National Health Conferences and Participatory Processes in the Brazilian Federal Public Administration[1]

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Introduction

This case about National Health Conferences aims to support the debate about participatory processes and the emergence of new patterns of relationship between State and society. Under the framework of the New Synthesis Project, it relates especially to the concepts of governance, emergence and resilience. This paper tries to demonstrate the advancements, dilemmas and potential of participatory mechanisms comparing the examples of the 13th National Health Conference (13th NHC), held in 2007, and the 8th National Health Conference of 1986 (8th NHC).

Given its impact on the Brazilian legal and institutional framework, the 8th NHC is considered a watershed in health policy, a true pre-Constituent Assembly of the sector. It also represented an innovation in the process of National Health Conferences: it was the first time since their creation in 1937 that the society could participate.

The so-called Sanitary Movement, formed by intellectuals, professionals, trade unionists and health care users is an example of **emergence** (WALLE & VOGELAR, 2010). They advocated for a comprehensive health reform in Brazil and led the 8th NHC of 1986, presenting and discussing their proposals with representatives of public sector and civil society.

The conceptual and doctrinal foundations for the health sector reform were laid within this public policy community (KINGDON, 2003 *apud* FERRAREZI, 2007), including the creation of the Unified Health System (SUS), and the planning of Conferences and Councils as mechanisms of social control.

Today, Conferences held by government are considered institutionalized spaces for social participation, in which civil society and the State mobilize and discuss and evaluate public policies. The end result produces proposals and guidelines to be incorporated into government agenda and actions.

Conferences are a means to deal with complex issues on public policy. They allow governments to acquire knowledge, to anticipate emergent patterns and demands, and to dialogue and collaborate with participants. They have a potential to generate **resilience** (NS6, 2009) – the capacity to adapt to adversities and to anticipate change.

Moreover, conferences are learning environments where society can learn about the functioning of the State and participation, taking part in the responsibility for public interest; while government can learn how to dialogue, recognize demands and adapt bureaucratic mechanisms to the exchange of ideas. They contribute to better public policy results as well as to **civic results**, recognizing actors' legitimacy, demands and decisions, and making reciprocal commitments in the public sphere.

The capacity of Brazilian social movements and civil associations to adapt, innovate, be **resilient** during the democratization period, has generated new roles for society (co-production of policies, collaboration, mutual commitments) and for the government. Once the latter is opened to dialogue, a new field of action appeared, one that needs to integrate information and knowledge that comes from the social base.

Society, Participation and Democratization in the Brazilian State: an overview

In the 1980s, the role played by new actors (SADER, 1991), organized in various social movements, strengthened civil society and contributed to intensify the crises of the military rule. They acted upon various spheres of collective life: the struggle for democracy, civil, political and social rights; political and administrative decentralization; strengthening of regional and local decision-making, etc. By the end of the decade, many civil associations had arisen, not only in the political arena, but also in services and fields more and more specialized.

Social movements and associations of the 80s and 90s provided guidelines for transformations, pushing themes to the agenda, such as the case of the health movement (predecessor to what was to become the SUS), the mobilization of Non-Governmental Organizations (NGOs) to provide care to HIV-positive people (which became the current National STD/AIDS Program), the community health workers in the state of Ceará (leading to the Federal Government's Community Health Agents Program), etc. (FERRAREZI, 2007).

> *"The government is much more likely to get it right when it listens to the people rather than when it just hires some expert to design a program. Letting the people participate is to ensure that we will do things more democratically."* (President Lula)

The 1988 Federal Constitution incorporated into the political system forms of participation and representation, especially the plebiscite, the referendum and the law upon popular initiative, which have so far not been frequently exercised. The participation in social policies happens through public policy councils[3], conferences, hearings and public consultations.

Participatory models argue that classical representative institutions have failed to address the quality issues of democracy (SANTOS & AVRITZER, 2002:42). Representative institutions would be far from being able to enforce the rights of society segments historically excluded from public policies and to grasp and fulfill increasingly more diverse and complex demands. Therefore, there's a need to establish spaces for interlocution, providing public instances with information that represents not only the aggregate preferences of the majority, but also interests and demands not previously contemplated by or available to public entities (AVRITZER, 2000: 25-26).

In that sense, participatory spaces would contribute to the creation and sharing of a more comprehensive representation of society's reality and interests, as well as aspects and contexts that restrict or allow public actions. Advocates of participatory models call attention to its ability to break with the concept of immutability and institutional repetition of bureaucratic forms, assuming that better results can be obtained through **experimentation and innovation**, features of participatory experiences (AVRITZER, 2000: 27).

> The institutionalization of participatory mechanisms reveals **new roles** of the State.

In the 90s, recognizing the inability of the State alone to get effective results and adapting to the context of autonomy and participation of new actors in public sphere, the Brazilian Federal Government began to implement changes in its institutional arrangements that culminated in new functions. It was no longer the direct and exclusive provider, rather becoming the coordinator and enforcer of actions and services that could also be provided by civil society, incorporating participatory models and

co-production of public policies. This process was not immune to conflicts and reveals an important change in how State and society used to relate so far in social area in Brazil (FERRAREZI, 2007).

What the National Health Conferences are and how they were developed

Currently, Conferences are defined, according to the National Secretariat for Social Interaction of the General Secretariat of the Presidency (SNAS/SG-PR), as **"democratic spaces where different sectors of society, interested in evaluating, discussing, criticizing and suggesting public policies can meet. They fulfill the important function of building agendas for social dialogue"[4] .**

Traditionally, national conferences are preceded by preparatory conferences at municipalities and states[5]. All stages are conducted directly by the federated entity or with the support of the Ministry or Special Secretariat involved in the Conference, following a single agenda proposed by the federal government. The proposals that emerge from the previous stages are taken to the National Stage for deliberation and definition of priorities for the public policy agenda under discussion.

Conferences usually maintain parity between civil society and state. In many cases, there is a tripartite division, incorporating the "workers' segment" (usually comprising formal class representation, such as unions and confederations). As a rule, participants are elected during the early stages or, in the case of government representatives, officially nominated by the bodies they represent. There are natural members (they don't need to be elected), such as the national council members of the said public policy and, sometimes, national and international observers to the process.

Health Conferences have a long history and have been used under two different perspectives: from 1941 to 1980, as a strictly governmental space; and since 1986, as a space for social participation.

The 8th National Health Conference and the role of the Sanitary Movement: a watershed

As the first conference after the military dictatorship, the 8th NHC, held in 1986, marked a new position regarding the role of Health Conferences. It constituted a privileged locus to present proposals for changes in healthcare, taking advantage of the favorable political context. Driven by the wish to build a framework for the democratic reconstruction of healthcare, government representatives were mobilized, along with representatives of various political and social

segments. The 8th NHC had over 4,000 participants, including 1,000 delegates, of whom 50% were civil society representatives and 50% were representatives of public institutions and SUS workers.

The Sanitary Movement played a key role in organizing and conducting the preparatory stages, as well as the national conference. This movement emerged from the academic milieu in the 1970s, particularly in Preventive Medicine Departments. In the context of dictatorial repression, it was supported by students, healthcare professionals, study centers – especially the Brazilian Center for Health Studies (Cebes), the movement's representative and disseminating body–, the Brazilian Association of Post-Graduation in Public Health (Abrasco), councils, trade unions, parliamentarians and other segments of society (OLIVEIRA, 2005: 47).

The movement evolved from a critique of the dominant model of health care towards the design and defense of an alternative healthcare system (CARVALHO, 1995: 48), involving both political struggle and technical proposals. The movement proposed a radical reform of the health care system, marked "by the financial predominance of welfare institutions and by the hegemony of a technical bureaucracy that worked towards increasing marketization of health" (ESCOREL, NASCIMENTO & EDLER, 2005: 60).

At that time, the system was organized under the social insurance framework, where registered workers paid insurance contributions to the National Institute of Social Security (INSS). In case of illness, they were able to access healthcare. Healthcare was "centralized, institutionally fragmented, with administrative discontinuity, vertical and exclusionary" (BRAZIL, 2009: 15).

The partisans of the sanitary movement aimed to implement a **universal and free healthcare system** that would cover the entire population and would be based, among other pillars, on the community's institutionalized participation.

In this scenario, the 8th NHC was considered the health pre-Constituent Assembly. Its final report proposed the implementation of the SUS, which became the main input for drafting the Health Chapter of the 1988 Federal Constitution. The new Charter introduced social security: regardless of participation in the work market, all Brazilians became entitled to full health assistance, under a model of shared responsibilities between the three federated entities, with the main actor being the municipality.

Also as a result of the Conference, social control and community participation were incorporated into the new legal health framework: conferences and councils became components of the new system.

The health area "was the sector that made it to the National Constituent Assembly with the most widely discussed, legitimized and

complete proposal, containing the ideas of the health movement" (RODRIGUEZ NETO, 2003: 51).

The 13th National Health Conference: challenges of maturity

The description of the 13th NHC illustrates the potential and limits of that forum, observing how it directly affects the country's **democratic governance** and the achievement of **public results**, to the extent that they alter government agendas, incorporate new stakeholders, reshape the role of the State, and extend deadlines for the fulfillment of demands. Twenty-one years after the 8th NHC, the most recent National Health Conference, held in 2007, reveals the challenges ahead, which range from procedural issues related to their functioning to limitations in the incorporation of results by executive authorities.

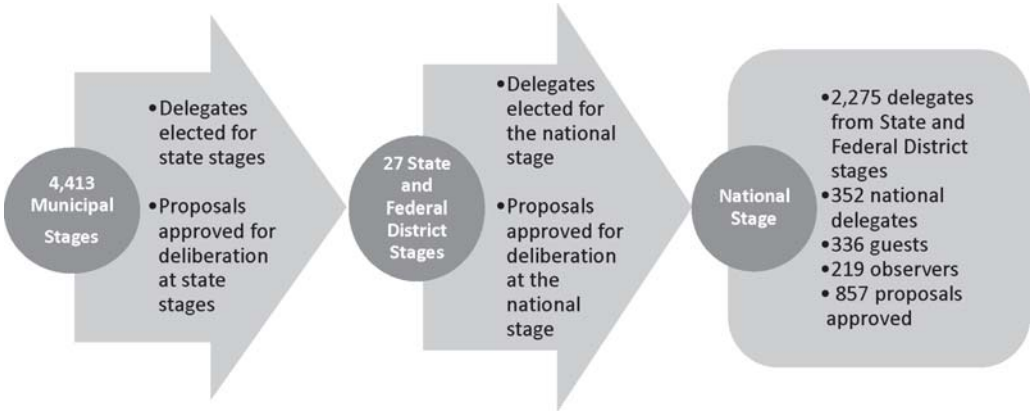
> *"The 8th NHC was historical, but the 13th takes place when SUS has reached its maturity"* (Ministry of Health)

The organization of the 13th NHC: stages, theme, objectives and participants

The 13th NHC began with the organizers of the process filled with expectations. They wanted to avoid the underachievement of works that occurred at the 12th NHC[6]. Promised to be broad and democratic, with methodological innovations and distinctive theme, it was marked by large mobilizations and adoption of controversial positions by the main actors.

The preparatory stages to the 13th NHC were conducted throughout 2007. They were held in 80% of the 5,564 Brazilian municipalities and in all states, which made this Conference the one with the greatest capillarity ever and the most participatory in the history of the sector.

Table 1 - Flow of Stages, Delegates and Proposals of the 13th NHC[7]



The central theme of the 13th NHC was "Health and Quality of Life: State Policies and Development". The selection by the National Health Council (NHC) of an eminently intersectoral central theme, divided into thematic axes geared towards a more preventive approach and linked to human rights, has been mainly supported by representatives of human rights and environmental protection movements. The idea was to overcome a corporate vision, focused on healing and self-centered, that generally permeates the processes of health conferences (healthcare services, social control in health, pharmaceuticals, hospitals, etc.).

Its objectives were to:

- assess the health situation, according to the principles and guidelines of the SUS;
- set guidelines to fully guarantee health as a fundamental human right and as a public policy, conditioned by and conditioning economic, social and human development;
- set guidelines to enable the strengthening of social participation and guarantee the implementation of SUS.

The participants of the 13th NHC[8] were divided into delegates, guests and observers[9].

Acting as delegates, public managers, health workers and SUS users discussed the proposed topics, diverging on many issues and reaching consensus on others; and finally allied to approve and disapprove proposals. The rules that drove the processes of discussion conferred equal rights and prerogatives to all delegates, regardless of their segment.

> *"We in the National Health Council feel a profound pride when we see that this Conference is the result of discussions carried out in all states, which involved more than 4,000 municipalities. Altogether 1.3 million people participated in the debate."*
> (General Coordinator of the 13th NHC)

Over the decades, there is a change in social movements in Brazil with increasing diversification of actors and demands to be included in the government agenda. SUS gradually incorporated new social actors with specific interests, which is reflected today in the composition of participatory spaces (CONASS, 2009: 24-28). A member of the National Organizing Commission (NOC)[10] believes that the 13th NHC gave visibility to actors that were already organized around health issues, such as the lesbian, gay, bisexual, transsexual and transgender (LGBTT) movement, black communities, riverside communities etc.

This became clear with the approval of proposals relating directly to these actors. Their participation, however, did not minimize the involvement of traditional actors.

The NOC was responsible for organizing the 13th NHC, following the deliberations of the NHC and the Ministry of Health[11]. The Commission, in addition to their regimental duties, had a role in mobilizing and articulating representatives, which impacted on the content discussed, positions taken and actors involved[12]. Apart from the General Coordinator of the 13th NHC, who, in compliance with the Statute, was the Chair of NHC, other NOC members were defined by the Commission itself.

Conferences are built upon the consolidation and systematization of the debates of previous stages. The Consolidated Report for the 13th NHC consisted of more than 5,000 proposals. The Reporting Coordination had a key role in the discussions by systematizing thousands of proposals in an objective document, in table format, facilitating group work at thematic plenary sessions.

In order to guide the discussion of the themes, a reference text is generally prepared by the body that convenes the Conference at national level. Instead, they prepared a Roadmap for Discussion and Presentation of Proposals. According to the General Coordinator of the 13th NHC[13], the option to have a document wider than a reference text was motivated by the fact that the latter could not be comprehensive enough to adequately present the complexity of the SUS and embrace the reality of each local context. Thus, there would be an incentive for actors to build creative understandings according to their needs and realities, without limiting the discussion.

The deliberative instances of the National Stage and the methodology for approving proposals

The CON tried to innovate on the debate methodology to avoid damages in the conclusion of the process as occurred in the 12th NHC, working with fewer themes and new discussion methods that were, however, considered controversial by some actors.

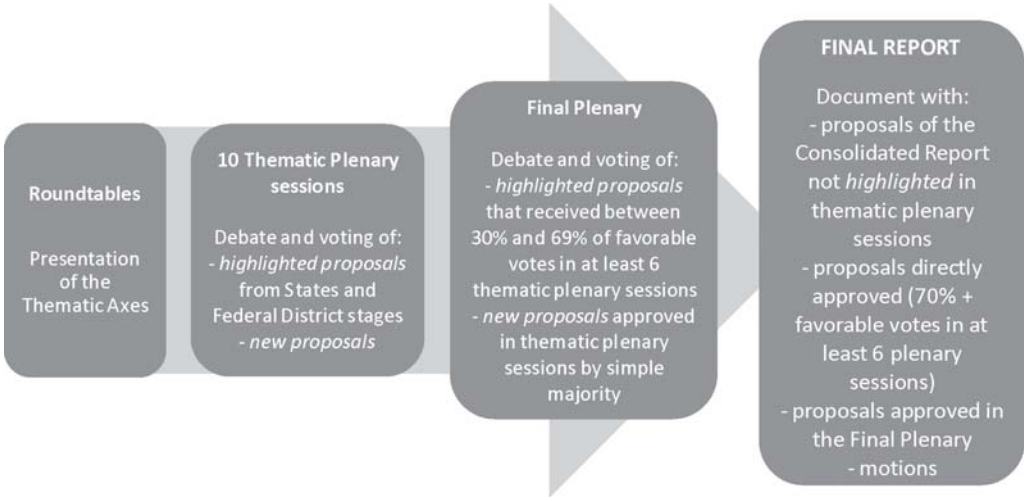
Unlike previous health conferences, in which delegates chose in which specific thematic group they would work throughout the National Stage, the methodology of the 13th NHC allowed all delegates to discuss the three themes in thematic plenary sessions[14].

The National Stage was structured into ten Thematic Plenary Sessions for discussion and voting on the proposals that emanated from state and Federal District stages. To warm up the debate, the thematic plenary sessions were preceded by Roundtables with presentations on each thematic area. Afterwards, the voting on proposals took place –

collectively built statements with the aim of intervening in the government agenda.

At each thematic plenary session, the delegates could only discuss the proposals contained in the Consolidated Report for the 13th NHC and the new proposals presented there (which had not been discussed at any other stage). Amendments to the proposals could only be for *total suppression*, which was criticized by some participants, especially those already used to more flexible rules adopted in other conferences. The possibility of presenting new proposals was not supported by the General Coordinator of the 13th NHC, who considered them a means for a theme to go to the National Stage without having been debated at previous stages.

Table 2 - Deliberative Instances and Methodology of the 13th NHC



In the final plenary, a proposal was approved by simple majority (50% + 1) of accredited delegates. The plenary decided if it was necessary to speak "against" and "pro" a specific proposal before voting. This possibility was questioned by participants who wanted to present their arguments for all delegates, arguing that important issues were not thoroughly discussed in some groups.

For the General Coordinator, this was a major methodological advance of the 13th NHC, since in previous conferences the final plenary session became "*real stages for personal and corporate manifestations; (...) an attempt to approve defeated proposals.*" For him, the methodology allowed a more productive conference and the discussion of all issues by all delegates, preventing the setting of a space free from rules that would be harmful to the process. The intention was to overcome the exhaustion of the traditional conference model that led participants to frustration at the end of the process. In his opinion, the methodological filters established (rigid editing of proposals, possibility of the plenary

to veto the defenses of proposals etc.) allowed the governance of the 13th NHC.

> *"We received a fine legacy from the 8th NHC. What legacy will we leave to the participants of the 18th?"* (Vice-Chair of the National Association of Health Defense Public Prosecutions Offices)

Final Report of the 13th NHC

After the end of the 13th NHC, a Final Report was prepared with 857 approved proposals and 157 motions[15]. Comparing the states' proposals with the national proposals, the result is:

Table 3 - Proposals of the Consolidated Report X Proposals of the Final Report[16]

Thematic Axis	From states (Consolidated Report)			Final Report			
	Presented	Rejected	Rejection %	Approved	New	Total	New %
Axis I	210	17	8.1	193	89	282	31.6
Axis II	284	40	14.1	244	162	406	39.9
Axis III	94	16	17.0	78	91	169	53.8
Total	588	73	12.4	515	342	857	39.9

Source: Ministry of Health and National Health Council, Consolidated Report for the 13th National Health Conference (2007) and Final Report of the 13th National Health Conference (2008)

Attention should be drawn to the low number of proposals rejected (12.4%), and to the fact that 40% of approved proposals in the final report are new.

The final product is a kaleidoscope. There are proposals that only need initiatives from the Ministry of Health; others that depend on actions of the SUS managing bodies of the three levels of government. Some require intersectoral actions within the Executive Branch; there are proposals for other branches that go beyond the deliberative scope of the conference, and there are also proposals that require a combined effort of two or three branches. The degree of feasibility also varies: there are abroad proposals that only indicate a political position but do not describe a specific action, while others include details for implementation.

The content of the proposals is wide-ranging: there are demands focused on the principles of the SUS and on the need to ensure quality healthcare for all, and proposals aimed at specific groups and interests.

Some entail the holding of specialized conferences, as, for example, a national conference on mental health, a national conference on occupational health etc.

There is a tendency to boost the number of final proposals in conferences. The 13th NHC produced 857 proposals, while the 8th NHC approved 49. The increased diversity of actors and interests as opposed to the block formed by the public health movement and convergence of interests that marked the 8th NHC, are increasingly evident characteristics of current participatory processes.

Regarding this issue, the National Council of Health Secretariats (Conass) analyzes: "*While these numbers reflect, on one hand, the increasing complexity of society and interests present at the conferences, they can reveal, on the other hand, the possible loss of substance of approved proposals and the* ***unfeasibility*** *of so many resolutions. It is interesting to compare the number of resolutions of the last two conferences with the 8th NHC, whose historical importance is undoubtedly greater and whose resolutions had a profound impact on the national health policy. This increasing fragmentation of deliberations, which virtually cover the entire spectrum of actions implemented by the system, makes it difficult to identify the guidelines that should conduct health policy and* ***do not allow identification of priorities****."* (CONASS, 2009: 23, emphasis added.)

The Brazilian Association of Post-Graduation in Public Health (Abrasco) also did an extensive analysis of the final report: "*The profusion of proposals, often reiterating resolutions from other conferences, indicates, on one hand, the huge* ***gaps in implementation*** *of health policies and actions, and on the other hand, strongly expresses fragmented and partial aspects regarding the regulation of health professions, the defense of labor markets and health protection of population's segments, which are defined by individual and socio-occupational attributes. In spite of all the positive dimensions of this scenario, a considerable part of these proposals are not directly focused on tackling critical bottlenecks in our system and complex factors that hinder the effectiveness of social policies for Brazilians' health and quality of life." (*ABRASCO newsletter, Editorial, December 2007: 2, emphasis added.)

The final report of the 13th NHC shows that times have changed. The **expansion of participation** made it difficult to achieve consensus and define priorities.

Controversial proposals and redirecting of the government agenda

Among the discussions and interests, emphasis should be given to two issues that polarized the National Stage: decriminalization of

abortion and state-owned foundations under private law. Both issues are important topics for government.

In Brazil, abortion is a crime. It is allowed in only two cases: if there is no other way to save the mother's life or if the pregnancy resulted from rape. For some years the Ministry of Health has considered abortion a public health issue. In his key-note speech, the Minister asked the delegates of the 13th NHC to take a stand "*without fear of discussing the termination of pregnancy*." In his favor, there were organizations in favor of women's rights; against, religious entities, particularly those linked to the Catholic Church.

The Consolidated Report of the 13th NHC included the controversial Proposal n. 37 of Axe 1: "*To ensure sexual and reproductive rights, respecting women's autonomy over their body, recognizing it [*abortion*] as a public health problem, and discuss its decriminalization through a bill of law*."

In the voting of this proposal at the thematic plenary sessions, discussions heated and the conservatives sought to convince the undecided delegates. Despite intense conflict, the proposal was approved in the thematic plenary sessions.

Before the final plenary, the conservative group lobbied intensely. They joined forces with the indigenous movement and other groups and movements in defense of life. The mobilization succeeded. For the voting, despite pressure from the feminist movement to speak out, the final plenary decided that there was no need for defense. Without a final debate, the total abolition of Proposal n. 37 from the final report of the 13th NHC won, under shouts of "Yes to life! Life won!". While the Executive Secretary of the 13th NHC celebrated the victory together with civil society, the representatives of the Ministry of Health suffered their defeat. The final plenary also approved a motion opposing the decriminalization of abortion[17].

For the Executive Secretary of the Feminist Health Network, a movement in defense of health, sexual and reproductive rights of women, the position taken by the delegates of the 13th NHC shows the invisibility of the problems caused by abortion and also that, despite the fact that the State is secular[18], catholic and protestant groups imposed a religious idea, based on the denial of rights rather than their assertion:"*the Conference postponed the debate, but it will return*"[19].

According to the National Council of Health Secretariats (Conass): "*the rejection of this resolution (*proposal*) is a sign of the distance between managers and social movements and represents a clear setback in addressing an issue that generated, in 2005, almost 250,000 admissions to treat complications of unsafe abortion. It is a major cause of maternal mortality* (Conass, 2009: 44). The rejection of the proposal is contrary to

the previous deliberation of the 11th NHC, when the decriminalization of abortion was proposed.

The discussion on the decriminalization of abortion highlights the clash within civil society itself, a topic which has been submitted to several participatory instances without reaching a consensus[20]. Some actors involved are guided by moral and religious values, unlike the Ministry of Health, which supports decriminalization of abortion because of the costs of illegal abortions to public health.

> The more dispersed decision-making and the exercise of power are, the more important the **role of government management** is.

Another polemic proposal was the creation of a new type of governmental entity under private law. It has been supported by public managers and some scholars as a possible solution to bureaucratic and management weaknesses of the system. These new foundations would be more autonomous than entities under public law and would follow a rationale of result-based performance through management contracts. However, since the beginning of the Conference, the proposal wasn't accepted by workers and social movements that saw it as a veiled move towards outsourcing healthcare, which could cause difficulties to labor relations between SUS and its workers, and privatization of the management of hospital units.

Lack of dialogue and information permeated the discussions on the subject. For the General Coordinator of the 13th NHC, the Ministry of Health had been building the proposal "*in an excluding and veiled way",* without debating it at the National Health Council.

The National Council was against the proposal of state-owned foundations under private law and took it to all stages of the 13th NHC. At the National Stage, delegates of users' and workers' segments were advised to not accept the proposal.

At the roundtable of Axis 3, the chair of Cebes, speaking to an audience that was against the state-owned foundations proposal, said that the discussions on that matter should be deepened (RADIS n. 65, 2008: 21). Despite her pleading, the theme was kept at bay in the thematic plenary sessions. Those who tried to argue in favor of it, generally public managers who deal with day-to-day difficulties of the system, were even booed. At the final plenary, no proposal endorsing the government's project on the state-owned foundations under private law was approved and several counter proposals were accepted[21].

The General Coordinator of the 13th NHC celebrated the result: "*all proposals for public partnerships with private companies were rejected. (...) Some people told me they found it an exaggeration, but I believe that the delegates realized that the system is privatized and needs to be restructured"* (RADIS, n. 65, 2008: 14).

For Abrasco, "*the confusing recommendations of the Ministry of Health regarding the presentation of the project on state-owned foundations under private law to the NHC and the eminently plebiscitary nature that sealed its immediate rejection by this forum undermined the essence of formulation of alternatives and construction of new hegemonies and consensus about social control in healthcare*" (ABRASCO, December 2007: 5).

The Minister of Health, one day after the end of the 13th NHC, said to the press that the result regarding state-owned foundations was a "*mistake*", even more so because the delegates did not present alternatives. He said that the government respected the Conference's position, but would continue to advocate at the National Congress for "*a law that allows SUS to operate its hospitals with some efficiency*" (RADIS n. 65, 2008: 10).

With the maintenance of the project by the government, some actors held demonstrations and other forms of protest, handling to congressmen a document containing records of the discussions, decisions of the 13th NHC and SUS guidelines.

Participatory processes can leverage the opposition to government projects – an inherent risk in collective construction of agendas. They are governance mechanisms that highlight the emerging needs of specific groups that no longer organize themselves in blocks and consensual positions, and halt the progress of agendas that were not agreed or in which consensus was not achieved among stakeholders. The democratic governance points out that a long way should be paved before changing public policy agenda.

After almost a year, the largest National Health Conference in history came to an end, in a propitious setting for assessing the role of participatory spaces in the design, control and evaluation of public policies, and for discussing possible adjustments in its dynamics and outcomes.

Concluding Reflections

National conferences stimulate the debate on the emergence of new patterns of relationship between State and Society, and on the management of the state apparatus regarding participatory mechanisms.

It can be said that there was **resilience** in Brazilian social movements and civil associations to boost the democratization process through political mobilization, transformation of public spaces into places for defense and expansion of rights and for the autonomous social action. This process provided new roles for society (co-production of policies, collaboration, mutual commitments). The question is whether society's capacity for resilience, adaptation and innovation will continue in current participatory processes, in a different environment, as now there is a greater complexity of interests and actors involved, with unequal power resources and thousands of alternatives trying to enter the agenda.

> Governments do not act alone. Increasingly they need to work with other actors to achieve results. The focus on **governance** is essential: sharing responsibilities, risks and power is difficult, yet necessary to achieve public results.

The increase of actors and social movements in conferences indicates continuity in the occupation of participatory spaces and a larger number of public policies stakeholders. There is a **democratizing potential** in these spaces because they add information, diagnosis and collective knowledge and enable the development of respect for diversity, interaction, expression of ideas and interests, engagement with public affairs, and dialogic learning. This dynamic produces social and governmental learning, contributing to better results and also civic results.

Conferences can foster **the emergence and legitimacy** of new actors before the State and among themselves; enable recognition of the multiplicity of issues and interests not previously accessible to or considered by the state; and generate mutual commitments. The expansion in participation has a positive value in itself; nevertheless, the increasing complexity of the process brings challenges to its governing model.

When comparing the 13th NHC with the 8th NHC, we realize that in the latter there was consensus about diagnoses, themes and alternatives, with clear public results, since it allowed the creation of the SUS. With the expansion and diversification of participants and interests at the 13th NHC, there was a plethora of resolutions and conflicting positions that made more complex for the government to process the conference's decisions. The risk here may be the low incorporation of resolutions – those that are disparate, fragmented and non-consensual –, which would frustrate expectations.

Moreover, the possibility of presenting new proposals at the national stage brought an unpredictable component that contradicts

the essence of participatory processes, built on dialogue and negotiation. Would this be an attempt to directly capture the emerging issues that come from the social base without passing through the rules and approval filters? Are new proposals inputs that help the government to capture collective intelligence? Or was this a concession to social local bases?

Resilience in government involves experimentation and continuous review of management tools, legal and political frameworks to dialogue and incorporate actors in decision making and transform the knowledge generated into actual results. This is so mainly because the bureaucratic arrangement is slower and less adaptive than the unpredictable current context requires. In the analyzed case, adapting the participatory mechanism to the new social configuration (which is complex, diverse, reflective and participatory), learning from mistakes and reviewing methods and management tools are necessary to facilitate the equitable prioritization and selection of actions that should enter the decision agenda.

Simplification and reduction of alternatives in the decision making process is part of the dynamics of public policies. There is much complex information to process and a broad variety of actors to consult in order to build consensus. There are problems in coordinating so many actors, organizations, interests, alternatives, projects and political decisions. The alternatives are limited by political priorities, technical feasibility, legal constraints and law interpretations that reduce the set of the solutions (FERRAREZI, 2007: 268). Given these characteristics, the profusion of diluted, generic alternatives and the weak materiality of resolutions of the Conference "liberate" the government to define what goes into the agenda, how and when; and obstruct the monitoring and social control.

How can governments cope with multiple, growing and distinct demands of actors that have organization power and are able to impose their themes? What is the representativeness of these interests?

Would the conferences be seen by government leaders only as consultation mechanisms or as effective spaces for developing guidelines for public policies in a particular sector? Given the challenges in transforming the proposals that emerge from the Conference into inputs for public policies, to what extent are they considered spaces for influencing decisions by civil society? To what extent can the government yield a public policy that is considered important, since the government remains the steward of public interest?

In spite of the efforts already undertaken, governments have not yet fully adjusted to the innovations and social settings of recent decades.

It is more about management of governance in a complex environment, enabling flexible and coordinated responses among networks in order to achieve results, connecting the internal processes of organizations with collective intelligence, reformulating spaces, than necessarily creating new structures. The challenge for governments today is to create, restructure and manage democratic forms of governance aimed at achieving better public results.

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Annex A - Program and Development of the 13th National Health Conference

<table>
<tr><th>DAY 1</th><th>DAY 2</th><th>DAY 3</th><th>DAY 4</th><th>DAY 5</th></tr>
<tr><td>Registration</td><td>Voting of Statute
The moment was tense because the statute brought methodological changes to the deliberations, as compared to previous Conferences. Several highlights were requested – 12 out of 28 articles were highlighted for amendment, but only minor changes were approved.</td><td colspan="2"></td><td rowspan="4">Final Plenary

Last deliberative instance of the 13th NHC.

Its goal was "to approve a Final Report that would express the outcome of discussions at the three Stages of the Conference and contains national guidelines for policy formulation for the SUS in the 21st Century".

In addition to approving proposals to compose the final report, the final plenary had the task of approving motions at national level.</td></tr>
<tr><td rowspan="2">Opening Ceremony
With the participation of the President of Brazil, the Minister of Health, the Chair of the Council, other Ministers of State and authorities, besides the participants.</td><td colspan="3">Roundtables
Presentation and discussion on each Theme</td></tr>
<tr><td>Roundtable - Axis 1
The speakers were the General Secretary of the Presidency of the Republic, a representative of the Brazilian Forum of NGOs and Social Movements, the Feminist Health, Sexual and Reproductive Rights Network, and the Technical Committee of Black Population Health.
It addressed issues such as marketization of health, abortion, national development and capitalism.</td><td>Roundtable - Axis 2
The speakers were a representative of the National Movement for Fighting Against AIDS, a researcher from the University of Brasilia, a former congressman of the Workers Party responsible for a bill on financing of public health and the chairman of Cebes.

The themes discussed were intersectoriality, social security and state-owned foundations under private law.</td><td>Roundtable - Axis 3
The speakers were the vice-chair of the National Association of Health Defense Public Prosecutions Offices (Associação Nacional do Ministério Público de Defesa da Saúde), a public health doctor, the chair of Conasems and the chair of the National Confederation of Agricultural Workers.

The session addressed spaces for social participation.</td></tr>
<tr><td rowspan="2">Keynote Speech

Minister of Health</td><td colspan="3">10 Thematic Plenary Sessions
Worked simultaneously as forums for debate and voting on the proposals from State Stages and new proposals, in which approximately 300 delegates, guests and observers participated in each of the 10 rooms.</td></tr>
<tr><td>Thematic Plenary Sessions

Axis 1
Discussion and voting on proposals under Axis 1.</td><td>Thematic Plenary Sessions

Axis 2
Discussion and voting on proposals under Axis 2.</td><td>Thematic Plenary Sessions

Axis 3
Discussion and voting on proposals under Axis 3.</td></tr>
</table>

Annex B - Composition of Participation in the National Stage of the 13th National Health Conference

STAGE	ELECTION AND PARTICIPATION RULES	NUMBER OF PARTICIPANTS	PROPORTION OF PARTICIPANTS
Municipal*	Rules set by the Municipal Health Council + municipal councilors (natural delegates **)	—	—
State***	Elected among the group participating at municipal stages + state councilors (natural delegates)	—	—
National	- 26 states and Federal District: Sending of at least 16 delegates (depending on the population of the state) - 85% of total delegates **** - Natural delegates from the National Health Council + Delegates elected by entities nationwide - 15% of total delegates	2275 delegates from state Stages	Users - 50% Healthcare Workers - 25% Public managers and providers of health services - 25%
		352 national delegates	
		336 guests	Guests - 5% (calculation base: projection of delegates)
		219 observers	Observers - 10% (calculation base: projection of delegates)
		800 support staff	

*Each municipality had a total number of participants and their own rules for guests and observers.

** At all phases, the respective health counselors and substitutes were considered **natural delegates,** which mean that they did not have to go through the electoral process to have voice and vote at meetings.

*** Each state had a total number of participants and also their own rules for guests and observers.

**** For elected delegates, (85% of the national delegation) criteria were established according to the proportion of the population base, and each state had a minimum number of 16 delegates.

Footnotes

[1] The authors thank Paula Montagner and Sonia Amorim for discussions on the research themes, reflections and contributions to the text; and Amarílis Tavares who helped translating the text. Special thanks to Clarice G. Oliveira, who helped to put this text into final form.
This case study was written for the *New Synthesis Project for Public Administration (http://www.ns6newsynthesis.com/)*. The findings, interpretations and conclusions do not necessarily reflect the view of the Brazilian government.

[2] **Elisabete Ferrarezi** is PhD in Sociology at the University of Brasília and holds a MA in Public Administration at the FGV/SP. She belongs to the career of specialist in public policy and government management of the Brazilian Federal Government and serves as General Coordinator of Research of the Brazilian National School of Public Administration (ENAP). **Mariana S. de Carvalho Oliveira** holds a LL.B. of Laws and a MA in Law, State and Constitution at the University of Brasilia. She belongs to the career of specialist in public policy and government management of the Brazilian Federal Government and serves as advisor of the General Coordination of Research of the Brazilian National School of Public Administration (ENAP). **Natália Massaco Koga** is a PhD student in Politics at the University of Westminster. She holds a LL.B. of Laws and a MA in Public Administration and Government. She previously served as Chief of Staff of the National School of Public Administration.

[3] Councils (at national level) are "Sectoral or thematic institutional organizations, with an advisory and/or deliberative and supervisory nature, aimed at producing and monitoring public policies within the federal government." (Definition used in official presentations of SNAS/SG-PR).

[4] Concept used in official presentations delivered by SNAS/SG-PR.

[5] There are recent cases of secretariats and ministries that are innovating within this structure, proposing virtual conferences, free conferences, regional conferences, etc. Free Conferences were first held during the 2007 National Youth Conference and were replicated at the 1st National Conference on Public Security - 1st CONSEG (2008/2009) and at the Conference on Culture and Communication (2009/2010). They are mechanisms that enhance, simplify and diversify the participation of anyone interested in the theme of the Conference: any social group can organize a space for discussion. At the 1st CONSEG, for example, free conferences were held inside prisons, battalions, universities, NGOs, councils etc.

[6] At the 12th NHC, held in 2002, the voting on the priority proposals was not completed, which resulted in 4,000 proposals and hundreds of motions being sent by mail to the delegates, for them to vote afterwards, in a process that delayed the final report by one year (RADIS; Jan/2008: 10) and undermined the deliberative procedure that requires actual presence at the conferences.

[7] At the National Stage, the Statute of the 13th NHC forecasted 3,068 delegates (1,534 healthcare users, 767 health workers and 767 public managers and service providers); however, only 2,627 delegates had their attendance registered.

[8] For more information on the composition of the participants of the National Stage, see Annex B.

[9] Delegates: participants with voice and vote. The general rule was 50% representatives of SUS users, 25% of workers of the system and 25% of public managers and providers of health services[9]. Guests: they had voice in

discussions and were representatives of agencies, organizations, institutions or national and international personalities, with key roles in health and related sectors. Observers: people interested in attending the Conference.

[10] The speaker was interviewed by Mariana Oliveira and Elisabete Ferrarezi in May 2010. His words highlighted throughout the narrative were extracted from this interview, except when another source is cited. More data on the interviewee: NHC council member, representative of healthcare users and member of the Organization and Mobilization Coordination of the NOC.

[11] It was made up of 23 members distributed as follows: 16 directors of the NHC (eight representatives of users, four managers and four employees), two representatives from the Ministry of Health and five guests. The positions of General Coordinator, Secretary General, Rapporteur-General and Deputy Rapporteur, Coordinator of Communication and Information, Organization and Mobilization Coordinator and Coordinator of Infrastructure were chosen from among them. All of them had specific tasks defined in the Statute of the 13th NHC.

[12] The NOC was supported by an Executive Committee, appointed by the Ministry and comprised by representatives of its departments, to provide administrative, financial and technical support and infrastructure for the implementation of its activities. Each level of government and their health councils were responsible for conducting and funding the stages.

[13] The Coordinator of the 13th NHC, also Chair of the NHC, was interviewed by Mariana Oliveira and Elisabete Ferrarezi in May 2010. His words highlighted along this narrative were extracted from that interview, except when another source is mentioned. He was the first elected chair in the history of the Council, a representative from the segment of the workers (National Confederation of Social Security Workers). Until 2004, the Chair of NHC was, by inherent position, the Minister of Health. Elections for the chair were an achievement of council members.

[14] For more information on the composition of the program of the 13th NHC, see Annex A.

[15] At conferences, motions are documents approved by consensus among participants, and are related to other issues than the themes proposed or the instance where it is being discussed. They have a political nature, often presenting a position of "applause" or "rejection." After approval, the motions are forwarded to the appropriate instance.

[16] Table extracted from CONASS, 2009: 18.

[17] Motion n. 106: "*Repudiation to Bill (PL n. 1.135/91) that legalizes (sic) abortion until the ninth month of pregnancy.*"

[18] It should be noted that Proposal n. 157 of Axe 1 of the Final Report of the 13th NHC states: "*To ensure a secular State, so that health issues and public policies are not guided by religious precepts.*"

[19] Interview to Radis, n. 65, January 2008.

[20] The theme of "decriminalization of abortion" also emerged in other national conferences such as the National Conference on Human Rights and National Conference on Policies for Women.

[21] In Proposal n. 42 delegates were explicit: "*To strengthen health management and public health care network and to reject the adoption of the management model through state-owned foundation under private law (...)*". Proposal n. 45: "*Not to privatize the SUS. The 13th National Conference should take a stand against the project of State-Owned Foundation under Private Law (...)*". As a final blow, the plenary also approved a motion against the bill that the government had already sent to Congress to regulate state-owned foundations. Motion n. 28: "*Motion of Rejection of the State-Owned Foundation under Private Law - We, the delegates of the 13th NHC, take a stand against, and reject and demand the withdrawal of bill PL N. 92/2007, submitted to the National Congress, which intends to establish the state-owned foundations under private law, and any model of outsourcing and privatization of public health care*".