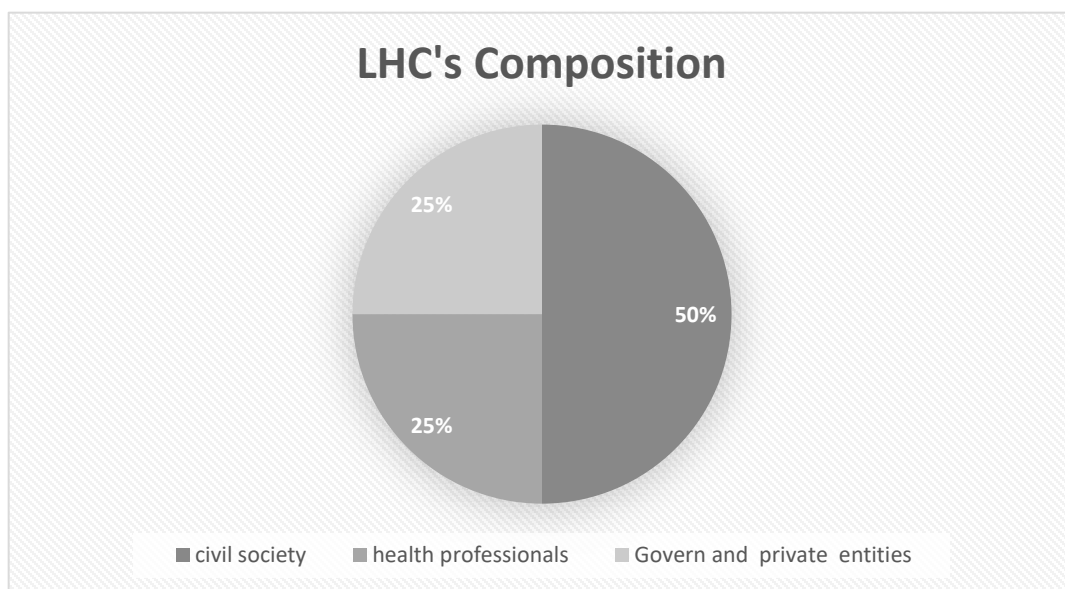
Once we have recovered the process of creation of the LHC from the SUS and their goals, it is necessary to understand their means, as method of functioning, design and tools. The institutional design of the Local Health Councils is determined by federal legislation that established certain universal principles that cannot be changed by the local governments of the different Brazilians cities. This "main design" includes rules about the composition, selection procedures, budget and resource transfers, specific competencies, and internal procedures. Although the main design is unalterable, each local council is partly independent and can determine how it will conduct meetings, allow access, handle discussion and set the agenda.

This paper does not have the objective to analyze one specific health council (from one city), nor does it intend to be a comparative study between council designs. The focus of this paper is on the tools and procedures used to draw a permanent and deliberative collegiate institution with government representatives, service providers, health professionals, and SUS users, designed by federal legislation.

The functioning of the Councils can be described as the holding of regular meetings (usually monthly) convened by members of the local government where SUS users, health professionals, public and private managing entities can debate and approve health plans and budgets. These meetings are always open to public participation, without restrictions, and participants enjoy the freedom to share their concerns, problems, and possible solutions regarding health care management.

One of the most important actors on Health Council is the "councilor". Councilors are elected in the first meeting representing a specific composition of members. For every representative, there is a substitute. In addition to innovation with respect to actuation and rules, the council's composition (Participation Design) draws attention. Civilians (the SUS users) were granted 'parity' in relation to all other sectors. Municipal councils are composed of civilians (50%), health professionals (25%), and government or non-governmental entities (25%). The latter entities represent churches, social movements scientific institutions, and other interest groups (carriers of specific diseases, medical companies and associations).

Figure 2: LHC'S Composition



As mentioned before, leading convening and establishing the dynamics of the assemblies as well the internal regiment are responsibilities of elected councilors whose mandate is established and voted upon during the preparation of internal regiment. The size of council meetings varies, depending on the degree of engagement and interest in the proceedings by those who do not occupy title positions. The number of formal representatives varies with the size of the area being represented.

Formulated in a moment of intense social and institutional change, this policy is marked by extreme conditions of ambiguity in which complex issues, like decentralization, participation, social control, and power, may reveal conflict

over policy goals. Thus, the examination of Brazilian Local Health Councils policy design and tools provides a complex and important subject area of study of policy design.

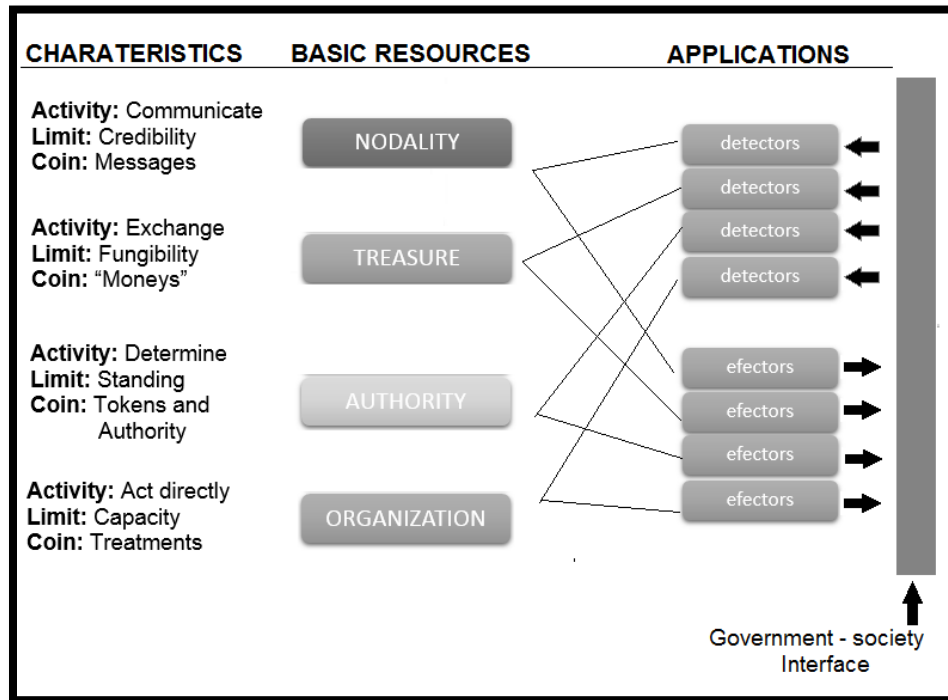
Theoretical and methodological approaches

Policy formulation is understood as the stage in which solutions are proposed to established problems. Since the problems are social constructs subject to multiple interpretations, there is no single or unanimous answer for their solution. This phase of policy process is marked by the policy-makers' identification and selection of alternatives considering issues such as technical restrictions (availability of technology, administrative capacity, budget and costs, human capital, etc.), and the conditions of the social and political environment (political regime, internal and external relations, social groups and associations). Based on these assumptions involving institutional constraints, pressure from interest groups and the need to provide answers, policy-makers consider not only what to do, but how to do it (Howlett, Ramesh, Perl, 2009).

Inserted in the process of choices and policy formulation, policy tools are an important element influencing the policy-making process (Peters, 2000; Smith and Ingram, 2002). Therefore, the choice of the tools reflects the way policy-makers intend to achieve their goals (Hood, 1986). Thus, the choice and design of the policy tools can indicate both the distance and the approximation of the original objectives. Policy-tools structure public policies and can be described and classified according to several typologies (Peters, 2000). For over more than three decades, some recognized typification of tools were developed which include: Lowi arenas (1966; 1972); "NATO" composed of four characteristics (Hood, 1986); the proposed split into 14 basic types of Salamon (2002); and a 63 instrument types proposed by Kirschen (1975) (Howlett, Ramesh, Perl, 2009).

An important aspect of the use of policy tools in the practice of policy process involves uses of multiple instruments at the same time. Analyzing the mix of instruments and how the mixture is chosen is not easy, especially when the tools are interrelated. For the analysis of Local Health Councils, based on the structure and objectives mentioned above, NATO typology will be used. According to this typology (Fig. 3), the tools can be separated and grouped according to their nodality, treasure, authority and organization (Hood, 1986).

Figure 3 – Basic types of government tools – “NATO” (Hood, 1986)



Adapted from Figure 1.2 "Eight basic types of government tool (HOOD, 1986, p. 25)

The nodality shows the government's ability to operate as a node (a focal point) in an information network. Informational resources are very significant and can be understood as an important policy tool. Examples of this typology are: Public information campaigns ("this information is often fairly general, intended to make societal actors more knowledgeable so they can make informed chronicles"); benchmarking ("it enables structured comparison and can enhance the opportunity for policy learning by presenting relevant information in ways that can generate policy insights"); commissions and inquiries ("temporary bodies to gather information about an issue or something just to procrastinate in making a decision") (Howlett, Ramesh, Perl, 2009).

Treasure denotes government resources used in each instrument. It refers to all transfers (penalty or bonus) seeking to stimulate or limit the action of the actors. Positive reinforcement tools are allocated as "subsidies, grants, tax incentives and loans". On the other side are "financial disincentives, taxes and user charges". The last tool type is "Advocacy, Interest groups and Think Tank Funding" (Hood, 1986, Howlett, Ramesh, Perl, 2009).

According to Lasswell and Kaplan, "'Authority' denotes the possession of legal or official power" (LASSWELL, KAPLAN, 1950, p.76). This is the power to officially demand, forbid, or link to a condition, and is "traditionally seen as one of the defining properties of government" (HOOD, 1986, p.5). Command-and-Control Regulation, Delegated or Self-Regulation and Advisory Committees are types of this policy instruments. The main difference among them is in how the regulation happens, the autonomy of the actors, government intervention and the nature of the adjustments.

The final resource of government is Organization. This Policy instrument deals with the ways a government acts on its subject. It can act by direct provision, public enterprises, Quangos, partnerships, family, community and voluntary organizations, market creation and Government (Re)organization. The figure below (Figure 4) summarizes some tools within the four main types of instruments of government.

Figure 4 – Policy Instruments by Principal Governing Resource

Nodality	Authority	Treasure	Organization
Information Collection and release	Command and control regulation	Grants and loans	Direct provision of goods and services and public enterprises
Advice and exhortation	Self-regulation	User charges	Use of family, community and voluntary organization
Advertising	Standard-setting and delegated regulation	Taxes and Tax expenditures	Market creation
Commissions and inquiries	Advisory committees and consultations	Interest groups creation and funding	Government reorganization

Adapted from Figure 5.1 "Policy Instruments, by Principal Governing Resources (HOWLETT, RAMESH, PERL, 2009 p. 116)

Identification and analysis of instruments and tools from Local Health Council

Considering this analytical approach to policy tools, as well as Local Health Councils' formulation and their design, a methodological question seems relevant: Can the councils be analyzed according to their tools and instruments as an independent policy, or should they be analyzed as instruments inserted in the SUS and in the Brazilian health system? The answer to this question cannot be simply summarized. Councils can be understood and analyzed either as a policy or an instrument. In this paper, the analysis will be conducted in order to explore both dimensions: to identify and analyze instruments and tools that make up the design and the internal dynamics of the Councils (as a singular policy), as well as to analyze the Council as a tool within the proposal of the Brazilian health system - SUS (as an instrument).

If we take as a starting point the relationship between SUS and the creation of LHCs, one of the most significant instrument types for this analysis seems to be "Authority". As the Local Health Councils are a legal regulation (Law 8080/90), the law provides for the conditions for the promotion, protection and recovery of health, the organization and the functioning of the corresponding services and other measures. Law 8142/90 provides for community participation in the management of the Unified Health System (SUS) and on intergovernmental transfers of financial resources in health and other measures. As an institutionalized part of the Brazilian health system, they can be understood as a type of regulatory tool - a "Command-and-Control Regulation". According to Kerwin (1999) regulation tools are often referred to as "rule making" and can be described as a prescription by the government that must be complied with by the intended target. Regulation can be both social and financial. SUS imposes social rules based on regulations about health care and the rules for formation and coordination of councils. In addition, financial regulation occurs through a mix of instruments of regulation and treasure, the conditional tokens (Hood, 1986; Howlett, Ramesh, Perl, 2009).

Directly related to the regulatory instrument, failure to comply with such rules and regulations involves a penalty. In LHC's case, one of the penalties of their non-existence is made by treasure instruments. As mentioned above, the transfer of resources for health from the federal government to municipalities is conditioned on the existence of active LHCs. Thus, if the municipalities do not comply with the legislation that ensures the existence of the councils, the

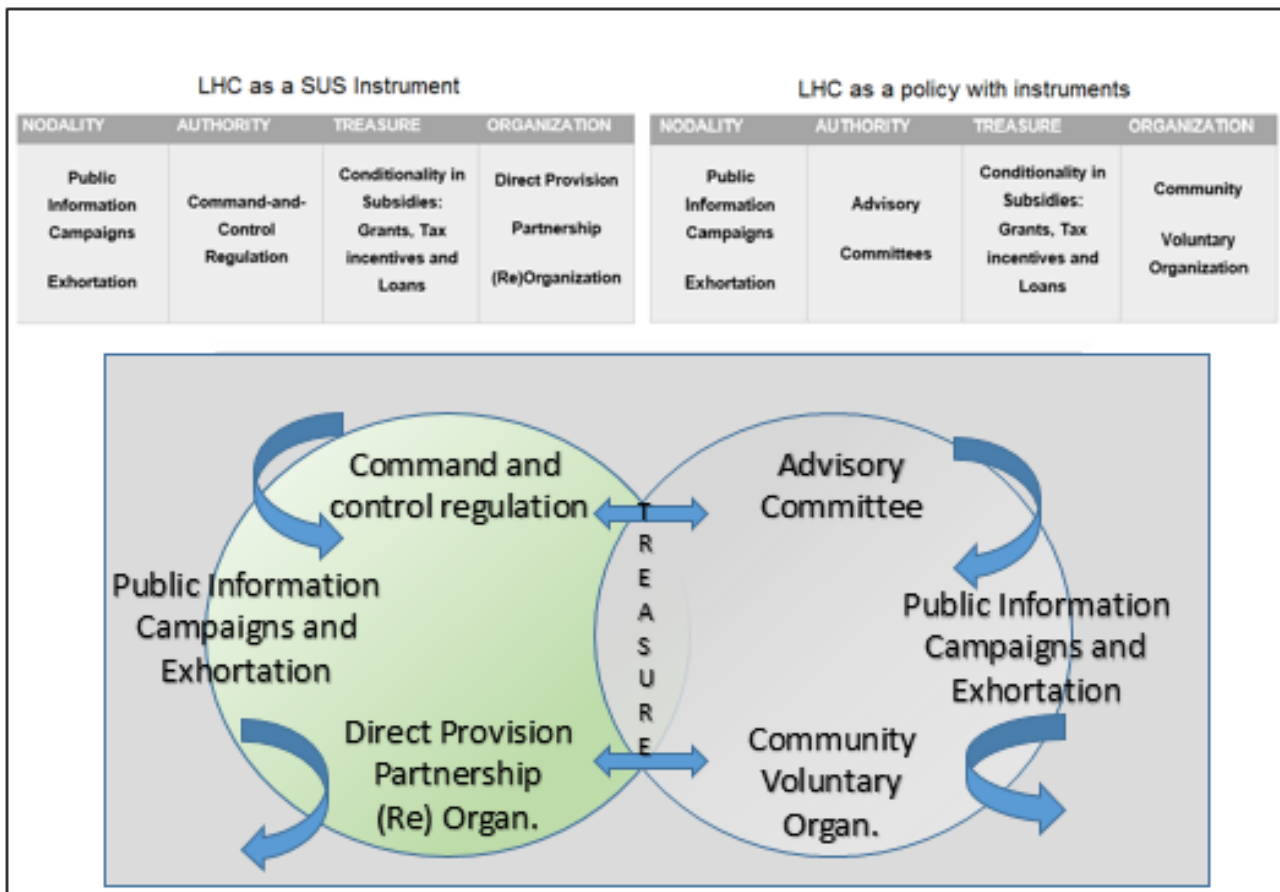
transfer of funds is not made. The SUS design uses subsidies, grants tax incentives, and loans tools in order to condition transfer of funds for health in cities. This relationship shows a mixture of authority and treasure instruments.

However, if we look at the structure of LHCs, regardless of their regulatory relationship with SUS, we can note their internal dynamics have characteristics of an institutionalized committee, with elected representatives and direct action in the decision-making process which is characteristic of a procedural tool called "Advisory Committee". From two different points of view, it is possible to identify the use of different instruments. On the one hand a direct link through regulation of the existence of councils; and on the other hand, an internal dynamic consisting of a multi-stakeholder committee.

Another important aspect of the health council design refers to the Organization-based Policy Instruments. The SUS, recognized as one of the biggest and most studied public health systems in the world, coordinates and provides free and universal health care services. In addition to providing directly, the legislation also provides for the possibility of partnerships with the private sector in a complementary way (BRASIL, Art. 4 § 2). If the object of our analysis were the public health system in Brazil in general, we certainly could understand it as a mix of tools from "Direct Provision", "Partnerships" and "voluntary actions, and non-governmental entities".

By another angle, if understood as an instrument within SUS actions to promote participation and decentralization of the health system, the health council can be classified as a direct provision tool in which "the government often performs the task itself, delivering goods and services directly through employees, funded from the public treasury" (HOWLETT, RAMESH, PERL, 2009, p.126). This is because the convocation, initial regulation and coordination of local councils is a government responsibility regulated by federal law. Still using this perspective, the creation of the Councils can also be interpreted as a Government re-organization tool, since it involves the creation of a new agency (or a local government organization) with activities of new participants and new dynamic to the decision-making process. Understood as an instrument of the Brazilian health system reform, the LHC is an example that involves changes in the relationships between central government (Health Ministry) and the local government (municipalities) (Howlett, Ramesh and Perl, 2009).

Figure 5: Local Health Councils' Design



Regarding the "Nodality or Information-based Instruments", the main tools used are the "public information campaigns" and "Exhortation". Inserted into SUS regulation and also on LHCs laws, information is a central instrument not just to inform, but also to guide user actions. The Health Councils 1- disclose information about the potential of health services and their use by the user; 2- evaluate and disseminate the health status of the population and the environment; 3- prepare and disseminate a national health information system, integrated throughout the national territory, covering issues and epidemiological service (BRASIL, 1990).

This data is generally informational and is "intended to make societal actors more knowledgeable so they can make informed choices". The information can also adopt a more persuasive character "devoted to influencing the preferences and actions of societal members", rather than just Informing the public about the situation with the hope that behavior will spontaneously change in the desired manner (HOWLETT, RAMESH and PERL, 2009, p. 118). The figure below summarizes the use of various instruments and tools in the policy design of Local Health Councils in Brazil.

Identification of the instruments and tools used for the design of the Councils shows a variety of mixtures of instruments and tools. From this perspective, it is interesting to note the coexistence of four types of instruments in "NATO". Initially, this mix of instruments can seem complex or incomprehensible if taken out of the social and political context in which they are inserted. The following analysis aims to relate the goals of the makers and their choices on instruments and tools selection for the formulation of Local Health Councils. This process, marked by a moment of intense instability and changes in the Brazilian political system, resulted in one of the most complex and innovative policy designs in Brazil.

The transformation of the Brazilian political system towards democracy, decentralization and participation in the production of policies gathered various actors and institutions. On the one hand, multilateral organizations influenced the proposals for decentralization of social policies based on the speech for the sake of efficiency. On the other, the struggle of social movements against the military dictatorship arose with the decentralizing agenda and the demand for higher quality services and greater social participation in decision making. Paradoxically, the process of democratization consolidated in the Federal Constitution of 1988, while decentralizing the provision of services, created a new kind of relationship between the Federal Government and local government, with strict regulations, involving the transfer of services, responsibilities, power and resources of the federal to the state and municipal governments. These instruments of regulation were necessary given the low capacity of municipalities to generate revenue. The proposed decentralization could not take place without coordination with the Federal Government.

The first conclusion indicates the choices of instruments that could promote decentralization of the health policy, as well as ensuring efficiency and financial resources. However, these goals could not be achieved without control tools. How to ensure that resource transfers will be used to promote decentralization in a participatory manner? That was one of the challenges of the Health System Reform in Brazil and choices characterize the political moment of re-structuring of Brazilian health system.

Thus, when we consider the Councils' design related to the objectives of decentralization, it is possible to identify the use of instruments as direct provision, regulation and conditional transfers of funds. In a moment of re-structuring of the health system, the regulations are instruments that allow better planning and government coordination. These instruments allow quick response and provide greater predictability relating to their goals. When combined with other instruments, such as subsidies in direct provision, an important relationship of conditionality and cooperation is established. On the one hand, the federal government has the resources and information to produce decentralization and popular participation (through the Councils), with a low cost control. On the other, the local governments depend on financial transfers to run local health policies.

Still considering the health reform objectives, the tools discussed above are chosen to give control of the Federal Government and to guarantee the existence of the Councils in local level, but they don't say too much about their organization and performance as a participatory policy. If an instrument consisting of direct provision, regulation and conditional transfers can ensure the decentralization of health policy, which design (with mixed instruments) can be used to ensure popular participation in decision-making?

The answer to this question seem to be in the internal dynamics and duties given to Councils. Two aspects deserve attention: 1- Council as a deliberative advisory committee; 2- Access to broad participation and Composition of the Directing body – councilors (community and voluntary organization).

According to Law 8142/1991, which defines the jurisdiction of the Health Councils: art. 1, paragraph 2: "The Health Council in permanent and deliberative character, a collegiate body composed of government representatives, service providers, health professionals and users, operates in the formulation of strategies and control of the implementation of health policy in the instance correspondent, including the economic and financial aspects" (BRASIL, 1991).

These characteristics can be related as an advisory committee as described by Howlett, Ramesh and Perl:

Advisory bodies are often situated closer to social actors than the formal governments they report to. They are usually quite specific in their focus and conduct different types of hearing and “stakeholders” consultations to receive input and, at times, to engage in dialogues than seek to build consensus with, and among, societal actors. [Committee] provide a venue for organized and unorganized interests to present their views and analyses on pressing contemporary problems, or to frame or reframe issues in such a way that they can be deal with by government” (HOWLETT, RAMESH, PERL, 2009 p. 122).

The participatory and inclusive characteristic proposed by the reform of the health system are elements linked to the deliberative nature of the councils. Organized as an open-access committee, the proposals discussed can become deliberations.

Results of pressures from social movements to create participative policy-making processes regarding the composition of Local Health Councils must comply with the provisions of Law No. 333 of November 4, 2003, which regulates the creation, formulation, structuring and functioning of health councils. According to this legal resolution, the composition of the boards should be made via the election of representatives in accordance with the principle of parity: 50% of seats occupied by SUS users (civil society); 25% for organizations of health workers and 25% for representatives of government, insured private services or non-profit providers (BRASIL, 2003). In addition, after local government convocatory, the elected "councilors" have privileged access in decision making, deliberation and production control policies, as well as the supervision of the health budget. Furthermore, as the LHC entails a universal participation policy, this internal organization makes the Councils a type of open sub-system with free entry of new players and new ideas. The principles of decentralization and popular participation allows all parties involved to represent the localized needs and specificities of each city.

Another analysis can also be made on the Organization-based policy instruments: the internal organization of councils all elected councilors to compose the governing body of health Councils are volunteers and are not paid for providing that service. The internal regulation of the councils, containing the amount of councilors, process of election and mandate time, is prepared independently by each of the local councils according social, demographic and geographic differences. With these characteristics in the composition of its members, the design of the councils seems to approach the "Voluntary Organization" tool.

Conclusion

Being the focus of Smith and Ingram studies (1993, 2002), the use and the type of policy tools for democracy may help us understand the design and internal dynamics of the Councils. The relationship between civil society and government, part of the debate on democratization of government institutions, opened a discussion regarding the design of governance, particularly participatory governance. New approaches to solve public problems and new policy designs resulted in a repositioning on relationships of these two actors.

Smith and Ingram claim that the choice of policy tools is fundamental to the relationship of government and citizenry and the same tools can affect different dimensions of governance, expanding scope but reducing authenticity. The authors explore consequences on uses of policy tools for democracy and argue about the development of policy tool design and selection more sensitive to civic impact. Based on increased openness and transparency, as well as promoting inclusive decision making, the Local Health Council are an example of this innovative and complex policy-design.

The composition of the councils and the role played by local councilors show important changes in the decision-making process. Accountability and transparency are elements included in the logic of the Councils performance in at least two aspects: the first is related to approval of accounts. This process is no longer an insulated instrument elaborated by technicians (bureaucracy). Inserted on councilors' activities, the budget needs to be approved in open monthly meetings, ensuring social inclusion in a process previously dominated by professional politicians and technicians. The second part, gives accountability regarding decisions about what to do and how to do it because they are taken in an open environment for popular participation and voted on by representatives. This design can be identified as an example of "changes have been made to make administrative procedures more open, accessible, equitable and democratic. Advance notice must be given of proposed rules changes, and the public, must be given the opportunity to comment" (Smith and Ingram, 2002, p.579). This design can ensure greater openness and transparency about budget use as well as strategies and policy action choices. More than that, the Councils' design can promote an inclusive decision making process. Coordinated by legal regulations, the complex intergovernmental relationship (Federal system), the LHC is the place where public meetings are convened to promote discourse in formulating and implementing of local health goals. "Grants are now something designed so that local communities have a clear role in setting goals and allocating resources along with a clear obligation to deliberate" (SMITH and INGRAM, 2002, p. 580).

Comparing the goals intended by the health reform with the types of tools chosen for the creation of LHCs and linkage to the new Brazilian health system (SUS), appears to be a convergence in the choice of policy-makers in an attempt to modify the objectives of the policy. The types of instruments used for the creation of the Councils as a solution to the health problem, is not intended to make subtle changes or minor adjustments. With the inclusion of new actors in the political and social demographics, changes in policy design are significant and give control and stability to the councils.

This study aimed to identify and analyze the types of instruments used for the formulation of Local Health Councils in Brazil. Based on our analysis, it is possible to conclude that this policy is made up of a variety of inter-related tools. Looking at this theoretical framework, several points can be highlighted as elements that can be seen as problems for social participation. The first of them, would be the continental size of Brazilian lands. The coordination of more than five hundred municipalities is, for sure, one of these points. The second one is related to the culture of non-participation. Policy-making process was an elite-thing in Brazil. Promoting participative policies doesn't mean instant social participation. Sometimes, regular citizens don't know, or don't feel capable, or even have time to participate and make political choices. Taking into account the ambitions of its idealizers, the tripartite structure of the Councils may be theoretically ideal, but it doesn't consider the limited interests among other factors of Brazilian culture. With multiple objectives, decentralization, public participation and democratization of health service were guaranteed by different instruments. One of the most relevant issues about this selection process refers to the relative youth of the Brazilian democratic system. The complexity conferred on the health Councils combines federal regulations with local committees, at the same time decentralizing the decision-making process while retaining control by the Federal Government through conditioning budget transfer.

With nearly twenty years of existence, local governments, academics and managers are still in the process of understanding and evaluating the Councils. Deviations, goals, fraud and other aspects have been calling attention to the need to create new tools that ensure popular participation in decision making. This paper aims to contribute to the understanding of this new governance model.

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