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Brazilian Federal District Health council actions regarding the Primary Health Care reform, 2016 to 2018: case study

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Abstract *The Social Participation in Health has been consolidated in the Unified Health System through the efforts of the Municipal, State, National Councils and Health Conferences. The division into municipalities isconstitutionally prohibited in the Federal District and, therefore, there is a District Health Council and the Regional Health Councils. The aim was to describe the profile of the Federal District Health Council, analyzing its actions in Primary Health Care from 2016 to 2018. This was a qualitative case study, with documentary collection using the Iramuteq software. A statistical report of the Health Council Monitoring System and public minutes of the Federal District Health Council were collected, dispensing with approval by the Ethics Committee. The Federal District Health Council is in agreement to what was stated in Resolution 453/2012 of the National Health Council. We analyzed 43 minutes, generating two categories and five classes. It was concluded that the Federal District Health Council originated the reform of Primary Health Care during the study period, through the publication of a resolution that established guidelines for the reorganization of the primary care level.*

Key words *Health systems, Unified health system, Community participation, Primary health care, Qualitative research*

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Introduction

For a long time, Social Control has encompassed a principle of authoritarian and regressive inspiration, practiced by the Government in its relationship with society, assuming repressive characteristics, keeping society inits subservience[1,2]. In the past, there was the opposite of the paradigm of citizenship observed today, despite the fact that society is being controlled by the government'sactions.

Social Control, in a participatory manner and as a component of the Government'sinstitutionality, is a recent reality in the Brazilian historical process, with the 1980s being the theoretical landmark of its institutionalization, namely: constitutionally instituted and ruled by specific legislation and resolutions, of which attributionsare situated in the deliberation, co-management, monitoring, formulation and inspection of health policies at Municipal, State / District and Federal levels[3-5].

Once this history was rescued, we chose to use the term *Social Participation in Health* to refer to the democratic interventions existing in the Health Councils to replace the term *social control in health*. The Social Participation in Health was institutionalized in the Unified Health System (SUS) through Law N. 8142 of 1990 which establishes, among other issues, that the Health Councils are permanent deliberative bodies[4], of which composition equally occurs between 50% of users, 25% of SUS workers and 25% of managers and service providers[5]. In addition to the Health Councils, there are Health Conferences that occur ascendingly(regional/municipal, state/district and national stages) every four years. Health councils and conferences are consolidated as participatory democracy mechanisms, adopted by related areas and also differentones from the health area[6]. Both Councils and Health Conferences, adjusted to the principle of community participation, are public spaces for collective deliberation on the guidelines that must guide the structuring and management of SUS[7].

In this sense, what would be the role of the Health Council in the reform of the Federal Districthealth system? What would the health system be and why reform it? TheHealth System is understood as the set of political and economic relations responsible for the health care of a certain population, which are operationalized in actions, services and pacts, preconized by the conception of health prevailing in the society that implements it[8].

The Federal District is a unique federation entity in the Brazilian reality that requires attention for its singularities, especially in the health sector. The health system reform is a challenge required by the improvement of the health and life conditions of the populations and by the inconclusive processes of public health policy effectiveness of the Federal District. These processes, which areunfinished or undergoing constant implementation, are related to Primary Health Care, as care controller and coordinator of the Health Care Network (HCN), the Psychosocial Care Network (PCN), as well as the processes of regulation, decentralization and regionalization of health. Thus, the aim of this study was to draw the profile of the Federal District Health Council and analyze its performance in the creation, proposal of strategies and in the control of health policyperformancein Primary Health Care from 2016 to 2018.

Methods

This is a qualitative research, based on an intrinsic case study, covering the actions of the Federal District Health Council (CSDF) in relation to Primary Health Care (PHC). Intrinsic case studies are those in which the case constitutes the research object itself, being justified its use in unique or special cases[9].

The assertion that the CSDF is a unique case in the Brazilian reality is justified by the distinct political-administrative organization of the Federal District, when compared to the other Brazilian Federation Units, in spite of the observation of the nonexistence of multiple municipalities, but of 31 Administrative Regions.

According to estimates by the Brazilian Institute of Geography and Statistics (IBGE,*Instituto Brasileiro de Geografia e Estatística*), Brazil has 27 Federation Units, with 5,570 municipalities and a total population estimated at 207 million individuals in 2017. The Federal District is one of these FederationUnits, having Brasília (RA I) as a municipality.

The last demographic census, carried out in 2010, pointed out that there is a population of more than 2.5 million individuals in the Federal District[10]. The estimated population for the year 2017 was over 3 million. The Human Development Index (HDI) of Brasília was 0.824 in 2010, the last year in which the measure ranging between 0 and 1 was conceived[10].

This rapid demographic and territorial characterization, together with the well-known his-

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torical underfinancing, presupposes the existence of a network of complex and at times insufficient health services, according to the capacity of available human and financial resources. The health service network characteristics are related to the performance of the Health Councils, which become more active as the network demands increase[11].

The case study proposed herein was carried out through a mixed methodof research using the convergent parallel study design[12], referring to (i) the descriptive statistics for characterization of the Federal District Health Council profile, based on the existing data in the Health Council Monitoring System (SIACS) and (ii) the document analysis, supported by the internal regulations and minutes of the Federal District Health Council, from 2016 to the fifth month of 2018. The collection period comprised the period between the months of April and May 2018.

The SIACS details the organization, operation and compliance of legal standards related to Social Participation in Health in the SUS. The data for profile characterization, as well as the minutes of the CSDF constitute public documents and are easily accessed, justifying the choice for their analysis. The inclusion criterion consists of updated data (2018) related to the institutionalized spaces of social participation in health in the Federal District.The data exclusion criterion was the fact of having no relevance for characterization purposes, such as administrative data or information on physical and electronic addresses.

The selected analysis period, from 2016 to 2018, was chosen because it is the year after the conclusion of the 9th Health Conference of the Federal District that took place in 2015, the last conference that established the guidelines that directed the health policy in the following years, especially regarding Primary Health Care and the processes of decentralization and regionalization in the region. The end of the study analysis corresponds to the most recent year available for analysis (2018).

Data analysis consisted of basic statistics (absolute numbers and percentages) for the CSDF profile and the creation of a matrix of selection and analysis of the minutes, by carrying out a search using the following keywords: "Primary Health Care", "PHC", "Basic Health Care", "Family Health Strategy", "FHS", "Family Health Program", "FHP" and "Conversion".

The keywords found in the minutes were copied together with the context in which they were found. Based on the selection and analysis matrix, we selected the minutes that had at least one keyword in their content. The minutes were gathered into a text corpus and with the help of a public-domain software, called Iramuteq, it was possible to perform the lexicographic analysis of the content of these documents.Initially the basic lexicographic analysis was performed, which mainly covers the lemmatization and word frequency calculations, multivariate analyses using the Descending Hierarchical Classification (DHC) and post-factorial correspondence analysis[13].

The inclusion criteria of the minutes referred to the minutes of the ordinary and extraordinary meetings of the CSDF, as well as the existence of the descriptors in each selected minute. The exclusion criteria comprised the lack of inclusion of key words in the minutes. As it used secondary and public domain data, itdid not require approval by the Research Ethics Committee (REC). However, the Standard for Qualitative Research Reports[14] was considered to add scientific reliability to the study.

Results

Description of the Federal District Health Council profile in 2018

The Federal District Health Council (CSDF) had an updated registry in the Health Council Monitoring System in 2018. Through the statistical report, as well as the statement provided by the system, it was possible to situate the analyzed council in comparison to other Brazilian councils, as well as in the region of the country where it is located (Table 1). One can observethe concerns about the equality provided by the regulations that institutionalize Social Participation in Health.

At the national level, there was a significant registering of Health Councils in SIACS, also established in the great majority by legal instruments. Similarly, a large portion of the Municipal Health Councils formally established in the Midwest are monitored, which is not the case for the Federal District, specifically.There were six health councils registered in SIACS. Of all the registered councils, five correspond to the Municipal Health Councils and one to the State Health Council, with the latter being related to the CSDF and the other five to the Regional Councils (Table 2). It should be clarified that there are no multiple municipalities in the Federal District, so the

Table 1. Statements of Health Councils in Brazil, Midwest and the Federal District, Health Council Monitoring System, November 2017.

Statement	Tool	Resolution #453/12	With SIACS		Without		Total IBGE
Brazil	Total IBGE	**N**	**n**	**%**	**n**	**%**	**n**
	Lei	3351	4657	82,70	974	17,30	5631
	Decreto	99					
	Portaria	35					
Midwest	Lei	274	411	81,39	94	18,61	505
	Decreto	13					
	Portaria	5					
DF	Lei	0	6	16,67	30	83,33	36
	Decreto	2					
	Portaria	3					

Source: Health Council Monitoring System, DATASUS, 2017.

Table 2. Statistical Report of the Federal District Health Councils in the Health Council Monitoring System, November 2017.

Type of Council	n	%
State	1	16,67
Municipal	5	88,33
Creation tool		
Decree	2	33,33
Ordinance	4	66,67
Internal Committees		
Yes	3	50
No	3	50
Periodicity		
Monthly meeting	4	66,67
Biweeklymeetings	2	33,33
Total	**6**	**100**
Total health councilorsper segment	**n**	**%**
Users	84	50
Health care workers	42	25
Service providers	8	5
Managers	34	20
Total	**168**	**100**

Source: Health Council Monitoring System, DATASUS, 2017.

Municipal Councils to which the SIACS refers to correspond to the Regional Councils of five Administrative Regions of the Federal District.

The CSDF is a permanent instance of SUS social participation. It was instituted through Decree n. 2,225 of March 28, 1973, with its Internal Regulations being formalized in Resolution n. 32, dated of November 22, 2011. According to the characterization obtained through the SIACS, it is a council chaired by a representative of the user's segment, female, with age ranging from 51 to 60 years. It performs the training of counselors, has its own headquarters, as well as an Executive Board and Executive Secretary with a College/ University degree.

The CSDF consists of 28 health councils, 14 of which correspond to the user's segment, 7 to the worker's segment and 7 to the segment of managers and service providers. It states that it is in agreement to what is established in Resolution n. 333/2003 of the National Health Council. According to internal regulations, minutes of the meetings and information on the CSDF website, the council has budgetary allocation, uses permanent committees, performs and participates in training processes.

Ordinary meetings are held monthly, and when necessary, special meetings are held; the president may belong to any segment, as long as they are chosen through vote, meetings are open, and the public has the right to speak when previously authorized by the full board.The meetings are published on the website of the Federal District State Health Secretariat (SHS-DF).

Federal District Health Council Actions regarding the Primary Health Care Level Conversion

It was observed that 23 minutes (53.5%) were related to ordinary meetings and 20 (46.5%) to extraordinary meetings of the Federal District Health Council. The included minutes (n = 43) resulted in 81.1% of the total collected (Figure

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1). The mean health councilors' participation in the studied period (2016 to 2018), by segment, resulted in 37.81% for the user's segment, 29.4% forthe health workers' segment, 26.2% forthe managers' and service providers' segment and 6.6% of justified absences.

The corpus of the minutes, analyzed by the IRAMUTEQ software, recognized 43 units of texts from the Descending Hierarchical Classification (DHC). We identified 2,957 text segments, retaining 86.74% of the total, which generated 2 categories of analysis, one containing 3 classes and the other containing 2 classes, with 5 classes in total (Figure 2). The software divided the corpus into three subcorpus: the first comprising classes 2 and 3, the second comprising classes 1 and 4, and the third comprising classes 5 and together with classes 1 and 4.

Detailing of the Descending Hierarchical Classification (DHC)

Class 1, termed "The social participation between legal, political adequacies and of management models", accounted for 21.6% of text segments. The main elements (words) related to this class were: politics, public, dialogue, management, social control, politician, and worker, among others (Figure 2) The content of Class 1 dealt mainly with subjects related to management models, including the social participation in the legal and ideological scope in this process. The excerpts shown below outline this context:

Excerpt 1. [...] *Said that the user's participation is important, and it is up to the users to say whether the answer was to their satisfaction or not, reaffirmed the importance of the user in the decisions and deliberations, praising the social participation regarding the of health policy decisions in the DF.*

Excerpt 2. [...] *Said that the manifestation of the council has been carried outthrough the public model and format and considered it important to have a discussion before other proposals regarding management models, Institutes, Oscips, etc. appear. He stressed that the council must manifest itself.*

Excerpt 3. [...] *Said he thinks it is unfair to users to withdraw the possibility of stringently analyzing the issue and said that as a manager he has the obligation to analyze all management models and as along-time manager he recognizes in each model advantages and disadvantage, ass none is perfect.*

Class 2 entitled "Rite of regulatoryconductionof meetings: performance of the councilors in relation to the management instruments being discussed", was responsible for 18.8% of the text excerpts. The main segments related to this class were: committee, president, meeting, opinion, plenary, RAG (Annual Management Report), CSDF (Federal District Health Council), highlight, referral, voting, counselor, among others (Figure 2).

The content of this class depicts the formation of the several committees in order to qualify the debate, conveys the organization of the Re-

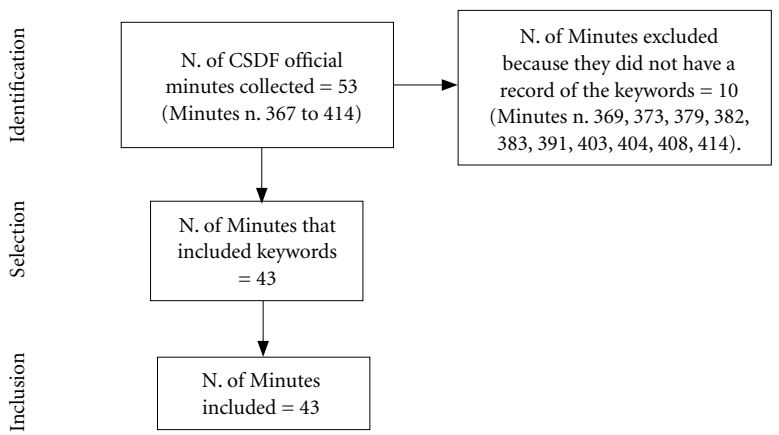

Figure 1. Flowchart of the selection process of the Federal District Health Council minutes, from 2016 to 2018.

Source: Federal District Health Council Official Minutes, January 2016 toMay 2018.

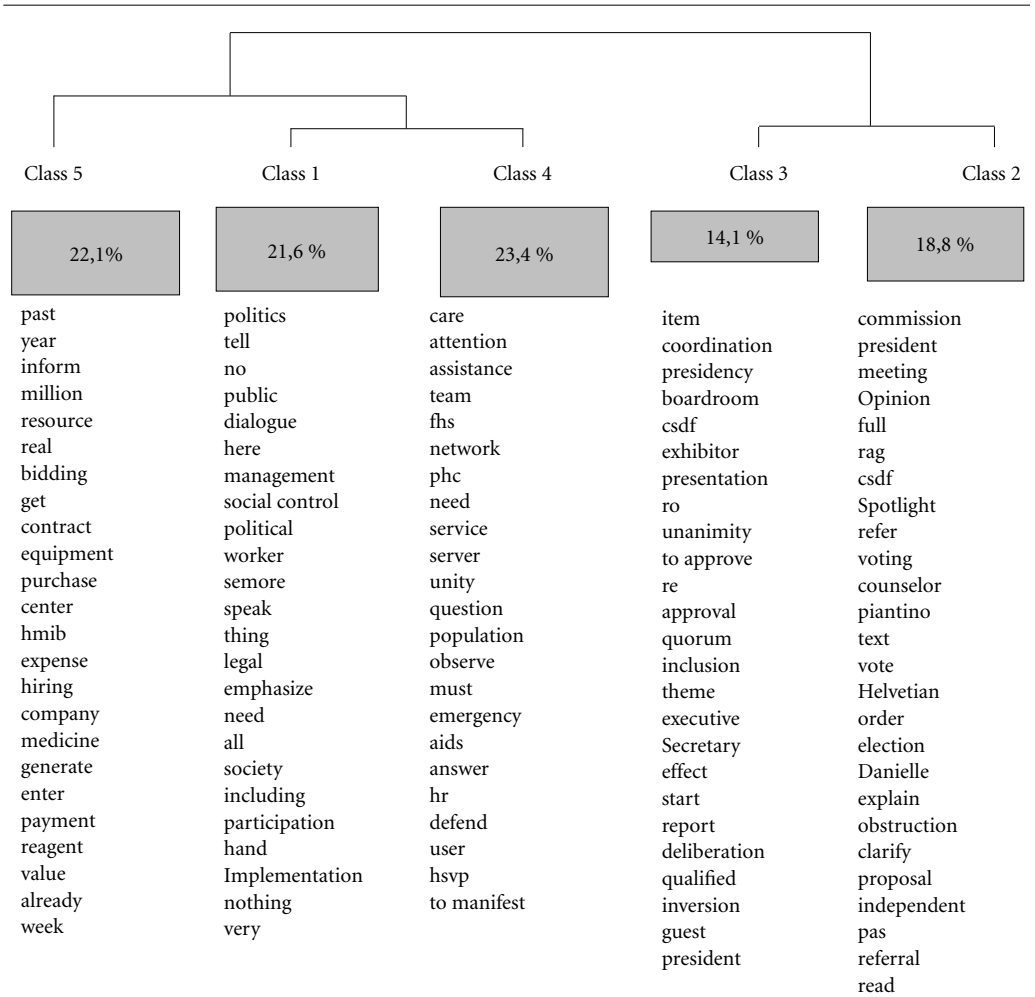

Figure 2. Descending Hierarchical Classification of the contents of the CSDF minutes selected from January 2016 to May 2018, Brasília, DF, 2018.

Source: Corpus processed in the Iramuteq software, version 0.7 alpha 2

gional and District Health Conferences, as well as the commitment to implement the proposals coming from the conferences, regarding the management decentralization. It describes the activities of the councilors through ordinary and extraordinary plenary meetings of the council, committee meetings, meetings with the legislative chamber, with the attorney general's office and the Superintendences.

Excerpt 1. [...] *proposed the implementation of a committee whose fundamental base is the PHC technical chamber,consisting mainly of individuals from the SHS management to define the PHC strategic plan for the DF.*

Excerpt 2. [...] *in a health seminar in which only representatives of the workers' segment were present and stressed the importance of the seminar ... reminded that it is necessary to verify the budget for the health conferences of 2017.*

Excerpt 3. [...] *president of the CSDF stressed that the decree was not a unilateral act of the governor; he carried out what was approved at the 9th conference, corroborating with all previous conferences that recommended the health management decentralization to regional.*

Class 3, characterized as "Rite of regulatory-conduction ofmeetings: administration, procedural developments and completion of several is-

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sues", was responsible for 22.1% of text excerpts. The main elements related to this class were: coordination, chair, board of directors, CSDF, exhibitor, presentation, agenda, among others (Figure 2). The content of this class portrays the presentation of the topics / items discussed in the agenda in the Health Council Plenary, inclusion and / or inversion of items and approval of the agenda through the voting process, as well as an appropriate quorum for deliberation and approval of the annual managementreport, annual health plan and minutes. The excerpts below show a close definition:

Excerpt 1. [...] *Read the agenda and proposed the inclusion in the agenda of the approval of the calendar of the CSDF meetings for 2018, in addition to the presentation of the minuteof resolution N. 491, suggesting that this should be the first item, followed by the appraisal and approval of the calendar of CSDF meetings for 2018, presentation of the annual RAG management report for 2016 and, lastly, the PHC service infrastructure in health.*

Excerpt 2. [...] *President of the CSDF started the meeting explaining his motivation and then gave the floor to the presentation, discussion, and deliberation of the ... 2017 annual health plan.*

Excerpt 3. [...] *President of the CSDF started the meeting presenting the minutes for approval, until the quorum for deliberation was established, quoted and clarified to theplenary the content of resolution 465 of the CSDF that deals with representativeness.*

Class 4, called "Instruments and actions aimed at the structuring of Primary Health Care as a regulator of the service network and levels of health care", accounted for 23.4% of the text segments, showingthe greatest percentage in the analysis. The main elements related to this class were: care, attention, assistance, equip (equip, equipment), FHS (Family Health Strategy, Network, PHC, (Primary Health Care), necessity, service, family, civil servant, unit, question, population, and observe, among others (Figure 1). The content of this Class depicts how often the health care levels of SUS were discussed during the studied period, mainly related to PHC and the future perspectives of Secondary Attention structuring.

Excerpt 1. [...] *Thus, as a personal highlight, PHC acts as a regulator through the identification of users' needs, while coordination is management, and when we reach the other levels of health care, the main levels must be clearly defined in the PHC reform itself.*

Excerpt 2. [...] *Has drawn attention to the logic of the PHC, as the question of where the workers are assigned to in the network has already been brought to the CSDF, that it is necessary for the CSDF to bring to bear this responsibility of discussing the allocation of HR in the network.*

Excerpt 3. [...] *Thanked the SHS for having considered the work of the permanent committee and emphasized that changing workers'assignments is difficult, but there are plans to achieve success and commented that is the correct path, as one cannot perform PHS except through FHS.*

Class 5, identified by "Temporalities for bidding, hiring, purchasing, performing and payment of supplies and personnel", accounted for 22.1% of the text segments. The main elements that are related to this class were: past, year, inform, million, resource, real, bidding, obtaining, contract, equipment, purchase, center, among others (Figure 2). The content of this class discloses the recurrent discussions of the CSDF regarding the inspection and hiring of services and personnel, as well as of bidding processes and purchase of supplies. The excerpts expressing this context are shown below:

Excerpt 1. [...] *Concluded the presentation by explaining the need to extend for two more years the processes of acquisition of materials and supplies through a CSDF deliberation.*

Excerpt 2. [...] *Mentioned as a second step that when it is possible to organize adequately the SUAG health fund,aiming to have good hiring and cost regulation routines, the regions will be trained so they can perform their own actions and then it will be the responsibility of the regional superintendents to do that.*

Excerpt 3. [...] *Said there is a lack of human resources in the SHS as a whole, in both heart surgery, surgical center, but there is also a lack of hiring, procurement and maintenance processes.*

Discussion

Evidence on the deliberative behavior of the Federal District Health Council (CSDF) worked as a trigger to conduct a discussion based on the understandings related to deliberative democracy. Expressive international scientific contribution on deliberative practice started to associate it with the effectiveness of deliberation[15,16].

The possible consequences of political decisions affect those who make them. This is a hypothesis, presented by Habermas[17], widely accepted in the theory that establishes deliberative democracy. In association with it, we found a Health Council in constant activity, conduct-

ed by a representative of the users' segment. In what aspects could the CSDF profile influence the products decided by this instance?The CSDF –when compared to the national scenario with more than 4,600 legally established Health Councils,and to the Midwest region,to which it belongs, with more than 400 legally instituted Health Councils –have the challenge of representing, together with the Regional Health Councils, the demands of more than two million users, as well as the complexity of the health system in the region with a predominance of health facilities under the direct administration of the State Health Secretariat of the Federal District (SHS-DF).Based on structural issues, the described results have demonstrated that the CSDF has its own headquarters, budget allocation, as well as a Board of Directors implemented with parity, uses permanent committees, performs and participates in training processes. Such data in the literature refer to the institutional design, which focuses on dynamics and functioning, on the definition of rules and norms, reflecting the democratizing potential of health councils[18].

Moreira and Escorel[19], when researching more than five thousand Brazilian municipalities, discussed issues related to the structuring of councils based on three factors: (i) autonomy, (i) organization and (iii) access. Regarding the autonomy (i) variable, the results found pointed to the structural difficulties of the health councils,such as the lack of a ground telephone line, Internet access, human resources, a head office for operation, as well as budgetary autonomy. The most serious situation was observed in municipalities that had up to 50,000 inhabitants, that is, in this case, the population factor was strongly associated with the autonomy[19]. Regarding the organization (ii) category, the results were negative in relation to the participation in training, internal operation committees, being positive only regarding the frequency of meetings, which is monthly[19]. This differs from the reality presented by the CSDF, which shows autonomy and organization based on the listed parameters.Access (iii) was the best evaluated dimension among the Brazilian municipalities, signaling the possibility that political actors may assume the presidency of the council according to the legal scope, supported by the internal regiments of the councils, as well as ensuring thepopulation'sparticipation during the ordinary meetings[19]. This fact resembles the reality evidenced in this case study of the Federal District.

The Health Councils, in the 1990s, became institutionalized and expressed the need for an approximation between Government and society. They formalized the participation of society and the social control in the construction of the political health agendas, being influenced by the national political situation[20]. Based on the analysis of the minutes and the constitution of thematic classes, it was verified that in fact the national situation of the SUS organization in Health Care Networks (RAS), with Primary Health Care (PHC) as the health serviceregulatory body was predominant in the health agenda of the Federal District during the studied period.

The references to Resolution 465, dated of October 4, 2016, of the CSDF, showed that this legislation materializes the guidelines proposed at the 9th Health Conference of the Federal District, allowing the implementation of the PHC conversion in the Federal District, determining that the Family Health Strategy (FHS) would be considered the priority strategy of SHS-DF, being responsible for the redistribution of health professionals already found in the human resources structure of the department, as well as the reorganization of the healthcare model of the Federal District public health network.

The resolutions of health councils have already been the subject of studies and problematizations, in which their existence as an instrument of social control or bureaucratic document was considered, suggesting the practice of the council away from its role of proposing health policies, but focused on the approval of already established programs and projects of the health secretariat to which it was associated[21]. In contrast, at least regarding this situation related to the PHC Reform in the SUS / DF, anexperience that was distant from the CSDF was disclosed, in leading the reform of the PHC model embodied in Resolution 465/2016.

Up to 2017, the coexistence of the traditional model and specialties in the Basic Health Units with the Family Health Strategy (FHS) prevailed in the Federal District PHC, which in fact had a great impact on the overall restructuring of health services at this level of care.The CSDF case study differs from the findings of Van Strallen[11], who concluded that councils have little impact on health service restructuring, whereas it agrees with Dúran and Gerschman[20] regarding the need for an approximation between Government and society for the construction of political health agendas.

There is no doubt that the Constitution of the Republic and the infraconstitutional legislation create a model of public management that seeks

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to stimulate the population's participation in reaching the full exercise of citizenship, with social participation beingin close harmony with the process of democratization of the public power, as it advocates the democratic principle.The construction of consensus, therefore, is the method that allows and consolidates the conditions for greater social access and participation in the decisions of public managers, and the meetingof the different interests of multiple social groups, paving the way for the responsible exercising of citizenship[22].

Social participation in the public health management of the Federal District wasdemonstrated in the analysis of the minutes, since their contents showedthe discussion of the management models, the creation and structure of permanent committees, the consensuses and debates for deliberation of varied subjects, among which are the restructuring of Primary Health Care, analysis of Annual Management Reports, Annual Programming and Health Plan, voting, approval, inspection and participation in hiring services.

However, despite having a co-management character, the deliberative democracy within the CSDF is the result of the voting process carried out in its plenary sessions and not the result of debates that reach a consensus, that is, the process of exchanging ideas, the production of divergent proposals and the search for consensus, must precede the votes. This process was not evidenced in the minutes. For those whodeliberate, not all topics and subjects should be submitted to deliberation[23].

Regarding the CSDF, it is necessary to seek congruences between the Health Conferences' guidelines and the topics and demands that emerge circumstantially. The advances achieved in the Federal District health policy through social participation are plentiful, including the actions of the Regional Health Councils and also of the most assorted Health Conferences held in the region.We highlight the advances in the consolidation of SUS as a Government policy that has PHC as a component and a preferential gateway to the service network, capable of meeting 85% of the population's health needs[24] and the search for effective achievementof organizational and doctrinal principles, such as decentralization and regionalization, as well as integrality and universality, respectively.

Final considerations

It is sensible to characterize the Health Council of the Federal District as a permanent and deliberative instance of social participation in health of the SUS, which aggregates the segmented and equal representations of managers, workers and users. These social actors timely and jointly constructed a new organization of PHC services in the Federal District, aiming at increasing coverage, expanding service provision and guaranteeing the right to health.

The descending hierarchical classification showed that Class 4, called "Instruments and actions aimed at the structuring of Primary Health Care as a regulator of the service network and levels of health care", as the most frequent category (23.4%), among the five existing classes. Thus, we demonstratedthe central role performance that the Federal District Health Council exercised, concerning the origin of the primary health care model reform in the region,by proposing and creating a specific resolution that included guidelines and had an impact on decision-making by the SHS-DF, namely: Resolution 465/2016 of the Federal District Health Council, which preceded Ordinances 77/2017 and 78/2017,which established the Primary Health Care Policy in the Federal District.

Collaborations

DSS Vilaça, DS Cavalcante and LM Moura participated equally in the study design, definition of objectives, data analysis, writing and final review of the manuscript.

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