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Governance of Intersectorial Policies with the Population: Illusions and Reality

Ensuring participation in the regionalization of Brazilian health policy:

are the mechanisms enough?

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Abstract

Health policy in Brazil has at its core the Unified Health System (SUS, acronym in Portuguese), which is based on the principles of decentralization, participation, universality and integrality. Maintaining the service network and operation structures presents to be a complex issue, considering that Brazil has continental territorial dimensions, inequality between regions and a federative structure with three distinct and autonomous spheres of government. Because of these challenges, SUS is going through a regionalization process, punctuated in territoriality and common identity aspects. This paper proposes to draw a critical analysis of SUS's participation mechanisms, focusing on the regionalization of healthcare, as a mean to establish a system of governance that act in concordance with the principles and directives established in the creation of SUS.

Key-words: Unified Health System; regionalization; participation; participative management.

Introduction

The construction of contemporary public policies highlights the need to think about social participation, coordination and articulation between sectors and actors. As a mean to ensure these principles, the Brazilian democratic Constitution of 1988 provided mechanisms to strengthen the links between government decision making and civil society. With constitutional provision and created by a legislation published few years later, the Brazilian Unified Health System (Sistema Único de Saúde – SUS) shares this vision, being a complex structure that has as pillars decentralization, participation, universality and integrality of the services provided, valuing the instruments of social participation and active listening. For that reason, SUS has conferences and councils established in the three spheres of autonomous government (federal, state and municipal) as hybrid arenas of participation and commissions formed by managers, acting throw negotiation and agreement.

In the case of health policies, each federate entity has only one organism responsible for coordination, working in a single direction. It can be said that health policy in Brazil functions in a paradoxical way, established in cooperation and network, at the same time as it is ascending and hierarchical. The SUS's structure form is transversal and intersectoral, involving the multiple actors involved in the construction of the health public action.

In recent years, there has been an effort by general and regional governments to strengthen SUS health regions. Regionalization focuses on the territoriality of politics and the socioeconomic and cultural characteristics of each locality, understanding in a better way the specific need of each region. This form of organization works in reducing regional inequalities, a great challenge for a country with huge territorial extension. The health regions are established not only with the same level of government spheres, demanding actors to work in cooperation, integration and articulation.

Therefore, this paper proposes to draw a critical analysis of SUS's participation mechanisms, focusing on the regionalization of health, as a mean to establish a system of governance that act in concordance with the principles and directives established in the creation of SUS.

The methodology of the paper is based primarily on a bibliographical review, basing the precepts on participation, intersectionality and regionalization of health. It involves also a legislative survey of the construction of Brazilian health policy on these subjects, besides a vast documentary analysis.

It is structured in 5 different parts, beyond this introduction. First, it is presented the organizational aspects of SUS, its history and its connection to decentralization and participation. In the second part we develop the context of the institutionalized participative mechanisms of SUS. The third part is destinated to present the regionalization of the healthcare policy. In the fourth part, we discuss the effectiveness of the participative and collegiate arenas of SUS. For last, we present the conclusions of the study.

The creation of SUS and its organization: an arrangement already participative

Social policies in Brazil have gained a fertile ground for their implementation and consolidation through the 1988 Constitution, which has brought a text based on the guarantee of the dignity of the human person and the Democratic State of Law. It is in the constitutional text that many policies have moved to the status of being a right, reaffirming national commitment to human rights and reassuring the role of the State, to offer rights in the form of services (Lucio et al. 2015). It is in this context of the expansion of rights and services that the Unified Health System is created.

The claim of a public healthcare system in Brazil is ancient. The first healthcare policies are from the beginning of the 20th century and emerge as a form to resolve sanitary and epidemiologic issues. However, the medical care was restrictive (Mapelli Jr., 2015; Brazil, 2007). The conception of health as a right only arises during in the 1970s and 1980s (Ministério da Saúde, 2009a). In 1986, a major milestone occurred for the formulation of SUS: the 8th National Health Conference (Conferência Nacional de Saúde), with impacted the constitutional text promulgated in 1988. The Sanitary Movement, that turned possible the creation of SUS, is one of the examples of social movements that had its demands adhered in the first constitution post-military regime (Daroit et al., 2018).

The story of deliberative and participative arenas in the health policy starts in 1937, when the federal government predicted the Health Conferences, first institutionalized conference in the country, with the first one occurring in 1941. The purpose of the initiative was to inform the Federal government sphere of what occurred at the state level in health policy. In 1963, there was a Conference that included more actors, but still governmental, already pointing to a decentralization of health policies. During much of military regime, which began in 1964, the meetings return to have a technical character. The concern with a Health Conference with popular participation occurs in 1980, becoming real in 1986. It reported as a popular will the establishment of health as a right and the creation of a Unified Health System, based on the organizational aspect, in decentralization, highlighting the role of the municipality and social participation.

Therefore, in 1988, the Brazilian Unified Health System was created, whose pillars are the decentralization, participation, universality and integrality of services provided. Health as a right stop being for few people and became universal, free and integral.

As a policy for health promotion, SUS aims to understand the needs and demands of the population, understanding that each region as its particularity, culture, socio-political condition and its different needs from each other (Ministério da Saúde, 2009a).

It is important to emphasize that Brazil is the only country that has adopted constitutionally a federalism in three layers, giving the municipality autonomy, which can be described in three different competences: self-organization, in elaborating its own constitution; self-government, in electing its own rulers; and self-legislation, in developing their own laws (Chagas, 2006).

The structuring of the State on three distinct levels brought a number of advantages and increased the number of challenges. We believe that this form of organization represents the greatest federative precept, of diversity in unity (Bernardes, 2010; Schütze, 2009; Hueglin, 2015), and that allowed the "expansion of freedom of political participation" (Zimmermann, 1999:05).

This organizational arrangement is only possible through cooperation, intrinsic characteristic of human beings when they cannot overcome challenges alone (Sennett, 2012). By bringing this logic to the function of the State, cooperation is understood as a founding element, a constitutionally established commitment, with the "progressive substitution of the rigidity of the competency allocation constitutionally consecrated by the flexibility of intergovernmental cooperation" (Silveira, 2007:443). The logic of cooperation as a foundation is not only fundamental for the proper functioning of the federative arrangement, but also for a new democratic proposal. In this sense, the idea of participation is intertwined as a constituent element of the federative arrangements that cherish consolidated democracies. Papadopoulos & Warin (2007) point out that the possibility of the functioning of new approaches of participation is due to the approximation of the ideas of cooperation, solidarity and mutual aid.

The debate over the new federative arrangements around the world is based on the principles of decentralization, participation, founding new ways of circumventing the limits of representative democracy adopted in several nations. It is important to keep in mind that the

discussion of democracy, as participatory and deliberative, does not mean that the first model is abolished (Fung, 2006; Progrebinschi & Samuel, 2014). Participatory democracy includes popular participation in the attempt to reconnect democracy and active citizenship, since the participation of civil society makes it possible to recognize information brought by the population of its reality that are important in the decision-making process (Moura et al., 2011).

Bernardes (2010) proposes that federalism is a concrete practice that has spaces of daily participation in the deliberative sphere of the constitution of the public autonomy, emphasizing the popular sovereignty that highlights values and collective identities.

In Brazilian experience, the municipality can be understood as a fundamental autonomous entity for the realization of rights in form of services. It is in the municipality where the relations between governors and governed are better stablished, prioritizing the need of the communities.

It is understood that the choice to provide the municipality with autonomy is due to this will of the constituent approach of governors and governed, to establish more direct communication between civil society and the State, in addition to establishing greater principles of cooperation, understanding and local knowledge for the implementation of public policies and state design. "That is, the central focus fort the actors in general, and for the entities of the federation – adequately addressing the problem of power distribution – was to seek an adequate institutional design to endow public policies with greater efficiency" (Rocha, 2013:31).

Following a trend that has been establishing itself worldwide for decades, there is a substitution of a centralized structure that is highly hierarchical by a more decentralized structure and that implement transversally as a cooperative element of Public Management entities.

Mansbridge et al. (2012) point to the growing concern about the quality of deliberation in democracies and the alternatives found to improve this deliberative process by focusing on two main strategies: the first is to change the deliberative processes in the legislative order; the second is the creation and strengthening of small deliberative initiatives provided by citizens.

Understanding the improvement of the quality of democracy through the increase of participatory initiatives represents a great step in understanding policies in the Brazilian context as public action, since it is undeniable the variety of social actors that are constituents of public

action, of actors that today make up the framework of public policies throughout its process (Lascoumes & Le Galès, 2012).

Given the undemocratic history of the military regime, there is an expressive concern in the construction of state policies and organization in creating participatory instruments in various sector that ensure the democratic characteristic constitutive of the Brazilian State. This concern can be perceived in SUS.

The main structing legislation of SUS is composed of Brazilian Federal Constitution, which indicates the guidelines of the system, and two Laws enacted in 1990 (Law No. 8,080 and 8,142), and other minor legislative acts, respecting the country's state organization, which provided mechanisms for popular participation and social control.

The legislation delegates unique direction stems from a common will, which had been reinforced by the Sanitary Reform of 1970, when health policies reported to five different Ministries. Therefore, the elaboration of a single direction of health policy is made with the possibility of having a general competence in each federated entity of realization and formulation of health directives (Santos, 2003).

Despite the lack of hierarchy among governmental sphere, health policy has an upward planning. This form aims to guarantee the unicity of 6the system, recognizing the difficulty of homogenizing the logics of functioning, predicting only a document called Health Plan (Plano de Saúde) as a basic reference instrument of each federate entity (Ministério da Saúde, 2009b). The document itself predicts that the Health Plan is a way of guaranteeing social participation and uniqueness, understanding that Brazil has several realities that prevent the operation of a single model.

In this same sense, the question of how to establish participatory mechanisms in a community is unanswerable, that the participatory process in communities cannot follow a recipe, since each community sees itself in a different way. Community can be understood as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical location settings" (MacQueen et al., 2001:1936).

Avritzer & Pereira (2005) point out that the great advance in terms of participation was the inclusion of hybrid spaces in the legal order, mainly in the constitutional text, transforming mainly the performance of local (municipal) power. First, the municipality gains more autonomy, involving, for example, the communities in the process of deliberation of social policies, extending democratic management.

It is possible to understand that SUS management is participatory, and that all the deliberative logic is elaborated in order to create hybrid arenas of participation and collegiate, as will be seen below. The importance of participatory management translates, then, in the construction of democratic means of realizing public policies in the area of healthcare, from its conception to its social control. In order to guarantee and follow up the forms of social participation in SUS management, several mechanisms have been created, legally constructed through laws, decrees, ordinances and regulation. Since the other federated entities – states, municipalities and Federal District (that incorporate hybrid competencies between state and municipality) – has to follow the national guidelines, all the government spheres have elements to guarantee participative management in the deliberation of health policies.

The management philosophy of SUS is a participatory management that encompasses various actors, government and society, as a transversal strategy that ensures better legitimation to governmental acts (Marinho, 2015).

In 1990 (Law No. 8,142), collegiate spheres of community participation were instituted, with each level of government counting on a Health Conference and a Health Council.

The structure of the SUS also counts on Intermanagement Committees (Bipartite and Tripartite), counting on entities representing the municipal and state health departments, which are spaces for negotiation and negotiation.

The collegiate bodies of SUS

The structure of SUS is coordinated in a way to ensure a broad discussion of planning, financing, action, services and management matters in a shared way with several actors, whether governmental or non-governmental.

Popular participation and SUS users' participation should be directly related to the decentralization of health policy, since it promotes the approximation between the public manager and the one who enjoys the system, translating in social control (Santos, 2009).

The composition of Health Councils and Health Conferences is defined by the Law No. 8,142/90, with equal representation of users in relation to the other components. In addition, each Council and each Conference has its own regiment, disposing on its rules of operation and organization. The creation of the inter-managerial Committees is predicted by the Law No. 8,080/90.

In the same way that planning happens, the process of information transmission is done in an upward manner. Thus, for example, the Municipal Health Conferences take place before the Regional Health Conferences, which take place before the State Health Conferences and these culminate in the National Health Conference.

It is possible to observe that the SUS structure is designed in such a way to ensure participative management and transversality of decision making, considering decentralization, regionalization and arenas of discussion and agreement.

The Health Conferences

The history of the National Conferences begins in Vargas government, specifically in 1941, with the 1st National Conference on Health. Since the 1988 Federal Constitution, the National Conference of Health and the National Conference of Social Welfare have gained constitutional status, and the role of National Conferences has grown rapidly since the first Lula administration, indicating a focus on participation, becoming the main participatory strategy of the federal government (Avritzer, 2012). Along the same path, Pogrebinschi & Samuels (2014) state that various civil society organizations have made a positive contribution to the implementation of mechanisms for participation in the 1988 Constitution, which have been

expanded in quality and quantity, especially in the federal level, with the National Conferences on Public Policies, since 2003.

Analyzing the data from a research conducted in partnership with *Vox Populi*, Avritzer concludes that a significant part of the Brazilian population participates in the participatory spaces (4.3%), such as participative budgeting and municipal councils. He also concludes that the participatory pattern of National Conferences does not differ much from the standard of the people found at the local level. In the same sense, the data analyzed showed that there is a greater participation of society at regional and municipal levels than at the state and national levels (Avritzer, 2012), which again emphasizes the importance of the sense of community of municipal governments.

Finally, Avritzer (2012) comes to three conclusions. The first is that there is a certain homogeneity between the Conferences at all three levels, since the pattern of participation is very similar to the standard at the local level. Secondly, the participants of the National Conferences believe that there is deliberation in the meetings, with strong debates among the actors, which had not happened before. Regarding effectiveness, he describes that there is a certain effectiveness, but there are problems stemming from "the fact that there is still no way of public managing it that clearly articulates with the decisions of the national conferences" (Avritzer, 2012: 22).

For the sociologist, in spite of these similarities found in the national and local spheres, there is a clear difference regarding the effects that the discussions that are established in these deliberative spaces have. At the federal level, the discussions stimulate the legislative power to discuss the deliberate matter, acting directly in Brazilian normative instruments, with proposals for bills that will be submitted to the National Congress and which impact the Executive in both management and change of the legal order. At the local level, the discussions are geared towards discussing the implementation of certain public policies, according to demand (Avritzer, 2012).

The National Health Conferences represent an important step towards the construction of a democratic and increasingly participative model of health services. Throughout its occurrence in history, it is possible to verify that the themes were getting more diverse, and that the concern with the decentralized form of SUS management and participation were taking center stage in

the discussions. For almost half of these conferences, access to the population was restricted and gradually extended to technicians, professionals and users.

If, at the outset, attempts were made to create policies that would integrate a way of combating the epidemics that spread throughout Brazil and understanding the sanitary capacity of the Member States, the new Conferences were based on the discussion of ways to achieve integrality health care, guided by the quality of health policies, and expanding the spaces for participation and management of health decentralization.

At the federal level, the National Health Conferences have an important role, to translate, through the compositional parity and its openness to users, political and management guidelines for the functioning of SUS, as Avritzer (2012) teaches, the ability to transform federal legislation, creating normative mechanisms that imply the entire population, and not only the Public Management.

At the state and municipal levels, they are seen as real participative arenas preparatory for the four-year National Heath Conference, incorporating social demands that, mainly for the Brazilian territorial extension, could be ignored by policy makers.

Health Councils

The councils bring the characteristic of direct participation, but with a more management-oriented bias, as provided by the legislation.

In the Health Councils, there is the discussion, with the participation of different social actors, of health policies, "having an independent performance of the government, although they are part of its structure [...] making possible the negotiation of the proposals and the direction of resources for different priorities" (Conselho Nacional de Secretários da Saúde, 2011: 27).

According to its internal Regiment, the National Health Council has the role to exercise social control and to contribute to the formulation and control of the national health policy, by proposing strategies, for example (Ipea, 2012).

On management councils, in general, even if in their performance there is representation by counselors, there is a great differentiation of the representation performed by parliamentarians: a. because they do not assume a representative profession, there is not an imbalance of the distribution of information in the representative relation and represented; b. because they are not remunerated positions and of high visibility, occupying positions people who do not have individual interests; the short duration of the mandates implies greater responsibility; c. because it is municipal in scope, there is greater contact with the community in the evaluation of policies; d. because it assists in promoting the active participation of citizens; e. because there is no massive media interference; f. because they are thematic or sectoral, there is how the represented to accompany the performance of the representative; and g. because there is how to directly relate the action of the counselor with the public policy formulated and executed (Gomes, 2015).

According to Côrtes (2009: 199), "health councils are deliberative only in the sense that they exhaustively discuss issues on the sector agenda", warning that "power relations within them are not egalitarian".

In addition, the Tripartite Intermanagement Committee (Comissão Intergetores Tripartite – CIT) and the Bipartite Intermanagement Committee (Comissão Intergestores Bipartite – CIB) are arenas for negotiation and negotiation between managers at various levels of government. Institutional representative entities include the National Council of Health Secretaries (Conselho Nacional de Secretários da Saúde – CONASS) and the National Council of Municipal Health Secretariats (Conselho Nacional de Secretarias Municipais de Saúde – CONASEMS).

CIT and CIB

The participation of CIBs and CIT does not take place directly because they are deliberative spaces that do not have direct actors of civil society, contemplating only managers of the Health Secretariats and the Ministry of Health.

The Bipartite Intermanagement Committees are essential for the decentralization process of health policies in the field of management, introducing the need for cooperation between different federated entities that coexist in the state territory.

It is important to realize that there are more than two spheres of agreement among federative entities, encompassing from the first notion of articulation between municipalities, the Regional Intermanagement Committee (Comissão Intergestroes Regionais – CIRs) that constitute the health regions, rising to the discussion established at the state level, with the CIBs , reaching the federal level, the CIT. This demonstrates the upward plan of health policies, while reinforcing the issue of decentralization of the SUS and reinforcing the creation of new federal interactions between federated entities.

Viana et al. (2002) emphasize the establishment of CIBs and CIT caused an involvement of the managers of the three spheres of government in the political process, highlighting the contribution of intermanagement commissions, especially bipartite, in the construction of intermunicipal systems.

The actuation of the Committees is very directly involved in discussing the operationalization of management.

Regionalization

The process of regionalization of health is inserted in the logic of development, especially the regional one, of Brazil. The country has a continental territorial extension, which makes it very difficult to act equanimously. Regional inequality is also striking. These large regional inequalities that are still found in Brazil are seen as barriers to the country's development process, which sought to articulate between governments and social actors existing in the vast territory and diverse ways of acting to reduce these inequalities (Silva, 2016).

Health networks are constituted not only by a territorial and geographical criterion, but by the connection established between the municipalities that comprise it, such as culture, means of transportation, communication, etc.

In this sense, the process of regionalization of SUS was largely based on Milton Santos' concept of used territory, especially after extending the competencies of the municipality. The planning of health policy regarding the provision of services and access to them requires a territorial organization, as a way of guaranteeing the principles of universality, equity and completeness (Faria & Bortolozzi, 2016). The territorial process followed the implementation of some programs and the decentralization of assistance and surveillance (Monken & Barcellos, 2005).

For Santos (2003), the regionalization of Health allows some problems, originated due to centralization, to be corrected, such as the isolation of some federative entity, or the lack of service provision and the lack of recognition of the needs of neighboring communities.

Santos (2017) explains that since the Federal Constitution did not assign specific functions to each federated entity and the Law No. 8,080/90 is not precise in the definitions, the entities themselves acted to define their attributions through the negotiations in the inter-managerial committees (CIBs and CITs) "with the public healthcare organizational contract used to define these inter-federative agreements, limited to each healthcare region" (Santos, 2017: 1282) the organization and operationalization of health services and actions.

It can be said that, in regionalization, neighboring municipalities that have a similarity in characteristics and sanitary needs, besides their geographical disposition, share in an integrated way services, as previously constitutionally disposed. The importance of this form of organization is due to the large number of municipalities, due to the difference in technical capacities and the impracticability of each municipality to act alone in the provision of medium and high complexity services, working in a regional network for health care, ensuring that Brazilian citizens can have access to health care regardless of where they reside.

It should be emphasized that thinking about the process of regionalization was only possible after the process of municipalization of health, and that decentralization is a fluid and continuous process that is not finished with the introduction of regionalization. Legislation on the subject is growing and is materialized in the Health Care Operational Standards (Normas de Operacionalização da Assistência à Saúde – NOAS), in the Health Pact (Pacto pela Saúde) and in Decree 7.508, of 2011, for example (Mello et al., 2017).

"2011 Decree 7,508 governs federative articulation, healthcare regions, the organizational agreement for public healthcare measures, regional planning, gateways to the SUS and other items. This Decree leaves it up to the federative units in healthcare regions to define, by common agreement, the responsibilities to be stipulated in the organizational contract for public healthcare activities to provide the necessary legal security"(Santos, 2017: 1283).

Regionalization drives the constitutional and infraconstitutional attributions of the state level, acting positively in the integration of its municipalities. These processes are reaffirmed with the emergence of the Regionalization Master Plan (Plano Diretor de Regionalização – PDR) and the Investment Master Plan (Plano Dirtor de Investimentos – PDI), as well as with the reinforcement of Integrated Pactual Programming (Programação Pactuada Integrada – PPI) (Fonseca et al., 2012). Mello et al. (2017) believe that these instruments are fragile and result from the lack of planning experience, with the Health Plan being only a formality, the PDR replete with the vices of the present policy in the municipalities that comprise it and the PPI is debating to function underfunded and still in the logic of competition among municipalities.

Since the regions are not strictly instituted, the public healthcare action contract is used to guarantee legal certainty to the consensuses that are signed in the inter-managerial commissions (Santos, 2017).

Regarding regionalization, it is important to emphasize that this is a result of the joint effort of the state and municipalities, which must act together to better distribute resources, and that "in SUS, collaboration is required" (Santos, 2017: 1288).

The performance of the state sphere in the process of regionalization is decisive for the articulation between the actors (Silva & Gomes, 2013). However, in a systemic review of literature on regionalization, Mello et al. (2017) conclude that there is still an absence of the state sphere in the process of regionalization.

The regionalization process requires a cooperative logic of municipalities, working together to improve efficiency, quality of services, equity and social costs, developing the idea of regional belonging and broadening the region's self-esteem (Silva & Gomes, 2013).

It is undisputed that regionalization has a vulnerability regarding the low technical capacity of some municipalities and the lack of continuity of policies due to the frequently exchange of politicians in the local elections. There is still a difficulty in overcoming inheritances and the reproduction of municipalities politics (Mello et al., 2017).

And what was the impact of regionalization for participation in the SUS context? The main issue that the regionalization brought to SUS participation was the replication of collegial and deliberative instances for the regions. Thus, each region has a Regional Health Conference, a Regional Health Council and a Regional Intermanagement Committee. In this sense, "regional bodies are widely valued as an innovative political space and regional governance" (Mello et al., 2017: 1305).

Materially, it is the enlargement of the means of participation institutionalized, generating more channels of participation for citizens to express their demands and questions. In addition, the regionalization of these instances allows citizens and managers to discuss common aspects to their municipalities, starting from the aspects of territorization above. Thus, "colleges spheres are valued as important spaces for innovation, but still in search of overcoming a bureaucratic and clientelistic political culture" (Mello et al., 2017: 1306).

Santos (2017) points out that this form of organization is vital for the existence of SUS from its purposes of equity and integrality of services.

Mechanisms of participation and their effectiveness

As seen, the participative management of SUS is concentrated in three large collegial spaces: the Conferences, the Councils and the Intermanagement Committees. Health policies and the Unified Health System include several participative mechanisms, which have to some extent been amplified and strengthened.

The first positive consideration that must be made is the institutionalization of these mechanisms. The great resources that exist, such as councils and conferences, are foreseen in SUS structuring legislation, which makes it difficult to eliminate them. The constitutional

prediction of the creation of participative mechanisms means that the revision of this principle and the mechanisms deriving from it are reviewed in a negative way, with the reduction of these spaces.

These aspects are important for maintaining the democratic aspects of public management, the national and regional development plan and the plan to reduce social inequalities. Thus, the dispersion of participatory spaces through decentralization, a characteristic of public management since the redemocratization of Brazil since the 1980s, is a fact to celebrate.

Decentralization has made health policy deliberations and policies more democratic, but it faces the problems of regional asymmetry. Paradoxically, what brings the need for regionalization, which is decentralization, finds barriers in its regulation by the central government (Mello et al., 2017).

There are two types of instruments that assure participation in SUS management: in one, the participation of the population exists in a broad way, guaranteeing parity between technicians, government officials and civil society; and, on the other, negotiation and compromise takes place within institutionalized and proper structures of the Public Administration, focused on the role of the public manager in the formulation and execution of policies.

However, some questions are raised about whether these mechanisms that have been elaborated in the context of the Unified Health System are sufficient to guarantee participation and democratic deliberation in health policies.

The first question that arises is about how participatory these arenas are. We believe that the Health Conferences are established as more participatory than the Health Councils.

The Conferences are four-year events that allow a discussion about the future developments of health policies, which are raised and discussed in a snowball process until the National Health Conference is held (from municipal to national). Its occurrence brings the weight of popular demand in the Brazilian legislative construction. It is important to remember that it was in the unfolding of the discussions of the 8th National Conference of Health that the creation of SUS was made viable.

The Health Councils are more inserted in the management of the SUS than the Conferences, with frequent meetings and the capacity to generate normative acts more concrete than the Conferences. However, although their responsibilities were not altered on paper, the Councils lost their importance since 1993 to the inter-managerial commissions, which assumed the role of the main decision-making and coordinating space in the SUS structure (Cortes, 2009).

Thus, management decisions are currently concentrated in the Intermanagement Committees, which are collegial spaces, but without the presence of representatives of society. They are important in the sense that the managers are close to the reality of the localities, passing on the demands of the municipal – and regional – citizens for the discussions, but they are not direct representations like the other two arenas. It is important to emphasize the importance of both CONASS and CONASEMS in these spaces, which are always seeking to promote a more democratic and more collaborative articulation.

The second issue that can be raised is about the normative value that the discussions, the negotiations, the agreements and the deliberations have in the Brazilian legal order and in the management of the SUS and the health policies.

In the Health Conferences, a space of popular representativeness is created, with the presence of several social sectors, with parity in the discussions. However, the representative deliberation that the conferences are proposed does not materialize, since the deliberations are not binding (Marinho, 2015).

Santos (2003) believes that in spite of the legitimacy of the councils within the scope of the SUS as instances of negotiation and agreement, and through its representativeness defined by CONASS and CONASEMS, there is no legitimacy arising from the legal system, thus not based on any legal force.

In the same sense, "The legal instruments guaranteeing agreements are weak, practically absent in the metropolitan, interstate and border dimensions" (Mello et al., 2017: 1305).

This low guarantee of the legal instruments that are generated by Councils, and also by the Intermanagement Committees, is due to its normative status. Resolutions, that are the result of the arduous work of compromise of these instances, are considered administrative acts, arising

from the regulatory power of administrative authority (Carvalho Filho, 2017). These acts, since they are the basis, the lowest ground, of a normative hierarchy – which in the Brazilian legal system is not formally constituted – are easily revocable by authorities of the public body or sphere of government that issues them. Due to the operational, financial and shared management aspects of SUS, the administrative acts are sufficient to fulfill its purposes, although fragile.

On the scientific production of participation and regionalization, "it may be argued that the focus of the analyzes is too concentrated on the regional content of reform, on networking, on assistance, to the detriment of the actors involved" (Mello et al., 2017: 1306).

In fact, reflections or studies that deal with the actors that currently make up the collegiate bodies of SUS are not easily found. There is a concern about how these councils act, in theory and in practice, and if they are capable of fulfilling their role, which was foreseen in the will of the 1970's Sanitary Movement or in the structuring legislation of the SUS. There are few who look to the Councils, for example in a successful way.

At present, what is perceived is that the councils are more connected to the idea of social control than to the expansion of social participation in the management and governance of SUS, as can be seen in Saliba et al. (2009) and Ipea (2012).

It is important to have mechanisms of social control, and the SUS has other mechanisms for this purpose, such as the Ombudsman. However, considering social control as the main function of Health Councils is a limiting factor to the expansion and the effective participation of the people. Participation should be distinct from a strictly evaluative view, encouraging its citizens to participate in the health policy process as a public action, bringing the user closer to building the service that realizes their right to health.

The institutionalized spaces of participation of SUS are shown as arenas in which actors, both collective and individual, can debate the viability of proposals and the reporting of successful solutions that are public (Dowbor et al., 2018).

These participatory mechanisms are strengthened in the precepts of democratic governance. In this sense, CONASS proposes that the SUS operate with a system of collaborative governance

acting in a network. The logic of this system of governance is consonant with the regionalization of SUS. However, it comes up against the hierarchical question of the SUS organization (CONASS, 2016).

This indicates the necessity of the creation of a own governance system for SUS, that includes this necessity of decentralization, the necessity of thinking in regions of healthcare, the ascendant aspect, and, especially, that continues and promotes popular participation.

Conclusions

Based on the model currently adopted in Brazil, social participation finds more ways to be effective. It is undeniable that the sphere that is most successful in consolidating the mechanisms of popular participation is the municipality, re-emphasizing the concept of democracy. In the same sense, participation within public management becomes a way of balancing the lack of representation in the Brazilian National Congress.

Brazil is a country of continental extensions, divided into 26 federal states, which are subdivided into more than 5,500 municipalities, plus the Federal District. Decentralization needed to be implemented in order to have an effective exchange of knowledge and experiences in different communities.

In this sense, cooperation, a fundamental element for a good federative arrangement, stands out, since negotiation and agreement are made only in establishing productive dialogue and in the possibility of actors to establish agreements of mutual interest contributing to highlight elements in common of neighboring communities. This brings the reduction of the logic of competition that exists between the municipalities to a more cooperative logic between these entities. In this regard, regionalization has brought the state as a key entity for its achievement, highlighting the need for cooperation and networking.

In the context of social participation, regionalization has provided an expansion of institutionalized participation mechanisms, which reinforces the democratic character that SUS has had since its inception. Participation is the reason of why collegial spaces are so important,

which are highlighted to the detriment of the monocratic decisions that some governments tend to establish as a standard method. The prediction and institution of participation as a constitutional precept gives legitimacy and more support to these spaces.

The mere existence of participatory and deliberative arenas does not actually ensure popular participation, and they do not always represent the representative of the various health regions and federated entities that make up such spaces. However, its existence is already valid. The constitutional prediction of participatory mechanisms preserved participation for health policies. In this way, it is not any normative act that can end these arenas.

It is also perceived that Conferences and Health Councils face some problems. The conclusion is that councils are becoming more and more a mechanism of social control than of social participation. This follows a trend of implementation of a governance based on evaluative logic, which can be a barrier to participatory and democratic instances and policies.

All the peculiarities found in Brazil and the SUS point to the need for a unique system of governance, guided by the constituent principles of the SUS of decentralization, participation, universality and integrality.

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